Summer 2008 Volume 23, Number 4

ASAM News

Newsletter of The American Society of Addiction Medicine

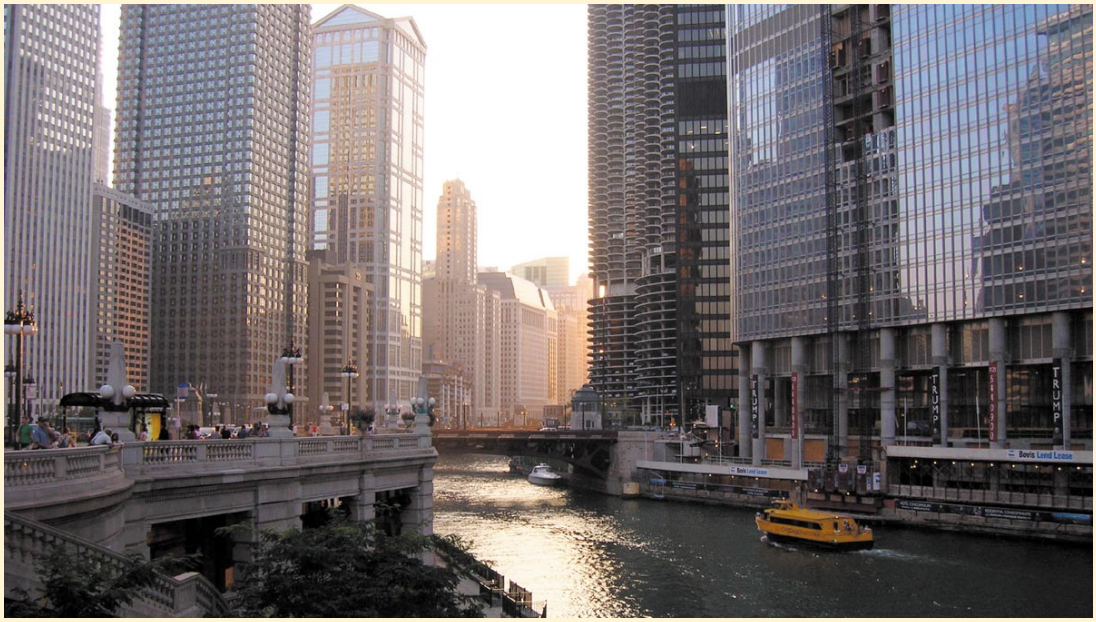
Inside

ASAM at Work for You:

Other News:

The Fall 2008 issue of *ASAM News* will feature the Presidential candidates' positions on issues relevant to Addiction Medicine. Watch for it!

WWW.ASAM.ORG



ASAM Sets Review Course for Chicago October 26th–28th

ASAM's 2008 Review Course in Addiction Medicine will meet Sunday, October 26th through Tuesday, October 28th, at the Westin O'Hare Hotel in Chicago. Co-chaired by Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM, the Review Course is designed to meet the needs of multiple audiences, including: (1) physicians who are preparing to take the ASAM Certification/Recertification Examination; (2) addiction specialists who seek an update on recent developments in addiction practice; and (3) primary care physicians, nurses, counselors and others who seek a succinct review of the knowledge needed to successfully identify and manage patients whose problems are caused or complicated by alcohol, tobacco or other drug use. *(For more information, see page 28 of this issue.)*

The course is approved for up to 21 Category 1 CME credits. For additional information or to register for the Review Course, visit the ASAM website at **WWW.ASAM.ORG** or contact ASAM's Department of Conferences & Meetings at **301/656-3920**.

American Board of Addiction Medicine is Launched

A major step toward specialty recognition of addiction medicine occurred in April, with the inaugural meeting of the American Board of Addiction Medicine (ABAM) and The ABAM Foundation. (The purpose of the Foundation is to support ABAM by defining the field of addiction medicine, conducting seminars for medical leaders, policymakers and the media, and developing fellowship training programs in addiction medicine.)

At the meeting, the following distinguished individuals assumed their posts as Specialty Directors: Hoover Adger, M.D., M.P.H., M.B.A. *(Pediatrics and Adolescent Medicine);* Richard D. Blondell, M.D. *(Family Medicine);* Kathleen T. Brady, M.D., PH.D. *(Psychiatry);* Gail D'Onofrio, M.D., M.S., FACEM *(Emergency Medicine);* Larry Gentilello, M.D., FACS *(Surgery);* Kevin Kunz, M.D., M.P.H., FASAM *(Preventive Medicine and Public Health);* Robert J. Sokol, M.D., FACOG *(Obstetrics and Gynecology);* and Jeffrey Samet, M.D., M.A., M.P.H. *(Internal Medicine).*

The new Specialty Directors joined seven Honorary Directors (Drs. Andris Antoniskis, Sheila Blume, Barry Stimmel and Norman Wetterau at ABAM, and Drs. Robert DuPont, Stanley Gitlow and Gary Jaeger at The ABAM Foundation) in conducting the inaugural meeting. Most of the discussion revolved around selection of seven At-Large Directors, who are to be elected by a vote of the Specialty Directors, the two MSAG Co-Chairs, and the Executive Vice President of ABAM or his/her designee.

As noted by ASAM President Michael M. Miller, M.D., FASAM, FAPA, "The very act of setting up ABAM sends a clear message to ASAM's members and the larger medical community that addiction medicine is moving forward" *(for more on the inaugural meeting, see page 5).*

ASAM Conferences Mark Progress in Addiction Medicine

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

Eileen McGrath, J.D

At the opening plenary session of ASAM's 2008 Annual Medical-Scientific Conference in Toronto, three important Federal officials reported real progress in understanding the disease of addiction. In my mind, this session embodied the excitement of current advances in the field, as well as the reason ASAM's educational programs are an important service to our members and the field of addiction medicine. As evidence, consider the following reports:

NIAAA Offers Interactive Training

Mark L. Willenbring, M.D., Director of the Division of Treatment and Recovery Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), used his Med-Sci presentation to announce the release of a Web-based, interactive training program that will help clinicians identify and treat patients with varying levels of alcohol use disorders. The program, "Video Case Studies: Helping Patients Who Drink Too Much," features four 10-minute case scenarios, each showing a physician interacting with a patient who has a different level of alcohol use. Each video is led by a clinical expert who offers insights into how to use specific criteria to reach a diagnosis, develop a treatment plan, and design follow-up strategies.

The video case studies program also includes a 20-minute tutorial based on the NIAAA Clinician's Guide, released last year. The program is available at no cost on the NIAAA Web site (**WWW.NIAAA.GOV**). It requires an hour to complete and can be studied for CME credit. The Web site also provides patient education materials.

NIDA's Research Addresses Medical Complications

Jag H. Khalsa, Ph.D., Chief of the Medical Consequences Branch in the Division of Pharmacotherapies and Medical Consequences of the National Institute on Drug Abuse (NIDA), reported on NIDA-supported research into underlying mechanisms of addiction, co-occurring medical disorders, and the role of genetics.

Specifically, Dr. Khalsa described NIDA's collaboration with researchers in Iceland to investigate genetic influences on the development of addiction and co-occurring medical disorders, such as HIV, hepatitis C, tuberculosis, and sexually transmitted diseases. Understanding such genetic vulnerabilities can enhance both prevention and treatment strategies.

CSAT: Progress Against HIV

Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment (CSAT), reported progress in reducing rates of HIV infection in drug-using populations. He cited a Federal report showing that in 2006, transmission of HIV in adults and adolescents by injection drug use declined to 13%. Among those with newly diagnosed HIV, the rate of transmission via injection drug use dropped from 34% to less than 20%. "We have made important progress in the HIV arena for children under 13," Dr. Clark concluded.

Such successes in combating HIV/AIDS are the result of a concerted effort among the drug-using community, persons in recovery, and organizations such as ASAM and CSAT, Dr. Clark said, adding that "I want to commend all of you who are working on communicating the relationship between injection-drug use and HIV. You are accomplishing something. We have made a significant public health change....in the arena of injection-drug use. The addiction community needs to feel proud of this."

Conclusions

The opening plenary was followed by many other excellent presentations. Not all reported successes – some were devoted to discussions of what we still don't know. Yet all contributed to the general understanding of addiction and its co-occurring conditions and complications. For this, we are grateful to all the participants — faculty and audience alike.

I hope you will make your own contribution — to your own career, to your patients, and to your Society — as a participant in a future ASAM conference.

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

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

Officers
President
Michael M. Miller, M.D., FASAM, FAPA

Immediate Past President
Elizabeth F. Howell, M.D., FASAM

President-Elect
Louis E. Baxter, Sr., M.D., FASAM

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

Treasurer
Stuart Gitlow, M.D., M.P.H., M.B.A.

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

ASAM News
is an official publication of the American Society of Addiction Medicine. It is published six times a year. Please direct all inquiries to the Editor at ASAMNEWS1@AOL.COM or phone 410/770-4866.

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

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

Founding Editor, 1985-1995
Lucy Barry Robe

Editor
Bonnie B. Wilford

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

Advertising
Advertising rates and schedules are available on request. Please direct inquiries to the Editor at 410/770-4866 or email ASAMNEWS1@AOL.COM.

Web Site
For more news visit ASAM's web site at WWW.ASAM.ORG.

SENATE, HOUSE REACH PRELIMINARY AGREEMENT ON PARITY LEGISLATION

Employers soon may be required to provide employees with coverage for addiction services and at parity with benefits for other medical and surgical care if a compromise parity bill is signed into law. The Wall Street Journal reported July 11th that House and Senate negotiators had reached agreement on a policy framework for legislation that contains elements of a Senate parity bill (SB 558) the Bush administration supports, as well as a broader House measure (HR 1424) the administration opposes. Rep. Patrick Kennedy (D-RI) is a chief architect of the House parity bill. Senators Edward Kennedy (D-MA) and Pete Domenici (R-NM) are key backers on the Senate side.

If passed, the compromise bill would expand the Mental Health Parity Act of 1996 by requiring that benefits for mental health and addiction services would be required to be on par with medical and surgical benefits, including treatments such as hospital stays, physician visits and cost sharing such as copayments, deductibles and out-of-pocket expenses. If a plan offers medical coverage for treatment outside its provider network, it must offer the same for mental health and addiction treatment. The legislation would exempt employers with fewer than 50 employees.

While many business groups endorse the basic concept, some say they are concerned about the legislation's potential impact on health care cost and coverage. Currently, insurers and health plan sponsors are able to restrict the level of mental health coverage and set higher co-payments for treatment of mental health conditions than for other physical ailments.

The compromise won the support of business groups because it does not mandate coverage of specific conditions or add liability risks under State laws. Many business and employer groups prefer the compromise version because it does not include the broad mandate to cover all illnesses cited in the DSM-IV, said Lisa Horn, manager of health care in the governmental affairs department for the Society for Human Resource Management (SHRM). Unlike the House version, the compromise bill also does not mandate out-of-network coverage if any other medical benefit is offered out of network. Horn told the *Wall Street Journal* she believes lawmakers could reach a compromise and pass legislation before the current session comes to a close in mid-September.

Peter Newbould, Director of Congressional and Political Affairs for the American Psychological Association (APA), agrees that there could be legislation in final form this year. If passed and signed into law this summer, the effective date of the legislation could be as early as January 2010, he said. The APA, which had endorsed the Senate version of the bill.

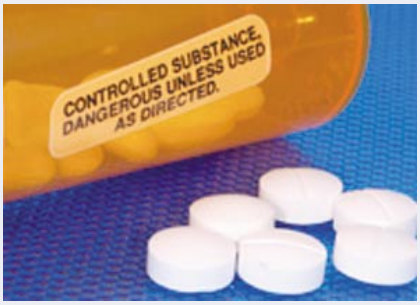
James Gelfand, Senior Manager of Health Policy for the U.S. Chamber of Commerce, agreed that the current system needs to change. "And if done correctly, it will have minimal impact on the bottom line" while preserving employers' rights to offer benefits, he said. The key is going to be providing parity while keeping it affordable and manageable.

Karen Ignagni, President and CEO of American's Health Insurance Plans, said her group supports the compromise legislation and that she does not believe the agreement would lead to insurers dropping coverage for mental health or addictive disorders.

Negotiators said the agreement would cost about $1.3 billion over five years and $3.4 billion over 10 years, mostly because of lost tax revenue. The plan would affect insurance coverage for 113 million Americans, including 82 million who are enrolled in Federally regulated plans that are funded by employers and 31 million who are enrolled in State-regulated health plans. *Source: Zhang/Fuhrmans,* Wall Street Journal*, July 11, 2008*.

Proposed DEA Rule Would Allow E-Prescribing

The U.S. Drug Enforcement Administration has announced a proposed rule that would allow electronic prescribing of medications classified as controlled substances. The rule likely will include security requirements to ensure the legitimacy of prescriptions for controlled substances, which account for about 10% to 13% of all U.S. prescriptions. The proposed rule — which requires a public comment period — would apply to medications in Federal Schedules II (the most restrictive, containing amphetamines and the potent opioid analgesics) through V (the least restrictive, containing cough and cold preparations).



Fewer than one in 10 U.S. physicians currently use electronic prescribing. Surveys show that many have been reluctant to invest in the required technology because of costs and concerns about DEA restrictions. The new rule, in conjunction with a Medicare bill that would tie reimbursement to physicians' use of electronic prescribing, could spur widespread adoption.

Source: Fields/Wilde Mathews, Wall Street Journal*, June 20, 2008.*

★ ★

See the Fall 2008 issue of ASAM News for the Presidential candidates' positions on issues relevant to Addiction Medicine.

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

How Can ASAM's Annual Meeting Address Your Needs?

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

One of the things ASAM members like best about ASAM is the Annual Medical-Scientific Conference — a time when we can get together with other physicians who share our interest in the care of patients with addiction (an interest unfortunately not shared by most of our colleagues "back home"). The educational content improves our knowledge and helps us build our skills so that we can do a better job of caring for patients, and the CME credits are really helpful in meeting requirements for continuing education in an efficient and cost-effective way. ASAM meetings feel like "coming home" to many of us, because they allow us to maintain friendships over the years. For some of us, attending 12-step meetings during Med-Sci week has a unique flavor.

But for others, one of the worst things about ASAM is the way we run our Medical-Scientific Conferences — it's just such a grueling grind, often keeping us going from 7:00 a.m. to 11:00 p.m. several days in a row. Many note that this is no way to achieve "life balance"!

The Medical-Scientific Conference is exactly that — a CME event. But we try to build around the educational events a number of "business activities" for our medical specialty society. The challenge always has been in where to find the time — time for ASAM chapters to meet; for specialty caucuses such as the Family Practice or Psychiatry Committees; for Councils and Work Groups, which usually meet via teleconference, to hold one face-to-face meeting a year. And if we do find time for those activities, what educational opportunities will we have to give up in order to participate in them? What other meetings will compete with the meeting that we feel we must attend?

Then there is the issue of our Component Sessions. They are an important part of our Medical-Scientific Conferences, but every year several Component Sessions are scheduled in the same time slot, so members have trouble sampling activities they want to try out.

A number of us on the Board have talked about these problems over the past few years — about how Med-Sci week is so crowded with activities because we're probably over-ambitious about what can be accomplished in just a few days. The bottom line is that our meetings have not been very "family friendly" at all. Many people ask: Even if it's a gorgeous hotel or resort in a very nice city, why would family come along if our daily schedule keeps us in meetings from 7:00 a.m. to 11:00 p.m.?

Yet others are concerned that our priorities have inadvertently become distorted, in that ASAM holds its Board Meeting and its Annual Business Meeting and its Awards Luncheon and a number of Council and Committee meetings during those days when we all get together, but which is the higher priority — the CME event or the convening of the specialty society? Should ASAM need to "ask permission" of the organizers of the educational event to "find time" for important activities of the Society such as having open forums with the membership to discuss parity or ABAM? Or is the main purpose of the meeting to "attend to the business of the Society", with educational opportunities secondary to the organization's needs? For the vast majority of attendees, CME is the reason they attend Med-Sci — they're looking to learn more, rather than to become more involved in ASAM governance or activities. But for those who do want to be involved with the organization in a substantial way, the schedule conflicts are more wrenching.

In response to all this, your Board has created an Annual Meeting Restructuring Action Group to take a look at what we're doing. The results will be apparent at next year's Med-Sci conference in New Orleans — the Board Meeting will begin not on Tuesday night but on Monday night, while Wednesday will be a day available for both family time and Council or Committee work. Time slots will be available for committees to meet without competing with educational activities, and there will be a chance to relax during the week and take advantage of the location where we will have our meeting — in this case, the Crescent City with all of its unique attractions.

Other questions are yet to be resolved. Is 7:00 a.m. the best time for an Annual Business meeting, or should it be at a more humane hour, such as noon? Should we hold an Awards Dinner every year? Should the transition of our Presidency have just a bit more substance or even ceremony attached to it — allowing for an inaugural address by the new President, providing a format in which we could invite Presidents of other medical societies to participate in the event, as some other groups do?

Our annual meeting should be a central component of how we support our members and how members become involved in our Society. We need to explore how to make our annual meeting week the most meaningful and useful it can be for ASAM members AND their families — and how it can be a "healthier" experience for all of us as well.

If you're interested in participating in further improvements in ASAM's annual meeting, please contact Eileen McGrath, J.D., at ASAM headquarters.

DID YOU KNOW…

The cost of publishing and mailing ***ASAM NEWS*** is rising in tandem with the prices you pay at the gas pump? That's because the cost of printer's ink, paper and postage all are directly tied to the price of crude oil.

To reduce costs and speed your access to the newsletter, you can choose to have your copy of ***ASAM NEWS*** delivered to you by email.

If you wish to do so, please send your email address to **ASAMNEWS1@AOL.COM**. Let us know whether you wish to have your electronic copy emailed to you *instead of* or *in addition to* your regular print copy.

ABAM Board Holds Inaugural Meeting

An April 15th meeting launched the American Board of Addiction Medicine (ABAM) and The ABAM Foundation by bringing together the newly appointed Specialty Directors of ABAM with the Honorary Directors and ASAM leaders.

Newly-appointed Specialty Directors of ABAM gathered April 15th at the inaugural meeting *(from left):* Kevin Kunz, M.D., M.P.H., FASAM *(Preventive Medicine and Public Health);* Hoover Adger, M.D., M.P.H., M.B.A. *(Pediatrics and Adolescent Medicine);* Jeffrey Samet, M.D., M.A., M.P.H. *(Internal Medicine);* Kathleen T. Brady, M.D., Ph.D. *(Psychiatry);* Larry Gentilello, M.D., FACS *(Surgery);* Richard D. Blondell, M.D. *(Family Medicine);* Gail D'Onofrio, M.D., M.S., FACEM *(Emergency Medicine);* and Robert J. Sokol, M.D., FACOG *(Obstetrics and Gynecology).*

Dr. David E. Lewis *(left)* congratulates Sheila Blume, M.D., FASAM, and Stanley Gitlow, M.D., FASAM, on their appointments as Honorary Directors of ABAM (Dr. Blume) and The ABAM Foundation (Dr. Gitlow).

ABAM Honorary Director Sheila Blume, M.D., FASAM *(left)* congratulates new Specialty Directors Kevin Kunz, M.D., M.P.H., FASAM *(Preventive Medicine and Public Health)* and Kathleen T. Brady, M.D., Ph.D.*(Psychiatry).* Dr. Kunz also served as co-chair of the ASAM Medical Specialty Action Group, which laid the groundwork for ABAM.

ABAM Specialty Directors Richard Blondell, M.D. *(left),* and Hoover Adger, M.D. *(center),* join ABAM Honorary Director Norman Wetterau, M.D., at the celebration of ABAM's founding.

Progress Toward ABMS Recognition of Addiction Medicine

The inaugural meeting of ABAM marks achievement of Phase III of the comprehensive plan for specialty recognition: Establishment of the American Board of Addiction Medicine.

The plan developed by ASAM's Medical Specialty Action Group lays out a blueprint for the development of accredited training in addiction medicine, ultimately leading to recognition of addiction medicine by the American Board of Medical Specialties. Interim steps outlined in the plan include the following:

STEP 1. ASAM will encourage and assist in the development of an American Board of Addiction Medicine (ABAM). ***Completed***

STEP 2. The ASAM President and Executive Vice President will communicate and engage in dialogue with officials of ABMS member specialty Boards and medical specialty societies regarding the ASAM initiative toward specialty recognition of Addiction Medicine. ***Ongoing***

STEP 3. The Medical Specialty Action Group will be reconstituted to include ASAM members who are Board-certified in the specialties whose Boards and medical societies are prospective sponsors of ABAM's application for recognition by the ABMS. ***Completed***

STEP 4. To submit a credible application to the ABMS, ABAM will work to identify and/or develop a sufficient number of ACGME-accredited training programs in Addiction Medicine. ***Under way***

STEP 5. When ABAM's certification of individual physicians is established and the ACGME has begun to accredit its training programs in Addiction Medicine, ABAM will submit an application for recognition by the ABMS, either as a conjoint Board of the ABMS, or for subspecialty certification of Addiction Medicine by multiple ABMS medical specialty Boards, whichever path best serves the interests of patients and the profession of Addiction Medicine.

AMA Adopts ASAM Resolution on Drug Screens

Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA, ASAM Representative to the AMA House of Delegates

Doctors Lloyd Gordon, Donald Kurth, Brian Hurley, and more than a dozen ASAM members who serve with other delegations joined me at the AMA's Annual House of Delegates meeting in Chicago. The June meeting of ASAM's principal policy-making body saw a number of actions important to our field, and notable successes for ASAM and addiction medicine.

Mandatory Reporting of Positive Drug Screens

ASAM introduced a resolution asking the AMA to work with appropriate groups to ensure that physicians are not required to report to the police their patients who have positive results on drug screens. Several states have such requirements already in place and it seems likely that additional states may move to adopt similar legislation. The resolution also contained language that would educate physicians regarding the importance of referring patients with positive drug screens for appropriate medical treatment.

Status: This ASAM resolution quickly passed the AMA House of Delegates without amendment.

Council Report on Substance Use

The AMA Council on Science and Public Health introduced a report discussing relevant issues in the field of substance use and substance use disorders. Of critical importance is an issue long recognized within ASAM, and now finally discussed in detail outside our organization, which is that not all individuals who use or misuse alcohol and other drugs suffer from the disease of addiction.

Naturally, the two populations overlap, but some persons who *don't* use or misuse alcohol and other drugs are addicted, whereas some who *do* use or misuse such substances do not. Thus, prevalence data on the number of persons who use or misuse alcohol and other drugs — even illegally or in large quantities — should not be misidentified as representing the prevalence of substance use disorders or addiction.

Status: The Council report was adopted by the House of Delegates. As a result, the AMA will promote screening, diagnosis, and appropriate treatment of both substance misuse and substance use disorders. The AMA also will support the enhancement of prevention, diagnosis, and treatment of substance use disorders through Federal and State legislation. Finally, the AMA will work to have substance use disorders addressed within medical education and to have physicians available as sources of reliable information for the general public. The report, which is being prepared for publication, also explores some of difficulties with terminology that plague the addiction field.

Action on Tobacco

The AMA has long opposed the use of tobacco and has been involved in four major court cases that hinge on scientific evidence about the nature of tobacco addiction and its health effects. These include *Altria Group v. Good, U.S. v. Philip Morris, Beachfront Entertainment v. Town of Sullivan's Island,* and *Rowe v. New Hampshire Motor Transport Association.*

Status: The AMA, which tracks smoking data, reports that current smoking prevalence in U.S. populations over the age of 12 remains steady at nearly 30%. At the same time, there has been a reduction in funding for comprehensive State programs for tobacco control and prevention, a failure of almost all States to use the funds available from taxes specifically meant for tobacco control, and a doubling of tobacco industry marketing expenditures from 1998 to 2005.

Copies of the full report can be obtained either from the AMA or from me — just send an email requesting it.

Board Report on Prescription Monitoring Programs

The AMA Board of Trustees introduced a report in response to State programs that allow physicians and law enforcement personnel to access programs that track prescriptions written for opioids and other controlled drugs. Such prescription monitoring programs (PMPs) can help law enforcement and regulatory agencies identify patients who may be obtaining prescriptions for such drugs from multiple prescribers.

The report focused on the privacy and confidentiality issues raised by PMPs, as well as the situation frequently seen along State borders where physicians and pharmacies may practice in a State other than the one in which a patient lives.

Status: The House of Delegates voted to approve the report, in which the Board recommended active support of State-based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances. The report also endorses allowing physicians to have real-time access to patient data.

In response to concerns expressed that physicians could find themselves under scrutiny or in trouble as a result of PMP data, the AMA advocated for physician education rather than civil action against physicians who inadvertently prescribe to patients engaged in diversion or abuse or prescription drugs.

I can be reached at **DRGITLOW@AOL.COM** for further discussion or to share information about AMA activities.

AMA Says Health Clinics, Tobacco Sales Don't Mix

Retailers should not be allowed to operate health clinics inside their stores if they continue to sell tobacco products, the American Medical Association (AMA) has said.

At its annual meeting, the AMA's House of Delegates adopted a policy position stating that retailers should either stop selling tobacco or shut down their health clinics. Some states, including Illinois, have considered legislation that would prohibit health clinics at stores selling alcohol or tobacco, although the Federal Trade Commission recently concluded that such bans "could limit the supply of retail clinics and the basic medical services they would provide if retail stores were to decide sales of tobacco and alcohol were more profitable than having a retail health clinic."

Retailers reacted quickly. The Convenient Care Association, a trade group, issued a statement saying: "We do not understand how forcing retailers to choose between having an in-store clinic and selling tobacco products serves the broader goal of providing consumers with easier access to high-quality, affordable health care."

Elizabeth F. Howell, M.D., FASAM

ASAM Members to Elect New Officers, Board Members

Elizabeth F. Howell, M.D., FASAM

Chair, Nominations & Awards Council

Candidates for ASAM President-Elect, Secretary, Treasurer, and Regional Delegates to the Board of Diectors are profiled in the following pages. Ballots will be sent to all ASAM members in good standing in October 2008. Completed ballots must be returned by December 1, 2008. Votes may be cast either through paper ballots or online.

ASAM campaign guidelines prohibit written or electronic communication campaigning, restricted or unrestricted, either by the candidates or on their behalf.

Candidates for Officer Positions

Nominees for the office of President-Elect, Treasurer or Secretary must be current members of the Board of Directors or have served on the Board within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a member who possesses the other qualifications for the post and who has served on the Finance Committee within the past four years. The candidates are:

FOR THE OFFICE OF PRESIDENT-ELECT:
Donald J. Kurth, M.D., FASAM
A. Kenison Roy, III, M.D., FASAM, DFAPA

FOR THE OFFICE OF SECRETARY:
C. Chapman Sledge, M.D., FASAM

FOR THE OFFICE OF TREASURER:
Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA (incumbent)

Candidates for Regional Director

Candidates for Regional Director must have been active members of ASAM for at least three years; must have demonstrated a commitment to ASAM's mission through service on a committee, task force, or other significant national or state endeavor; and must be willing to attend two Board meeting a year for four years at his/her own expense. The following individuals are candidates for the post of Regional Director:

REGION I (NY)
Marc Galanter, M.D., FASAM (incumbent)
Edwin A. Salsitz, M.D., FASAM (incumbent Alternate)

REGION II (CA)
Peter Banys, M.D. (incumbent)
David R. Pating, M.D. (incumbent Alternate)

REGION III (CT, MA, ME, NH, RI, VT)
John P. Femino, M.D., FASAM (incumbent)
Kenneth I. Freedman, M.D., FASAM (incumbent Alternate)

REGION IV (NJ, OH, PA)
John J. Verdon, Jr., M.D., FASAM (incumbent)
Jeffrey A. Berman, MS, M.D., FASAM (incumbent Alternate)

REGION V (DC, DE, GA, M.D., NC, SC, VA, WV)
J. Ramsey Farah, M.D., M.P.H., FAAP
Gary D. Helmbrecht, M.D.

REGION VI (IL, IN, IA, MI, MN, WI)
Dora D. Dixie, M.D.
Herbert L. Malinoff, M.D., FACP, FASAM (incumbent Alternate)

REGION VII (AR, KS, LA, MO, NE, OK, TX)
Howard C. Wetsman, M.D. (incumbent)
John P. Epling, Jr., M.D., FASAM (incumbent Alternate)

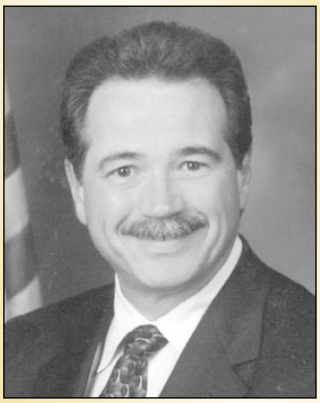
REGION VIII (AK, AZ, CO, HI, ID, MT, NM, NV, ND, OR, SD, UT, WA, WY)
William F. Haning, III, M.D., FASAM
Marvin D. Seppala, M.D. (incumbent)

REGION IX (CANADA AND INTERNATIONAL)
Raju Hajela, M.D., MPH, FASAM (incumbent)
David C. Marsh, M.D., CCSAM

REGION X (AL, FL, KY, MS, TN, PUERTO RICO, VIRGIN ISLANDS)
Bernd A. Wollschlaeger, M.D., FAAFP
C. Chapman Sledge, M.D., FASAM

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

Donald J. Kurth, M.D., M.B.A., FASAM
RANCHO CUCAMONGA, CALIFORNIA



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? The many ASAM committees I have chaired or co-chaired include Leadership Development, Public Policy, Membership, Finance, Legislative Advocacy, ASAM Fellows, Therapeutic Communities, Pain and Addiction, Legislative Day, and the Journal of Addictive Diseases Editorial Board. In addition, I have served as a member of the Medical-Scientific Conference Program Committee and many others.

Even beyond that, however, my personal leadership journey has provided me with a vision for the road ahead. For example, the California Leadership Development Retreat I helped create as President of CSAM will soon be replicated at ASAM to help train the leaders of our next generation of addictionists. Many years ago, I created the first Legislative Day in California, teaching physicians how to fight for parity and equal footing with other specialties. Then, as a Robert Wood Johnson Foundation Leadership Fellow, I used my grant to help create the ASAM Legislative Day. That ASAM advocacy training has paid off handsomely, with major national parity successes.

How do you feel your election would benefit ASAM and the field of addiction medicine? Sound financial management has been the hallmark of my success throughout my career in both the private, academic, and public sectors. My experience in both for-profit and non-profit organizations has galvanized my knowledge and insight in fiscal matters. Sound financial footing, of course, is really just the required foundation on which we can build our education, research, treatment, and policy activities.

Our organization is now facing tough financial challenges. We need a leader with the education, experience, and vision to guide us through the next few years without scuttling our core activities. As ASAM Treasurer and Finance Committee Chair, I helped stabilize ASAM's finances after the SARS disaster and brought us to firm financial footing.

You have seen what I have done in the past. You can depend on what I will do in the future. With ASAM on sound financial footing, our education, research, treatment, and policy activities can begin to move forward to achieve the goals we all hold dear.

A. Kenison Roy III, M.D., FASAM, DFAPA
METAIRIE, LOUISIANA

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Addiction is a leading cause of premature death and disability, in the U.S. and around the world. Treatments available to address addiction are known and improving. Addiction is clearly a chronic disease like others and deserves, like other diseases, to be treated in the mainstream of medicine and with the level of resources available to treat other chronic diseases. Yet the disease we have committed to understand and treat remains stigmatized and undervalued.

In the 1980s, physicians were joining ASAM in increasing numbers every year. At the time, practice opportunities were plentiful and payment was available. But our membership has remained constant at about 3,000 for the last few years, and that number includes many if not most of the physicians who treat addiction. A major difference now is the difficulty in obtaining reimbursement for our services.

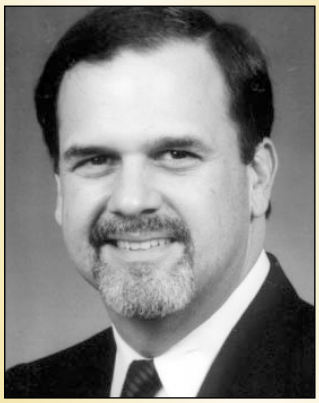
Our Strategic Plan lists as two top goals the attainment of specialty status for addiction physicians and parity in payment for addiction treatment. It could be argued that specialty status itself is a parity issue and that these issues are intimately related. ASAM has worked hard to develop the American Board of Addiction Medicine and to launch ABAM as an independent credentialing body. We are making great progress on the specialty issue. Insurance parity, as that may be defined by federal law, is close. But we have a long way to go to actualize these goals and implement them effectively.

How do you feel your election would benefit ASAM and the field of addiction medicine? In my work in ASAM, I have helped maintain a focus on the development of criteria-based, medically directed treatment models across a spectrum of care and multiple modalities of treatment. I have helped to define the implications of addiction as a primary disease and a brain disease. I have identified non-discrimination (parity) in insurance coverage as essential to the adequate treatment of addiction and the development of an active specialty of addiction medicine. As President of ASAM, I will continue these efforts at the most responsible level of leadership.

Candidate for the Office of Secretary

C. Chapman Sledge, M.D., FASAM

Hattiesburg, Mississippi



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have been a member of ASAM since 1990. I was a charter member of the Mississippi Society of Addiction Medicine in 1993. In 1994, I became involved in the work of ASAM as member of the Credentialing Committee. I later came to chair the Credentialing Committee, and ultimately, the Credentials Council. I have served on the Nominating and Awards Committee. In 2005, I was elected to represent Region X on the ASAM Board of Directors. I have been active on the Steering Committee of the Chapters Council.

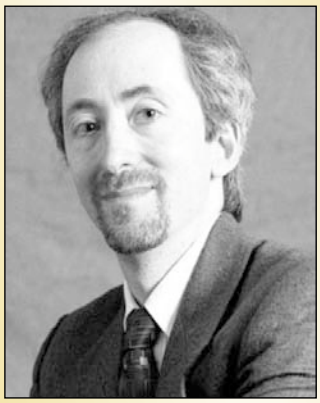
In 2006, the ASAM Board of Directors crafted a strategic plan for the organization. The first priority was recognition of Addiction Medicine as a medical specialty. The second goal was access to care through parity for addiction treatment. In two short years, the American Board of Addiction Medicine has come to fruition as the first step toward ABMS recognition and parity bills have passed both the Senate and the House. My greatest sense of accomplishment in ASAM has been serving on the Board of Directors during these historic events.

How do you feel your election would benefit ASAM and the field of addiction medicine? I am committed to advancing ASAM's strategic goals including ABMS recognition, access to care for addiction treatment, and inclusion of addiction medicine in medical education. The greatest challenge for ASAM will be developing the fiscal means to maintain momentum in accomplishing our strategic goals. The American Board of Addiction Medicine must be supported as the certification process transitions. The fight for parity has made clear the need for a more formal strategy for legislative advocacy. It is critical that ASAM continue to support certified members not eligible for ABMS Board Certification. While we must honor the history of ASAM, this crucial time in our evolution requires forward thinking and action.

Candidate for the Office of Treasurer

Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA

Providence, Rhode Island



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? The past two years have represented a fiscal challenge for ASAM. The reasons for this challenge are multiple but not particularly complex. The first group of factors are, relatively speaking, out of our hands: physicians simply are not joining organizations to the extent that they have in past decades. Membership numbers are therefore relatively stagnant from year to year, or are falling. If this were due to discontent about ASAM, we could assess and correct, but our surveys do not show this to be the case.

Inflation and increased costs of operation also fall into in this group. We have become quite efficient and operate without excess anywhere in the budget. It would be difficult to cut back further without cutting essential services to members. So we have increasing costs and stable revenue.

The second group of factors are within our control: these are the new efforts that we have undertaken in the past several years, each of which has significant associated costs but no current revenue. For example, our fight for parity has been tremendously successful, but this has been achieved with related expenses. Similarly, our work to launch ABAM has been taken seriously by our medical colleagues in other fields, but again there have been significant costs.

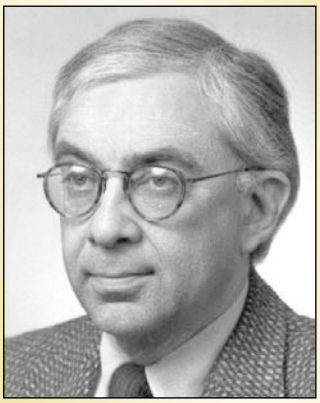
As an organization and a medical specialty, we can sit tight, not take on these new activities, not take any risks, and ASAM likely would gradually diminish in scope and importance to the field. Or we can push for the advocacy and acceptance that is critical to our patients and our members, doing so in as fiscally conservative a manner as possible, and make the organization not only more visible but more viable in the process.

How do you feel your election would benefit ASAM and the field of addiction medicine? Over the past two years, I have worked hard to share methods of achieving the balance necessary between fiscal conservatism and responsibility to grow the field and ASAM as an organization. I ask for your vote and your further dedication to help support ASAM so that I may continue walking the tightrope between these two roles.

Candidates for Director of Region I (New York)

Marc Galanter, M.D., FASAM

New York, New York



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? As President and Regional Director, I made sure that our concerns over constraints on treatment were heard nationwide, and have developed an effective working relationship with the American Academy of Addiction Psychiatry to accomplish this as well. As Program Chair and Co-Chair for the Medical-Scientific Conferences since 1983, I have worked to bring the very best treatment information to our members.

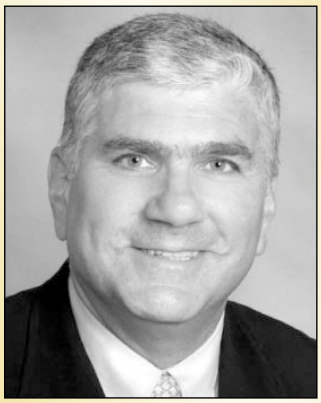
How do you feel your election would benefit ASAM and the field of addiction medicine? I would like to represent Region I in addressing the following issues:

1. We need to lift the restrictions of managed care on treatment availability. A survey that I initiated for ASAM showed that over the preceding decade, reimbursement available for substance abuse services declined by 75%. Achievement of parity for addiction treatment in New York State and nationally is our highest priority, and it is now within reach! I will work with my ASAM colleagues and other organizations to assure that this happens.
2. We must establish the place of addiction medicine within the medical mainstream. We need to secure recognition by the American Board of Medical Specialties. We should also strengthen ASAM's role in CME programs nationally and statewide.
3. We have to provide clinically relevant research to our members. For more than two decades, I have worked to assure that our annual Medical-Scientific Conference is of the highest caliber. We need to continue with the same mission in ASAM centrally and in our state societies, focusing on up-to-date topics such as buprenorphine, new medications for the treatment of alcoholism, innovative psychosocial treatments, and assuring the recognition of Twelve Step recovery within the medical mainstream.

Our support for physicians' health programs is crucial. We need to collaborate across the various states to assure that physicians who have substance use disorders get high quality help and support to return to work in full recovery. I have chaired sessions at our annual meetings on this vital topic, and work closely on it with the New York State Committee on Physician Health.

Edwin A. Salsitz, M.D., FASAM

New York, New York



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Entering addiction medicine from an internal medicine background, I immediately began to notice the difference in terminology and vocabulary. Addiction medicine used many "slang," or "street" terms, which are distinctly absent from other medical specialties. For example, physicians routinely referred to "clean" and "dirty" urines, or called patients "crack heads." I began to understand how this vocabulary stigmatizes both the patient and the field, and how it had obscured my own understanding of the disease of addiction. Moreover, all of the impressive advances in neurobiology of addiction are buried when we use a term such as "hard-core addict" to refer to a patient.

I began to speak out on this issue in 1998. As co-chair of ASAM's Review Courses in Addiction Medicine, I made sure a glossary of appropriate medical terms is included in the course syllabus. I've also published opinion pieces on this issue in ***ASAM News*** and the ***Addiction Treatment Forum***. My pursuit of the issue is a means to reduce prejudice against, and stereotyping of, addicted patients.

My most concrete contribution to the field of addiction medicine has been as principal investigator of an office-based methadone maintenance study at Beth Israel Medical Center in New York City. Over a 20 year follow-up period, we have shown that methadone maintenance is both safe and effective in stable, socially rehabilitated patients.

How do you feel your election would benefit ASAM and the field of addiction medicine? I have been a faculty member and co-chair of the ASAM Review Course, the State of the Art Course, and the Common Threads Course, and have presented workshops at three Med-Sci meetings. I also serve as a course director for ASAM-sponsored buprenorphine trainings.

If elected to the Board, I will continue to advocate for the concept that addiction is indeed an understandable brain disease, similar medically to all other chronic diseases. Eliminating stigma, using precise and medically correct terminology, and educating treatment providers and the general public would continue to be the core of my work.

Candidates for Director of Region II (California)

Peter Banys, M.D.

San Francisco, California

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My most significant contribution to the field has been 25 years of directing an addiction fellowship program. Along with other early fellowships, our fellowship helped to make addiction medicine a genuinely respected and evidence-based profession. I also am active in clinical research as a co-investigator in several NIDA-sponsored research centers at the University of California, San Francisco (UCSF).

I have been active for several decades in the California Society of Addiction Medicine, serving in many roles. I was chair of the Education Committee for six years and President of CSAM from 2000–2002. I brought CSAM's voice to questions vital to the integrity and effectiveness of our field. I also restructured the CSAM Board so that each member now carries a portfolio, with responsibility for a specific CSAM activity. With the collaboration of Drs. Gary Jaeger and Don Kurth, I led the Society into a politically active role in the state capitol and the Department of Alcohol & Drugs.

How do you feel your election would benefit ASAM and the field of addiction medicine? ASAM is at an historic moment, when the organizational structures of a young organization struggling for legitimacy no longer are fully adequate to the tasks at hand. Consequently, I will support Dr. Miller in his re-organization of ASAM Board roles.

The political struggle for parity has to be the single most important issue for ASAM at this time. I will work to achieve it, and ASAM will benefit from CSAM's experience at the state house in Sacramento.

While I will continue to support the very high quality of our conferences, our unequalled textbook, and our public policy statements, I also will continue to oppose affiliate or associate memberships for non-physicians. I will support fiscal responsibility and more conservative income projections than I have seen in the past.

If elected, I will continue to talk straight, work respectfully with colleagues, contribute to solving complex problems, and stand up for evidence-based medicine. I cherish the warmth, lack of pretentiousness, and collegiality of ASAM colleagues, and I want to serve.

David R. Pating, M.D.

San Francisco, California

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? As immediate past president of the California Society of Addiction Medicine, I advocate for our addicted patients' rights to access evidence-based treatment. But experience has convinced me that educating physicians and the public is not, in itself, sufficient to produce change. As addiction medicine physicians, we must be willing to persuade and counsel policy leaders to realize the credible outcomes of our clinical care: Addiction treatment saves lives!

In the last two years, I worked hard to strengthen our addiction medicine policy platform. I created a comprehensive blueprint for addiction treatment in California; directed the writing of an important California Senate white paper on the crisis of methamphetamine abuse; lobbied for treatment for non-violent offenders; and led efforts to resolve the closure of California's Physician Diversion Program. Most recently, I won appointment to California's prestigious Mental Health Services Oversight and Accountability Commission, which oversees a $3 billion dollar fund to improve the treatment of the seriously mentally ill, including those with co-occurring psychiatric and substance use disorders.

Addiction leadership is active, clear and focused. I would be proud to support and continue this work with ASAM as Region II Director.

How do you feel your election would benefit ASAM and the field of addiction medicine? ASAM is the nation's preeminent organization dedicated to improving the treatment of addiction. As Region II Director, I hope to build on my experience as an ASAM State of the Art planner and moderator, ASAM textbook section editor, and member of ASAM's Chapters Council.

I am deeply committed to our national ASAM efforts to promote access to treatment and quality care. We must continue to support parity through this election year and beyond; to seek recognition of addiction medicine as a boarded specialty; and to develop the next generation of ASAM leaders. I would support these efforts through (1) education to promote development of our addiction medicine leadership, (2) mentorship to strengthen our individual state chapters, and (3) prudent decision-making to foster ASAM's fiscal stability.

Candidates for Director of Region III (CT, MA, ME, NH, RI, VT)

John P. Femino, M.D., FASAM

North Kingstown, Rhode Island

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? As one of the first formally trained addiction medicine specialists in Rhode Island, and as an educator in the medical school and the community, I have helped define our field and represented our interests to the general medical community and to insurance companies.

My greatest contribution to ASAM has been in organizing our local ASAM membership to form a new chapter, the Rhode Island Society of Addiction Medicine (RISAM) and in assisting the New England chapters in integrating their regional meeting into the Cape Cod Symposium. I also have served ASAM as a member of the Chapters Council steering committee, the Quality Improvement Committee, and the Nominations and Awards Committee. In addition, my participation as a technical consultant on the application to the AMA to approve coding for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services resulted in its successful implementation.

My greatest contribution to the field has been in representing addiction medicine issues to major insurance companies in Rhode Island, and in the education of patients, family members and health care professionals. I have successfully developed innovative addiction treatment programs, including founding the Meadows Edge Recovery Center, a state licensed substance abuse treatment program.

How do you feel your election would benefit ASAM and the field of addiction medicine? My interest in seeking re-election as Regional Director is based on my success in organizing RISAM, the implementation of the Cape Cod Symposium, and the development of educational presentations regarding the practical aspects of making a living in addiction medicine. I have presented five workshops at a regional and national level on insurance negotiation and coding and billing for addiction medicine treatment services.

I continue to work closely with primary care physicians in implementing protocols for screening and brief intervention, and on training physicians in the interpretation of urine drug testing, as well as the pharmacotherapy of alcoholism and drug dependence. I also have provided videotape, photographic and graphic design consultation to the national ASAM Board, allowing for product development and fund-raising opportunities for state chapters.

Ken Freedman, M.D., M.B.A., FACP, FASAM

Boston, Massachusetts

What do you consider to be your greatest contribution to ASAM and field of addiction medicine? My greatest contributions to ASAM and the field of addiction have been:

As a founding member of the Connecticut Society of Addiction Medicine and officer for nine years, we increased the breadth and scope of ASAM's presence through educational events, public policy, membership activities and a newsletter.

In collaboration with other disciplines, CT-ASAM successfully lobbied the state legislature to create a Health Care Professional Assistance Program for impaired health professionals of all disciplines.

In 2001, I helped establish an on-site Hepatitis C clinic at the Hartford Dispensary, demonstrating the successful integration of psychiatric and substance abuse treatments into HCV care. Through participation in the 2002 NIH HCV Consensus Conference, we successfully influenced modification of the guidelines so that patients with substance abuse and psychiatric disorders would receive interferon therapy.

Over the past three years, I have worked closely with other New England chapters on regional meetings, including the Cape Cod Symposium. I was an elected delegate to the Connecticut State Medical Society for six years. I initiated the inaugural Lemuel Shattuck Hospital Addictions Conference; this conference presented state of the art strategies and evidence based interventions that promote long-term outcomes for addictive disorders.

How do you feel your election would benefit ASAM and the field of addiction medicine? Over the past 14 years, I have used my wide range of clinical and managerial skills to serve the needs of substance abuse and behavioral health patients. My professional commitment is to help move health care delivery toward the integration of medical care and substance abuse treatment in respectful and innovative ways.

My highest priority as Region III Director will be to promote the growth of our member chapters in New England, and to increase our members' involvement in our organization. Through the strength of our chapters, we enhance our ability to achieve higher levels of service and accomplishment. We will improve addiction treatment and education, support research and prevention, promote the appropriate role of physicians in the care of patients with addiction, and strive for ABMS recognition.

Candidates for Director of Region IV (NJ, OH, PA)

Jeffrey A. Berman, M.D., FASAM

Teaneck, New Jersey

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Treating addiction is my passion. Identifying new areas and ways of delivering treatment and teaching are what I do best. I joined ASAM and was certified in 1988. Subsequently, I've brought addiction medicine services to venues where patients with substance use disorders frequently had been ignored or treated for other disorders, while their primary illness — substance use disorder — was ignored.

As Medical Director of the Marworth Treatment Center in Pennsylvania, with mentorship from Dr. Louis E. Baxter, Jr., our team developed addiction medicine and pain m management practices at Geisinger's primary care clinics. I've since replicated these specialized services in settings ranging from Riker's Island Health in New York to the U.S. Disciplinary Barracks and Munson Army Health Center at Ft. Leavenworth, Kansas. Other sites included Jersey City Medical Center and pain management practices in New Jersey.

At the Robert Wood Johnson University Hospital, I introduced strong addiction medicine and psychiatry components to the consultation psychiatry service. The scope of care included trauma surgery, maternal-fetal medicine, internal medicine, and the Cancer Center of New Jersey. My teaching continues at Summit Oaks Hospital, a training site for both the New Jersey Medical School and the Robert Wood Johnson Medical School.

How do you feel your election would benefit ASAM and the field of addiction medicine? Service as Membership Coordinator and President of NJSAM were important direct contributions to ASAM, as was my participation in the Medical Specialty Action Group (MSAG), which led to the American Board of Addiction Medicine.

Teaching, program building and inspiring others are perhaps the greatest skills I bring to ASAM. As a member of the Physician Clinical Support Service (PCSS), and at various national meetings — including the American Psychiatric Association and the Academy of Psychosomatic Medicine — I plan to continue disseminating the art and practice of addiction medicine to other specialties and disciplines. As a delegate from Region IV, I will ensure that state chapters and member needs are met quickly and effectively by the Chapters Council and Board of Directors.

John J. Verdon, Jr., M.D., FASAM

Shrewsbury, New Jersey

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? In 1995, the emerging New Jersey chapter of ASAM was languishing. I was asked to represent the chapter at the chapter President's meeting during ASAM's Med-Sci Conference in Atlanta. There, inspired by Paul Earley and Jim Callahan, I accepted the challenge to participate in the resurrection of the New Jersey Society of Addiction Medicine (NJSAM), a demanding yet rewarding task.

Under my leadership, NJSAM became a model Chapter, even gaining tax exempt status from the IRS under the ASAM umbrella. (Tax-exempt status allows new chapters to avoid the expense — and headaches — encountered by the New Jersey chapter.)

How do you feel your election would benefit ASAM and the field of addiction medicine? I am fortunate to have matured as a physician during the evolution of addiction medicine as a recognized specialty. The breadth of my experience—in medical student and resident education, administration, consultant to the courts, jails, lawyers, industry, and as a clinician caring for myriad patients and their families—provides me with the perspective of a "Doc" who has "worn many hats." For example, in my private office-based practice, I recently evaluated and treated severely ill, acutely decompensated opioid-dependent patients with buprenorphine and engaged them, as medically appropriate, in opioid agonist maintenance therapy.

I am committed to bring to the Board the concerns of all Region IV members. From first-hand experience, I know the diverse problems encountered by the private practice physician who toils alone in his or her office, treating patients and their loved ones who are afflicted with the devastating but highly treatable disease of addiction.

Accordingly, I will vigorously pursue parity in access to treatment and reasonable reimbursement for those services. I encourage all of you to advise me of any problems you face and ideas you wish me to bring to the Board. You will find me accessible and interested in forcefully representing your needs to the Board of Directors of ASAM.

CANDIDATES FOR DIRECTOR OF REGION V (DC, DE, GA, MD, NC, SC, VA, WV)

J. Ramsay Farah, M.D., M.P.H., FAAP, FACPM, FASAM, CPE, CMRO

HAGERSTOWN, MARYLAND

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have founded, chaired or served as president or trustee for more than 50 committees, boards, commissions, societies, councils, organizations and associations, including service as Immediate Past President of the Maryland Society of Addiction Medicine (MDSAM). During my tenure as President of MDSAM, I rekindled the Society following several years of inactivity. I started a regional CME program, training more than 250 physicians. I chaired several courses, dinner meetings and letter-writing campaigns, increasing MDSAM reserve funds to more than $20,000, recruiting a significant number of new members, and a new MDSAM Board. I added an executive assistant, created a logo for the organization's website, and secured state tax-exempt status for MDSAM.

Legislatively, I was instrumental in filing an amicus brief in support of a pregnant woman with an addiction problem for a landmark case that reached Maryland's highest court of appeals, and secured a seat for MDSAM on the state commission studying a Prescription Monitoring Program.

As a member and Secretary of Maryland's State Board of Medicine, Chair of the Licensure and Practice Committee, and liaison to the Maryland Board of Pharmacy, I played an active role in assuring that the scope of practice of various groups meet current standards of care. I also represent the perspective of addiction medicine, including advocating for optimal management of impaired physicians.

Within ASAM, I have participated in the annual Legislative Days, chaired the Regional Nomination Committee, served on the Chapters Council and that council's Steering Committee. I have been very active as faculty in the buprenorphine training initiatives over several years, as well as in the alcohol and ADHD courses.

How do you feel your election would benefit ASAM and the field of addiction medicine? At the Regional level, my focus will be to strengthen the chapters' legislative efforts and to enhance membership recruitment and development.

At the Board level, I will serve as a resource with a successful track record in the political process and public relations, public policy initiatives and fund-raising efforts.

Gary D. Helmbrecht, M.D.

BLACKSBURG, VIRGINIA

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I bring several assets to ASAM and to addiction medicine. I am a subspecialist in maternal-fetal medicine, so I can share a unique expertise in women's health. For example, I recently published a review of addiction disorders in pregnancy in the Journal of Addiction Medicine, which will provide a reference for clinicians with gravid addicted patients. I serve as a PCSS mentor. I provide clinical guidance to physicians throughout the country in all areas of patient management, but with special emphasis on pregnancy.

As an officer of the Virginia Society of Addiction Medicine (VSAM), I have become an advocate for continued buprenorphine therapy in gravid patients who are incarcerated. I have developed a "template letter" to corrections officials that may be customized for the individual patient and sent along with supporting scientific data. This strategy has been used successfully in jails throughout Virginia. I was invited to address last year's annual meeting of the Society of Correctional Physicians on OAT in the gravid prison population, and I continue to work with that organization toward development of a buprenorphine policy.

As medical director of a methadone clinic, I see all the gravid opiate-addicted patients and coordinate their care through a comprehensive system that ensures optimal obstetric care, fetal surveillance, and psychosocial support. Use of this system has reduced fetal morbidity and mortality to a minimum. Finally, I have been a member of ASAM's Medical Specialty Action Group, serving on both the Medical Education Committee and as Ob/Gyn Liaison to the Executive Committee.

How do you feel your election would benefit ASAM and the field of addiction medicine? Election as Region V Director would allow me to bring my enthusiasm, talent and energy to a wider area. I look forward to sharing my vision with other chapters and assisting in the formation of public policy and practice standards that ultimately lead to improved treatment of addicted persons. I also relish the opportunity to assist others in pursuing their passions and interests, which ultimately move our entire field forward.

Candidates for Director of Region VI (IA, IL, IN, MI, MN, WI)

Dora D. Dixie, M.D.

Chicago, Illinois

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My first job was with a family medicine residency program. My duties included teaching, private practice, medical director of addiction and obesity services at Christ Hospital in suburban Chicago.

The second chapter of my career involved full-time work in addictions, specializing in women and their children's medical and addiction issues. For the third chapter in my career, I am in the process of starting a private addiction medicine practice and an addiction fellowship.

The greatest contributions I have made to ASAM and the field of addiction medicine is through teaching medical students, residents, and fellows. I have lectured at the ASAM Review Courses from 1990 through 2006.

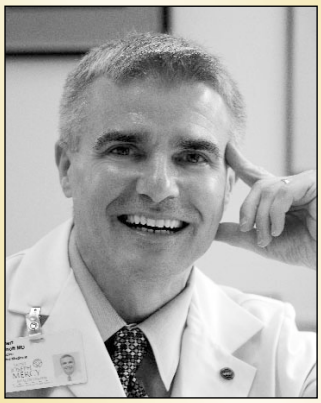
I have been active with the Illinois chapter of ASAM since 1988. One of our proudest achievements were helping convince legislators to repeal UPPL in Illinois.

How do you feel your election would benefit ASAM and the field of addiction medicine? If elected Regional Director, I will work as hard as I have with ISAM. I will try to facilitate all the states in Region VI in fulfilling the minimal requirements of an active state chapter through regular communication with each state president.

Any national organization needs directors that represent all the constituents. If elected, I would be the only female Regional Director on the Board. I would bring my own perspective on women's issues to the forefront of the organization.

Herbert Malinoff, M.D.

Ann Arbor, Michigan



ASAM's mission is "to increase access to and improve the quality of addiction treatment, to educate physicians (including medical and osteopathic students), other health care providers and the public, to support research and prevention, to promote the appropriate role of the physician in the care of patients with addiction and to establish addiction medicine as a primary specialty recognized by professional organizations, governments, physicians, purchasers and consumers of health care services, and the general public."

I'm Herb Malinoff, MD, and I have accepted the nomination to run for Region VI Director.

ASAM is fortunate to have experienced leaders carrying its mission forward at the national level. ASAM's Region VI has likewise grown under the strong leadership of Dr. Tom Haynes. ASAM and I owe a debt of gratitude to Dr. Haynes, our first Region VI Director. I want to continue the work in our Region, and at the ASAM Board.

As a co-founder, past and current President of ASAM's Michigan chapter, my goal always has been to advance the role of addiction medicine in mainstream medical practice. Our chapter's voice is heard at the Michigan State Medical Society, as we have a seat in its House of Delegates. MiSAM has a strong organizational structure, administrative support, supports well-attended CME programs and is financially viable. One of my goals as Regional Director is to advance these strategic priorities for all State chapters in my region. A strong regional voice for addiction medicine is important for the future of ASAM.

ASAM's top strategic goals are ABMS recognition and parity for addiction medicine treatments. Both goals will "treat addiction/save lives." As Region VI Director, I will be working with all of my State chapters to promote and achieve these goals.

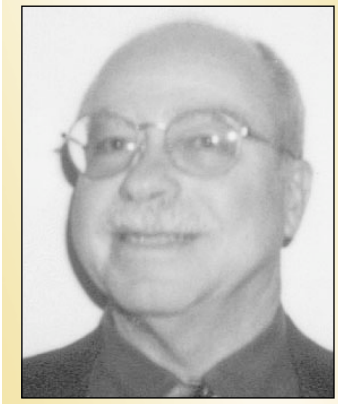
★ ★

Once the balloting is completed, all votes tabulated, and all candidates notified by telephone and letter, the vote results will be made available to the membership in ASAM News and through other venues such as the website.

CANDIDATES FOR DIRECTOR OF REGION VII (AR, KS, LA, MO, NE, OK, TX)

John P. Epling, Jr., M.D.

SHREVEPORT, LOUISIANA



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My continuing effort to promote and support ASAM as the leading national organization in the field of addiction treatment and education.

Over the years, I have served as the founding President of the Louisiana Society of Addiction Medicine and a member of that Society's Committee on Parity in Addiction. I have a private practice in addiction medicine and was certified by ASAM in 1990. I was certified in my original specialty, diagnostic radiology, in 1965. I also hold an appointment as Associate Clinical Professor in the Department of Psychiatry at Louisiana State University Center in Shreveport, where I conduct various seminars for medical students and residents.

At present, I am the Medical Director of Step Up Inc., a non-profit organization dedicated to supplying transitional living facilities, detoxification, and outpatient treatment for men and women with addictive disease. We supply more than 100 beds within the community of Shreveport and receive diverse community funding.

In the past, I opened an addiction medicine clinic in Lake Charles and worked at various intervals as Medical Director for Charter and the Council for Alcoholism in Northwest Louisiana. During Operation Desert Storm, I worked to strengthen the addiction services at Bayne-Jones Army Hospital. I also have been a consultant for the VA hospital in Shreveport. All of these positions have provided me with the opportunity to educate and promote up-to-date treatment and interventions.

How do you feel your election would benefit ASAM and the field of addiction medicine? I will work to implement ASAM's goals and keep an active line of communication open between the Chapters and the national ASAM organization. I believe that communication stimulates interest and involvement in both local and national activities. I have the desire to serve and the means and commitment to carry ASAM's leadership role into the future.

Howard C. Wetsman, M.D.

NEW ORLEANS, LOUISIANA

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Our specialty is at an historic crossroads. There is a confluence of political, scientific, and legal changes around addiction and its treatment that has never occurred before. With this confluence, we have great opportunities. Lawmakers, insurance companies, and others currently use as a "gold standard" the definitions and ideas that derive from the DSM-III, which predates most of the compelling research on the biological nature of the disease we treat.

I see these changes in my current position as Chief Medical Officer of Townsend Recovery, and in my academic role as Associate Clinical Professor of Psychiatry at the LSU Medical School in New Orleans.

As a director representing Region VII on the ASAM Board, as a member of the Nominating & Awards committee and the Public Policy Committee, and in my book, ***Questions and Answers on Addiction***, I have endeavored to get others to take a fresh look at the ideas we were taught about addiction and to compare them to recent scientific findings.

As we become a recognized specialty, with board certification, I would like ASAM to take the lead and to be the body that the world looks to for a definition of this illness and its treatment. I feel that my work in this area has been the best that I have to give.

How do you feel your election would benefit ASAM and the field of addiction medicine? As a member of the Board, I would continue to represent the interests of fiscal responsibility and return of value to our membership. Our members are our Society and their interests come first.

In addition, I look forward to continuing to advocate for ASAM to take the lead in defining addiction as a specialty and the best practices in the field.

Candidates for Director of Region VIII (AK, AZ, CO, HI, ID, MT, ND, NM, NV, OR, SD, UT, WA, WY)

William F. Haning, III, M.D., FASAM, DFAPA

Honolulu, Hawaii

Regional boundaries for Directorships derive geographically, but also and less obviously, culturally. Some of the cultural assumptions have significance for policy and advocacy initiatives, and that emphasizes a need for Region VIII to assert itself collectively. Samples include statewide mandates for management of impaired physicians, access to care and parity for first-generation Americans, research/treatment focus for drug use disorders that are regionally over-represented (e.g., methamphetamine), and reimbursement parity for addiction medicine practitioners that encourage fellowship training.

I am an educator, clinician, and researcher in addiction medicine, whose present state is detailed in the Biographical Sketch. My advocacy and developmental roles have included a range from chairing the State's Commission on Drug Abuse and Controlled Substances to consultancy for the State of Hawai'i Strategic Prevention Framework State Incentive Grant (SPF/SIG), with either soft-spoken or boisterous involvement as required. I am a great believer in the participatory process, and anticipate engaging the respective states' Societies of Addiction Medicine warmly. Said differently, I expect you to participate.

I can be an advocate, but there will remain a need for inertial mass. An incidental undertaking with your aid will be our regional support of the International SAM meeting in Honolulu in 2011. My present association & society relationships include: AMERSA (Program Committee), AAAP (PGY5 and CME Committees), APA (Chair, Corresponding Committee on Confidentiality; Consultant, Committee on Advocacy and Litigation Funding.

My ASAM/HSAM experience includes re-election to the Presidency of the Hawaii Society for 2009-2011, with a principal role in establishing Hawai'i's ASAM group, with Dr. Terry Schultz, since 1988. ASAM roles include memberships on the Medical Specialty Action Group, HIV Committee, Resident-in-Training Committee, Ruth Fox Foundation member, and Fellow. I am committed to addition of the American Board of Addiction Medicine to the ABMS. My other national roles include assisting in the current re-writing of the Substance Use Disorder guidelines for the DVA and the Department of Defense.

Marvin D. Seppala, M.D.

Beaverton, Oregon

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My career has been devoted to the care and treatment of people with addictive disease, so my greatest contributions are found in those I've had the privilege of working with — both patients and my colleagues in addiction medicine.

I dropped out of high school because of addiction and have experienced a remarkable turn of events since entering recovery at age 19. I completed medical school, psychiatric training, and a fellowship with the specific intent of working in addiction medicine. I have worked in almost every type of addiction treatment program: adolescent, Native American, Southeast Asian, methadone maintenance, and women's programs; public and private programs; outpatient, residential, halfway houses, HMOs and private practice; dual diagnosis and psychiatric hospitals.

Last year I left my position as Chief Medical Officer of the Hazelden Foundation to open an addiction clinic with outpatient treatment and detoxification programs in Beaverton, Oregon. My expertise is in the area of co-occurring disorders. I am a founding Board member of the Oregon Society of Addiction Medicine, was a member of ASAM's Publications Committee, and have been a lecturer at ASAM Medical-Scientific Conferences. I have been involved as a member of the Medical Specialty Action Group in supporting ABAM and establishment of addiction as a medical specialty.

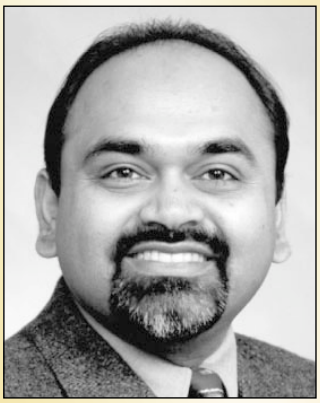
How do you feel your election would benefit ASAM and the field of addiction medicine? I believe I have a responsibility to those who have addictive disease, and I wish to work within ASAM to do what I can to help addiction medicine fulfill its role in addressing this devastating illness. I will continue to bring expertise and experience to the ASAM Board, but just as important, I bring the perspective and commitment of a person in recovery from addictive disease. I bring a very balanced, thoughtful perspective to the ASAM Board, based on my training and experience.

I have had experience with state and federal agencies and advocate regularly for addiction related causes. If elected, I would be able to contribute an experienced, passionate, and educated perspective to ASAM's activities.

Candidates for Director of Region IX (Canada and International)

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

Toronto, Ontario, Canada



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My greatest contributions have included the definitions project in the Canadian Society of Addiction Medicine (C*SAM), which led to the adoption of several definitions by the International Society of Addiction Medicine (ISAM), as well as building partnerships to establish a process for certification in addiction medicine in Canada, especially for physicians who were otherwise ineligible to sit for the ASAM certification examination. This initiative eventually led to ASAM revising its criteria for eligibility to allow for a practice-eligibility route.

I have assisted in the development and functioning of the Physician Health Program of the Ontario Medical Association. I also have been successful in initiating a novel mutual support network for recovery called RAiAR (Remember Addiction is Addiction Responsible) Recovery, which has been functioning since 2006.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? My re-election as the Region IX Director will allow me to continue to share my experience and expertise in a broader way, especially because more bridge-building is needed among ASAM, C*SAM and ISAM. I have enjoyed networking with colleagues from across the U.S., Canada and other parts of the world, which I hope to be able to continue in my second term.

I am interested in clarifying definitions, public policy statements, quality assurance in medical education, comprehensive addiction assessment, and treatment that recognizes addiction as a chronic disease that occurs along biophysiological, psychological, social and spiritual dimensions, and requires continuing care for a lifetime of healthy recovery. Workplace interventions, driving impairment and disability issues require attention.

I want to lend my support to the various activities related to the development of training programs in addiction medicine and recognition of addiction medicine as a specialty in the U.S., Canada and other parts of the world. I want to develop more personal contacts with the individual members in Region IX and continue to explore how international members can enhance the value of ASAM, while also addressing their professional needs.

David C. Marsh, M.D., CCSAM

Vancouver, British Columbia, Canada

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I trained in medicine, as well as graduate training in neuroscience and pharmacology, at Memorial University of Newfoundland. Since 1994, I have been working full-time in addiction medicine through a combination of clinical, research, teaching and administrative roles at the Centre for Addiction and Mental Health in Toronto (until 2003) and at Providence Health Care in Vancouver (from 2004 until the present). I am certified in addiction medicine by the Canadian, American and International Societies of Addiction Medicine and was one of the first members to receive ASAM certification through the practice-eligible route established by the Canadian Society of Addiction Medicine (C*SAM) in 2000.

I have held a number of leadership positions within C*SAM, including Ontario Board Member and President. I will serve as Past-President until October 2008 and as C*SAM Secretary-Treasurer until the end of 2009.

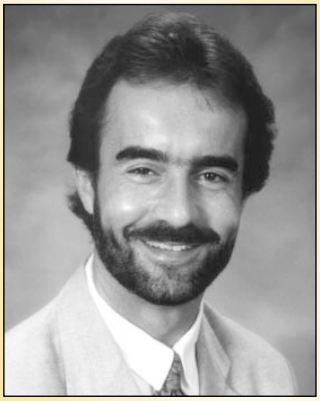
How do you feel your election would benefit ASAM and the field of addiction medicine? Key areas of interest in my teaching, research and practice are the treatment of injection drug users and specifically opioid agonist treatment. I have trained physicians, pharmacists and counselors in OAT across Canada, the United States and other countries, including as a buprenorphine trainer for ASAM. In addition, I have contributed to the development of evidence-based practice guidelines in several jurisdictions and was a lead author of the Health Canada Best Practices documents related to methadone maintenance. The American Association for the Treatment of Opiate Dependence recognized this work with the Nyswander-Doyle Award.

I have published more than 40 papers, book chapters and treatment guides and am a co-investigator on more than $14 million in research grants. This allows me to bring an academic perspective to discussions of policies and position papers. I also have trained medical students, residents and graduate students and can bring this experience to bear on efforts to have ASAM certification recognized as a boarded specialty.

I look forward to the opportunity to represent ASAM members from Region IX and to continue to build positive relationships among addiction medicine societies around the world.

Candidates for Director of Region X
(AL, FL, KY, MS, TN, Puerto Rico, Virgin Islands)

Bernd Wollschlaeger, M.D., FAAFP, FASAM
North Miami Beach, Florida



What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? As an active member of ASAM, I soon realized that the successful integration of addiction medicine into primary care and other specialties depends on local and regional representation of addiction specialist in organized medicine, involvement in academic medicine, and the development of an active ASAM chapter.

I therefore dedicate my professional life to teaching addiction medicine to medical students and residents, promote the recognition of addiction medicine within the Florida Medical Association, and to seeking collaborative relationships with local politicians to sponsor legislation that promotes parity and access to treatment.

Since 2007, I have served as President of the Florida Society of Addiction Medicine. We organize an annual scientific conference, which is attended by more than 100 medical professionals and features cutting-edge research presentations. I also had the privilege of participating in the Medical Specialty Action Group (MSAG) as a representative of family medicine and am proud to have contributed to the formation of the American Board of Addiction Medicine (ABAM).

How do you feel your election would benefit ASAM and the field of addiction medicine? With the formation of the American Board of Addiction Medicine, a tipping point has been reached in the path toward recognition of our specialty. Now we have to translate the science of addiction medicine into clinical practice.

Therefore, my goal is to proactively pursue the translation of ASAM's strategic plan into the clinical practice of medicine by focusing on:

1. Promoting excellence of care in addiction medicine through education and training of physicians and other health care professionals.
2. Educating political decision makers about the importance of sustainable funding mechanisms for community-based addiction treatment modalities and advocating for the promotion of addiction care and research in primary care.
3. Reorganizing regional chapters to promote the interests of health care professionals involved in addiction care, research, and treatment.
4. Achieving cooperative relationships with other medical specialties to foster the integration of screening and intervention modalities into patient care.

Richard G. Soper, M.D., J.D., M.S., FASAM
Nashville, Tennessee

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Within the State of Tennessee, I have:

- Reactivated the ASAM Tennessee chapter (TNSAM) in 2004, serving as its President from 2005 through 2007, and now as its Immediate Past President.
- Re-established addiction medicine as a medical specialty recognized by the Tennessee Medical Association (TMA), and represented our specialty in the TMA House of Delegates.

Since joining ASAM in 1994, I have:

- Been certified in addiction medicine in 2002, and named an ASAM Fellow (FASAM) in 2008.
- Co-Chaired the ASAM Membership and Involvement Action Group and served on the ASAM Medical Specialty Action Group, which developed the American Board of Addiction Medicine.
- Co-Chaired or Chaired the ASAM Chapters Council from 2006 to the present.
- Been an ex officio member of the ASAM Board of Directors, representing the Chapters Council, from 2007 to the present.

Within addiction medicine, I have:

- Served as a Mentor with the Physician Clinical Support System (PCSS), and planned, implemented, monitored and managed the use of Suboxone in primary clinical settings.
- Served as an ADM consultant for six county drug courts in Middle Tennessee. (I am a member of the National Association of Drug Court Professionals.)
- Promoted collaboration among the principal addiction societies and professional groups.

How do you feel your election would benefit ASAM and the field of addiction medicine? My journey and experiences continue to teach me the strategic role that addiction medicine has in healing and caring for the whole person and family. If elected, I will serve with dignity, humility, and patience. I want to continue to help our Society maintain our misson and focus as we gain momentum for the future, using new technologies and tools to help our patients; to achieve specialty recognition; to achieve enactment of parity legislation and repeal of UPPL statutes; and to deliver care to those touched by or suffering from these disorders and their sequelae.

Alcohol Disorders Increase Risk for Prescription Drug Abuse

Individuals with alcohol use disorders are 18 times more likely to report non-medical use of prescription medications than those who don't drink at all, according to researchers at the University of Michigan. Sean McCabe, Ph.D., and colleagues documented the link in two NIDA-funded studies; they also discovered that young adults were the subset of the population at greatest risk for concurrent or simultaneous misuse of alcohol and prescription drugs.

In the first study, Dr. McCabe and colleagues examined the prevalence of alcohol use disorders and non-medical drug use in 43,093 individuals age 18 and older who participated in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) between 2001 and 2005. Participants lived across the U.S. in a wide variety of household arrangements and represented White, African-American, Asian, Hispanic, and Native American populations. Although persons with alcohol use disorders constituted only 9% of the total study population, they accounted for more than a third of those who reported non-medical use of prescription drugs.

Since the largest group engaged in simultaneous misuse of alcohol and prescription drugs were between the ages of 18 and 24, the team conducted a second study focused exclusively on that population, involving 4,580 young adults at a large Midwestern public university who responded to a self-administered Web survey. Of this group, 12% reported use of alcohol and non-medical use of prescription drugs within the preceding year at different times (concurrent use), while 7% engaged in use of alcohol and non-medical use of prescription drugs at the same time (simultaneous use). The prescription drugs most like to be used in combination with alcohol — in order of prevalence — were opiate analgesics; stimulants such as those prescribed for ADHD; sedatives and anxiolytics such as Xanax and Valium; and sleep medications such as Ambien, Halcion, and Restoril.

"The message of these studies is that clinicians should conduct thorough drug use histories, particularly when working with young adults," said Dr. McCabe. "Clinicians should ask patients with alcohol use disorders about non-medical use of prescription drugs and, in turn, ask non-medical users of prescription medications about their drinking behaviors." The authors also recommend that college staff educate students about the adverse health outcomes associated with simultaneous use of alcohol and prescription medications.

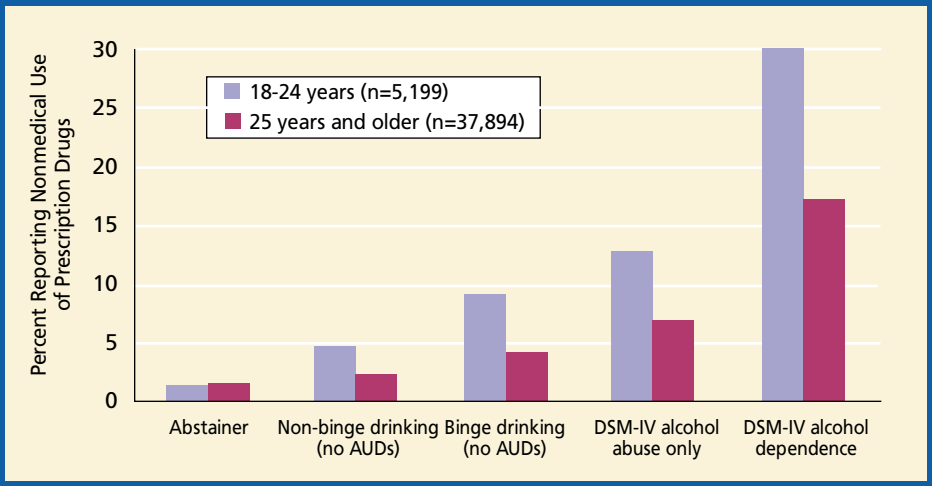
Source: NIDA Notes, Vol. 21, No. 5 (March 2008).

REFERENCES

McCabe SE et al. The relationship between pastyear drinking behaviors and nonmedical use of prescription drugs: Prevalence of co-occurrence in a national sample. *Drug and Alcohol Dependence* 2006;84(3):281-288.

McCabe SE et al. Simultaneous and concurrent polydrug use of alcohol and prescription drugs: Prevalence, correlates, and consequences. *Journal of Studies on Alcohol* 2006;67(4):529-537.

PAST-YEAR NON-MEDICAL USE OF PRESCRIPTION DRUGS BY PAST-YEAR DRINKING STATUS



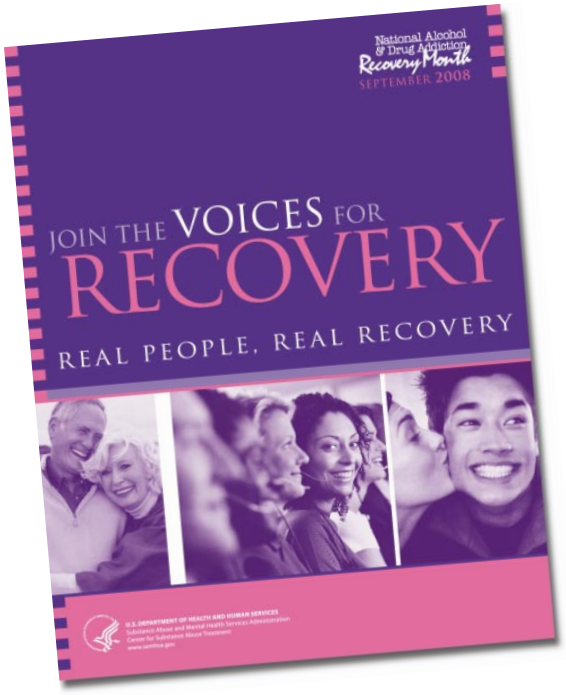
Source: NIDA Notes, Vol. 21, No. 5 (March 2008).

Federal Survey Finds Unexpected Patterns of Substance Abuse and Addiction Across U.S.

It is an oft-repeated truism that addiction and mental disorders affect every community in the U.S., but a new SAMHSA report shows that they do so in surprisingly varied ways. The report, *Substate Estimates from the 2004-2006 National Surveys on Drug Use and Health*, measures 23 addiction and mental health-related indicators in 345 substate regions across all 50 states and the District of Columbia, and offers highly detailed analyses of problems in local areas. The analyses employs combined data from the 2004 to 2006 National Surveys on Drug Use and Health (NSDUH) and involve responses from 203,870 persons age 12 or older throughout the U.S.

For example, data for one of the smaller geographical (or substate) areas in the survey — Utah's Salt Lake and Weber-Morgan counties — showed the Nation's highest rate of non-medical use of opioid analgesics by persons aged 12 or older. In the two counties, rates were as high as 7.9%. By contrast, areas of the District of Columbia showed some of the Nation's lowest rates of this particular form of substance abuse, at 2.5%. On the other hand, the same counties in Utah reported the lowest levels of underage binge alcohol use in the past month (as low as 8.7%), whereas rates of binge alcohol use in the District of Columbia were equally low in some parts of the city but among the highest in the Nation (as high as 39.0%) in other areas.

The full report is available on the Web at **HTTP://OAS.SAMHSA.GOV/SUBSTATE2K8/TOC.CFM**, as is a short report entitled *Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006*. For related publications and information, visit **HTTP://WWW.SAMHSA.GOV/**.



September is Recovery Month; Toolkits Available Online

September is the 19th annual National Alcohol and Drug Addiction Recovery Month, which is observed by towns, counties, and States around the country. Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT), Recovery Month recognizes the impact that real people and real stories have on recovery, and celebrates those who have worked to advance our understanding of addiction treatment and recovery. This public health campaign is designed to highlight the benefits to all Americans of addiction treatment and to promote the message that recovery is possible. This year's theme is "Join the Voices for Recovery: Real People, Real Recovery."

SAMHSA officials maintain that individual physicians and community coalitions can play a powerful role in educating the public that recovery is real and treatment is worthwhile. For example, one way to increase awareness about Recovery Month is to ask local officials to sign proclamations declaring September as Recovery Month. When local officials publicly sign such a statement, public attention is drawn to Recovery Month events and activities, and the community as a whole recognizes that local governments are committed to improving citizens' access to treatment programs for alcohol and drug use disorders. Such proclamations can be issued by governors, state legislatures, mayors, counties, cities, or towns.

To view sample proclamations, visit **WWW.RECOVERYMONTH.GOV/2008/PROCLAMATIONS.ASPX**.

Hosting a community event or launching a media campaign also are approaches that have been effective in many communities. To help in planning Recovery Month activities, SAMHSA and its partners have developed a Recovery Month Planning Kit, available at: **WWW.RECOVERYMONTH.GOV/2008/KIT/DEFAULT.ASPX**.

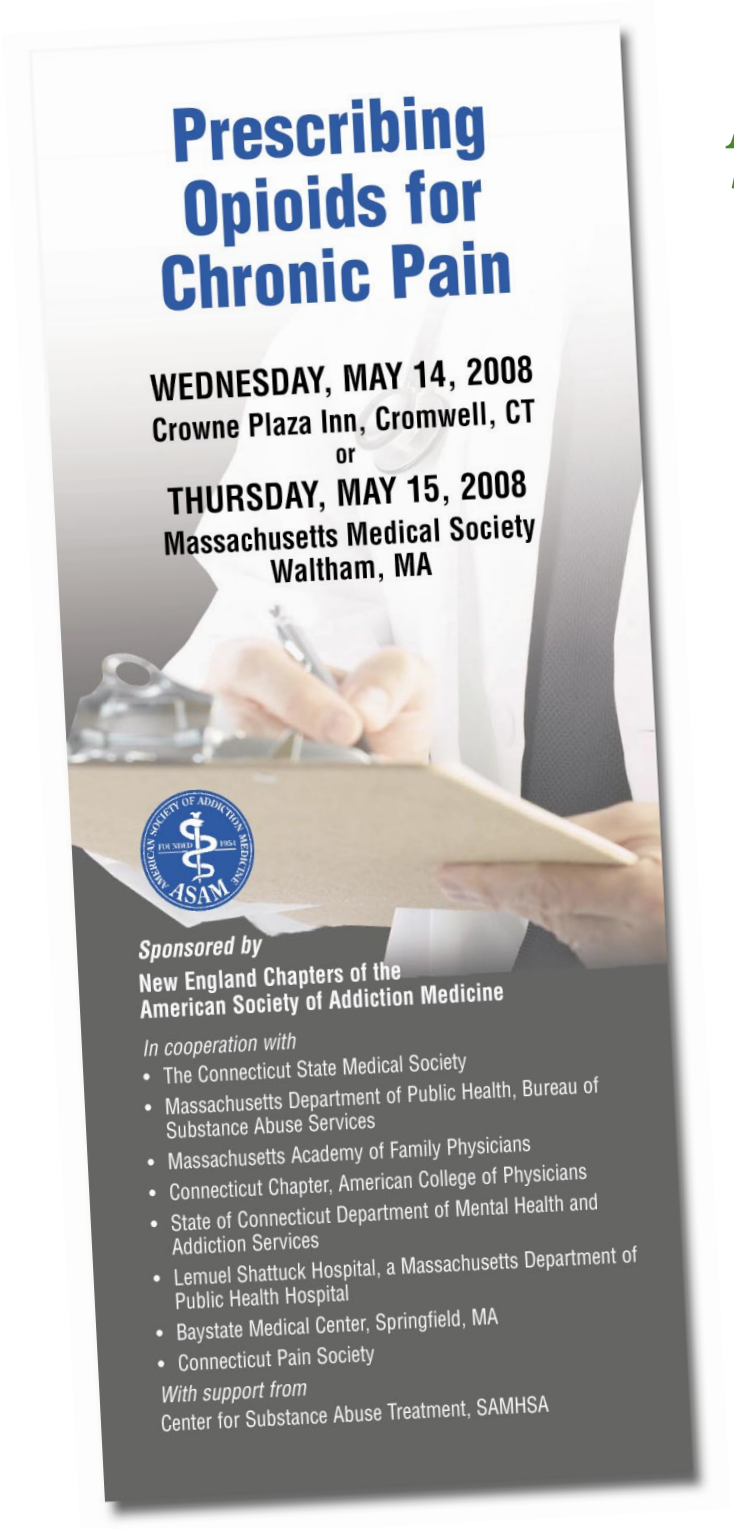
The kit provides ways to raise awareness about Recovery Month and materials to help plan Recovery Month activities.

Updated Directory of Treatment Programs Published

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced publication of its National Directory of Drug and Alcohol Abuse Treatment Programs 2008, which provides information on more than 11,000 treatment programs located in all 50 states, the District of Columbia, Puerto Rico, and five U.S. territories.

The directory lists public and private facilities that are licensed, certified, or otherwise approved by State Alcohol and Drug Abuse Agencies, organized in a format for quick reference by physicians and other health care professionals, social workers, managed care organizations, and the general public. Information provided for each facility includes levels of care and types of facilities, including those with programs for adolescents, persons with co-occurring substance abuse and mental disorders, individuals living with HIV/AIDS, and pregnant women. In addition, the directory includes information on forms of payment accepted, special language services available, and whether methadone or buprenorphine therapy is offered. The updated directory complements SAMHSA's Web-based Substance Abuse Treatment Facility Locator, which offers searchable maps, facilities' addresses and phone numbers, and specific information on services available.

An electronic version of the directory is available on the Web at **HTTP://FINDTREATMENT.SAMHSA.GOV/**. Print copies (inventory number 08-4335) can be ordered free of charge from SAMHSA's Health Information Network (877/726-4727). For related publications and information, visit **HTTP://WWW.SAMHSA.GOV/**.



ASAM Chapters Help Teach PCPs About Prescribing Opioids

ASAM's State chapters are taking a lead role in organizing courses for primary care physicians on appropriate use of methadone and other opioids to treat pain. The Chapters are collaborating with primary care organizations and SAMHSA's Center for Substance Abuse Treatment to offer an innovative continuing medical education (CME) program on "Clinical Challenges in Prescribing Controlled Drugs — Prescribing Opioids for Chronic Pain." In addition, many ASAM members are serving as teaching faculty.

Modeled after CSAT's successful Buprenorphine Training Courses, the prescribing courses also reflect the experience of educational programs offered at Case Western Reserve University, the University of South Florida College of Medicine, the Vanderbilt University School of Medicine, and elsewhere. They are designed to raise physicians' awareness of the abuse potential of controlled drugs and to give them the specific knowledge, skills and clinical tools they need to (1) assess their own prescribing practices and adjust them as required, (2) identify at-risk patients and respond appropriately, (3) avoid being defrauded by patients or victimized by thieves or other criminals, (4) adopt a collaborative approach in working with pharmacists, regulators and law enforcement authorities, and (5) help raise colleagues' awareness of the issue.

Each course features core content on legal and regulatory issues, as well as clinical strategies for managing difficult patients and expert advice on how to identify and deal with aberrant patient behaviors (including "doctor-shopping," requests for early refills, and prescription alteration and forgery). The courses employ structured discussions of cases drawn from real clinical situations to help participants integrate the knowledge acquired into their own clinical practices. Topics for teaching cases include: (1) patient selection and monitoring, with "red flags" for problems and responses to each; (2) indications and protocols for opioid rotation or dose modification; and (3) indications and protocols for discontinuation of opioid therapy and use of a different treatment approach.

The courses are eligible for Category 1 credit under the Physicians' Recognition Award™ of the American Medical Association and are fully compliant with the current ACCME guidelines for the content of CME programs.

A short version of the course will be distributed through Medscape™. The full course will be available online, with accompanying reference materials and clinical tools, in Fall 2008.

COURSE SCHEDULE & FACULTY

Pilot tests of the courses were conducted and evaluated in late 2006 by an expert panel led by Joyce Lowinson, M.D. The first course was offered at Case Western Reserve University and University Hospitals of Cleveland in September 2007, under the leadership of Margaret Kotz, D.O. A second course in Fall 2007 was organized by Norman Wetterau, M.D., FAAFP, FASAM, and hosted by the New York State Academy of Family Physicians (NYSAFP).

In 2008, courses have been offered in Cromwell, Connecticut, and Waltham, Massachusetts (with the support of the New England Chapters of ASAM); in Los Angeles, California (with the support of the California Society of Addiction Medicine); in Boise, Idaho (with the support of the Idaho Society of Addiction Medicine); and in Indianapolis, Indiana (with the support of the Indiana Society of Addiction Medicine). Other courses have been offered in Raleigh and Greensboro, North Carolina, in Seattle, Washington, and in Charleston and Morgantown, West Virginia.

Teaching faculty for the courses includes ASAM members Theodore V. Parran, M.D., FACP (who also chairs the course faculty); Daniel P. Alford, M.D., M.P.H., FACP; Anthony Dekker, D.O., FASAM; James W. Finch, M.D., FACP; Ken Freedman, M.D., M.B.A., FACP, FASAM; John Hopper, M.D.; Rebecca Kelly, M.D.; Margaret K. Kotz, D.O.; Mark L. Kraus, M.D., FASAM; Daniel P. McCullough, M.D., M.Phil., FAAFP; Richard K. Ries, M.D.; Andrew J. Saxon, M.D.; Larry Stoune, M.D.; Norman Wetterau, M.D., FAAFP, FASAM; and Stephen A. Wyatt, D.O. Other ASAM members, including John A. Renner, M.D., and Todd W. Mandell, M.D., have served as formal evaluators as part of CSAT's quality assurance plan for the courses.

Future course sites include Portland, Maine (with teleconferencing to five sites in Vermont), on September 12th, and Fort Lauderdale, Florida (at Nova Southeastern University), on September 20th. In addition, a short version of the course will be distributed through Medscape™ and the full course will be available online at CSAT's website in Fall 2008 *(watch ASAM News for a release date).*

Support for development and dissemination of the prescribing courses has been provided by JBS International's Center for Health Services & Outcomes Research, through a contract with CSAT. The project's team leader is Bonnie B. Wilford, M.S. For information about a scheduled course or to inquire about scheduling a future course, contact Gail Jara, Education Coordinator for the courses, at GAILJARA@PACBELL.NET

Cape Cod Symposium
September 4th–7th

The New England Chapters of ASAM once again are cosponsoring the Cape Cod Symposium on Addictive Disorders, September 4th–7th at the Resort & Conference Center at Hyannis, Cape Cod, Massachusetts.

The theme of the 21st annual symposium is *"Innovative and Effective Approaches to Intervention, Treatment and Recovery."*

The symposium offers up to 31 hours of continuing education credit. Faculty members include ASAM President Michael M. Miller, M.D., Andrea Barthwell, M.D., Karen Miotto, M.D., Marc Publicker, M.D., Josiah Rich, M.D., and Stephen Wyatt, D.O.

For more information, contact symposium coordinator Dee McGraw at DEEMCGRAW@AMERITECH.NET, or by phone at 616/475-4210. To register online, go to HTTP://WWW.CCSAD.COM/REGISTRATION.HTML.

STUDY: Binge Drinkers Poor at Assessing Their Own Driving Abilities

Many people believe that most alcohol-impaired (AI) drivers are alcoholics, but in fact, 80% of alcohol-impaired crashes are caused by binge drinkers who do not meet the DSM criteria for alcoholism. A recent study conducted among college students shows that binge drinkers, even when legally intoxicated, nevertheless believe they have adequate driving abilities.

"Binge drinkers are individuals who, when they drink, typically drink to get drunk," explained Dr. Cecile A. Marczinski, Assistant Professor in the Department of Psychology at Northern Kentucky University and first author of the study. She added: "Binge drinkers are often young individuals, like college students, who are drinking irresponsibly and most of them are *not* alcohol dependent."

College students are the population group most likely to binge drink, Dr. Marczinski said, noting that "binge drinking is widespread on college campuses, with almost half of students reporting binge drinking." These students "are also particularly prone to AI driving. Thus, we needed to understand why a population that knows better than to engage in impaired driving still does so."

Participants in the study were 20 male and 20 female social-drinking college students (24 binge drinkers, 16 non-binge drinkers) who ranged from 21 to 29 years of age. All of the participants attended two sessions: one during which they received a moderate dose of alcohol (0.65 g/kg), and one during which they received a placebo. Following each session, researchers measured the students' performance during a simulated driving task. They also measured their subjective responses, including self-ratings of sedation, stimulation and driving abilities.

"After being given an intoxicating dose of alcohol, all of these individuals — both binge and non-binge drinkers — were very poor drivers when tested on a driving simulator," Dr. Marczinski said. "However, when all of the participants were asked to *rate* their driving ability, the binge drinkers reported that they had a greater ability to drive than did the non-binge drinkers."

The investigators hypothesize that binge drinkers lack an "internal sedation cue" that allows an accurate assessment of their driving abilities after drinking. Dr. Marczinski said she hoped the team's findings might help policymakers and enforcement officials understand why the standard message of "don't drive when your BAC reaches .08 or more" may be not be as straightforward to follow as one might think. "A BAC of .08 may feel different depending on how much you typically drink," she said. "If you often drink to get drunk, as many young people do, you will be very bad at determining whether or not you should drive. Thus, prevention programs where college students are stopped leaving bars and given a Breathalyzer reading may help many individuals learn what .08 feels like. In addition, we might also entertain a lower BAC limit for driving. Many European countries have had great success in decreasing impaired driving rates and related accidents by lowering their BAC limit to .05."

She added that the study did provide some good news: "While a small portion of young binge drinkers may develop serious problems with alcohol, most of them will mature out of this behavior."

REFERENCE

Harrison ELR & Fillmore MT. Effects of alcohol on simulated driving and perceived driving impairment in binge drinkers. *Alcoholism: Clinical & Experimental Research (ACER). Jul. 2008;*31(7).

New Health Plan Requirements Limit Access to Treatment, Physicians Charge

Two major health plans recently announced that they will require prior authorization before allowing prescription orders for the buprenorphine medications Suboxone and Subutex to be dispensed — a move that physicians and patient advocates say will impose economic barriers to care of patients with addictive disorders.

United Healthcare and its Oxford Health Plans subsidiary announced the new policy in May in a letter to patients that said: "[C]overage for Suboxone and Subutex will be limited to the uses indicated in U.S. Food and Drug Administration approved labeling and other published clinical evidence. As part of our notification program, your doctor must provide information regarding your condition for which Suboxone and Subutex is being prescribed."

The letter added that physicians who wish to prescribe Subutex or Suboxone must call United or Oxford for a "notification review," after which the plan will "send a letter to you [the patient] and your doctor indicating whether or not your medication is covered under your pharmacy benefit plan." The policy applies to both new prescriptions and to refills, the letter made clear.

The policy elicited a skeptical reaction from practitioners. "I think their point is to save money and discourage utilization," concluded Michael W. Shore, M.D., of Cherry Hill, New Jersey. A physician with 100 current buprenorphine patients, Dr. Shore has been prescribing the drug since it first became available for the treatment of opiate addiction in 2002. He said that requiring prior authorization for Suboxone and Subutex is unworkable for both patients and physicians, explaining that, as a solo practitioner, he doesn't have time to spend 20 minutes on the phone answering questions. "If this policy is allowed to continue, I simply won't take on any new patients who have United Healthcare," he concluded, adding that "Patients can't wait two or three days for a decision to be made. They are in opiate withdrawal and they are going to go out and use. I've had two patients die while waiting for treatment and I won't let it happen again."

Tim Lepak, president of the National Alliance of Advocates for Buprenorphine Treatment (NAABT), agreed, explaining that while buprenorphine patients are "really happy to see that more plans are paying for [the drug]," requiring prior authorization will prevent some from getting treatment.

In an effort to make that case, Dr. Shore wrote to Richard Justman, medical director of United Healthcare, asking that the policy be reversed. "If the rationale…is to somehow reduce treatment costs, I would point out that the efficacious use of Suboxone actually reduces health care costs by avoiding the much more costly treatment option of inpatient detoxification and rehabilitation," Dr. Shore said in a May 6th letter. "It is one thing to require preauthorization for inpatient treatment, but to require it for the outpatient option that often eliminates the need for inpatient treatment is penny wise and pound foolish."

In response, Dr. Justman wrote on May 8th that United Heathcare's main objective in requiring preauthorization was to prevent off-label prescriptions of Suboxone and Subutex, including use of those drugs to treat pain. Dr. Justman later offered to meet with Shore and other addiction medicine and addiction psychiatry experts to discuss the policy.

A number of State Medicaid programs and private carriers have adopted policies similar to those of United Healthcare and Oxford. For example, Coventry Health Care requires prior authorization, while Value Options limits access to buprenorphine in other ways, including use of a so-called "fail first" policy (which requires that patients must have failed at other types of rehabilitation before being eligible to receive Suboxone or Subutex), limiting reimbursement for prescriptions to six months, and charging a $20 co-payment for each prescription dispensed *[see the accompanying box].*

A 2007 survey by the Center for a Healthy Maryland found that such policies are indeed suppressing access to care, citing responses showing that the prior authorization requirements, insufficient reimbursement, and confusing Medicaid rules have made many doctors in the state reluctant to prescribe buprenorphine at all.

Christopher Welsh, M.D., of the University of Maryland School of Medicine, found the survey results unsurprising: "One of the biggest barriers to prescribing buprenorphine is dealing with the insurance companies." Dr. Welsh said that some of his patients drive for hours in hopes of getting the drug. He added, "A few hours later, you'll get a call, and the patient will tell you that the pharmacy said the prescription wasn't authorized."

Concluded NAABT's Tim Lepak: "They're putting patients' lives at risk."

ASAM ACTS ON BUPRENORPHINE RESTRICTIONS

To address the situation, ASAM leaders convened a call in early June with Dr. Richard Justman, medical director of United Healthcare, and his staff. Joining in the call were Dr. Michael Shore and representatives of the "DATA 2000" organizations: Drs. Mark Kraus and Ken Roy of ASAM, Dr. Richard Rosenthal of AAAP, Dr. Stephen Wyatt of AOAAM, and Sam Muszynski of APA.

Summing up the call in a report to ASAM's Executive Council, Dr. Roy wrote: "Dr. Justman and the UHC staff were very gracious and listened to all of our concerns… Of course, no commitment to change could be made on the spot, but there was clear communication that reduced physician time requirements, freedom from hassle and good patient outcomes are values of UHC. There was a commitment to investigate ways to facilitate preauthorization and a follow-up call will be scheduled." *(Watch **ASAM NEWS** for continued coverage of the situation.)*

Study Confirms that Opioid Maintenance Treatment Saves Lives

A new long-term, prospective study shows that opioid-dependent patients are 13 times more likely to die than their age- and sex-matched peers in the general population.

To examine predictors of long-term mortality, Australian researchers conducted a 10-year follow-up study of 405 heroin-dependent patients who had participated in a randomized trial comparing methadone and buprenorphine. They found that overall mortality was 8.8 deaths per 1000 person-years of follow-up (0.66 during opioid maintenance treatment and 14.3 while out of treatment). Each additional opioid maintenance treatment episode lasting more than seven days reduced mortality by 28%. Moreover, subjects who were using more heroin at baseline had a 12% lower mortality rate overall, probably because they spent more time in opioid maintenance treatment.

Commenting on the results, Boston University's Peter D. Friedmann, M.D., M.P.H., noted that in the midst of controversies about opioid substitution therapy, critics sometimes overlook the fact that untreated opioid addiction has a high mortality rate. He added, "The current study highlights that opioid maintenance treatment saves lives.... The time is right to promulgate opioid maintenance therapy with either buprenorphine or methadone as *the* standard-of-care, first-line treatment for opioid dependence."

REFERENCE: Gibson A, Degenhardt L, Mattick RP, et al. (2008). Exposure to opioid maintenance treatment reduces long-term mortality. *Addiction* 103(3):462–468 and *Alcohol, Drugs, and Health: Current Evidence*, May-June 2008 (accessed at http://www.bu.edu/aodhealth/issues/issue_may08.html).

Heart Assn. Offers Guidance on Cocaine-Related Chest Pain

Of 500,000 cocaine-associated emergency department visits each year, an estimated 40% involve chest pain. This is not surprising, given that cocaine increases heart rate and blood pressure, constricts the coronary arteries, induces a prothrombic state, and accelerates atherosclerosis.

Guidelines recently released by the American Heart Association are designed to improve the care of patients with cocaine-associated chest pain (CACP). The AHA guidelines, which are based on a systematic review of the literature, contain the following findings and recommendations:

- Myocardial infarction (MI) occurs in 0.7% to 6% of patients who present with CACP.
- Persons presenting with CACP, unstable angina, or MI should be treated similarly to patients with possible acute coronary syndrome, including the provision of aspirin. In addition, intravenous benzodiazepines should be provided.
- Persistent hypertension should be managed with sodium nitroprusside, nitroglycerin, or intravenous phentolamine.
- Patients at low risk (no electrocardiogram changes and no elevation in cardiac troponins) can be safely observed in a chest pain observation unit for 6 to 12 hours.
- Patients at high risk (with ECG changes and elevated troponins) should be admitted to a telemetry bed. In these patients, beta-blockers should be avoided acutely, and antithrombic and antiplatelet therapy should be administered per standard guidelines.
- In all patients, counseling about the cocaine use should be part of discharge planning.

REFERENCE: McCord J, Jneid H, Hollander JE et al. (2008). Management of cocaine-associated chest pain and myocardial infarction: A scientific statement from the American Heart Association Acute Cardiac Care Committee of the Council on Clinical Cardiology. *Circulation* 117(14):1897–1907.

ASAM Drafting Guidelines for Methadone Induction

Working with the Center for Substance Abuse Treatment (CSAT), ASAM has convened a Clinical Guidelines Action Group to develop guidance for induction and stabilization of patients whose opioid addiction is treated with methadone.

The project was initiated by CSAT in response to findings of its July 2007 National Reassessment of Methadone Mortality, whose participants confirmed that the induction period of methadone treatment — whether for pain or addiction — is the time when most fatalities occur. They urged that CSAT develop a set of "best practices" to minimize overdose risk.

The Action Group — which includes experts nominated by AAAP, AOAAM, and AATOD as well as ASAM — is chaired by ASAM President-Elect Louis E. Baxter, Sr., M.D., FASAM. Following a systematic review of the peer-reviewed literature, the Action Group is now drafting the induction guidelines, which will be circulated for field review before they are submitted to CSAT.

ASAM members who are interested in serving as field reviewers should contact Angela Warner at **AWARNER@ASAM.ORG**.

Adherence to Practice Guidelines Improves Treatment Outcomes

Although treating opioid addiction with methadone and psychosocial services is well-supported by clinical trial data and practice guidelines, many opioid treatment programs (OTPs) do not follow evidence-based practices. To determine whether adherence to such guidelines improves patient outcomes, Keith Humphreys, Ph.D., and colleagues analyzed data from 232 patients recruited from OTPs in the U.S. Veterans Administration health system.

OTPs included in the study population were categorized as either "guideline-concordant" or "guideline-discordant." OTPs in both the guideline-concordant and guideline-discordant groups were geographically similar, as were baseline measures of patients' heroin use, employment, illegal activities, and mental health problems (the sample contained a large number of patients with co-occurring psychiatric disorders). The investigators found that:

- In the guideline-concordant OTPs, 79% of patients received doses of methadone in the recommended range, compared to 47% of patients in the guideline-discordant OTPs.
- Guideline-concordant OTPs had more full-time equivalent staff than guideline-discordant clinics, despite similar numbers of patients.
- At six-month follow-up, patients in guideline-concordant OTPs showed greater reductions in heroin use, greater improvements in global mental health, and a higher percentage of opioid-free urine tests.

According to Dr. Humphreys and colleagues, these results demonstrate that adherence to practice guidelines (which emphasize clinical practices found efficacious in controlled trials) improves treatment outcomes in severely impaired patients. Accordingly, they recommend that greater effort be made to increase adherence to clinical practice guidelines in OTPs.

REFERENCE: Humphreys K, Trafton JA, Oliva EM (2008). *Does following research-derived practice guidelines improve opiate-dependent patients' outcomes under everyday practice conditions?* Results of the Multi-site Opiate Substitution Treatment study. *Journal of Substance Abuse Treatment* 34(2):173–179.

Morphine Triggers Biological Events That Suppress Immune Response

Morphine and other opioids are known to suppress the immune system, requiring physicians to weigh the analgesic benefits of opioids against the added risk of infection — particularly to patients being treated for severe burns or certain cancers. Individuals who abuse opioids, many of whom already are vulnerable to infection because they use shared injection equipment, have poor nutrition and living conditions, are rendered even more vulnerable by use of these drugs. Now several studies funded by the National Institute on Drug Abuse are helping to elucidate the biochemical trigger that sets off a chain reaction ultimately resulting in suppression of immune cells. If confirmed by future studies, the research could lead to interventions to bolster the immunity of those who regularly use opioids.

Morphine suppresses the activity of three different types of white blood cells: T lymphocytes, B lymphocytes, and natural killer (NK) cells (see box). Researchers Dr. Donald Lysle, Dr. Timothy Saurer, and colleagues at the University of North Carolina, Chapel Hill, focused on NK cells and found that morphine-induced immunosuppression follows activation of dopamine-1 (D1) receptors in the shell of the nucleus accumbens (NAc). They further discovered that a train of biochemical events links stimulation of these D1 receptors with reduced NK cell activity in the spleen.

In earlier studies, the UNC team had established that blocking one of morphine's pharmacological effects in the brain — a surge of dopamine into the NAc — averts suppression of NK cells in the spleen. Based on this finding, the researchers reasoned that morphine-induced NK suppression must start with something that dopamine does in the NAc.

Dopamine's main action in the NAc is to interact with proteins called dopamine receptors, which come in several subsets: D1, D2, for example. Accordingly, Dr. Lysle and colleagues conducted experiments to determine whether any of these receptors were involved in morphine inhibition of NK cells. They began by giving rats morphine (15 mg/kg) or saline. An hour later, they measured NK cell activity in the animals' spleens and found it to be lower by about 40% to 50%, on average, among the morphine-exposed animals, compared with those given saline. Next, they conducted a series of trials and found that morphine-induced NK cell suppression depends on the activation of D1 receptors. For example, rats injected with a compound (SCH-23390) that prevents dopamine from accessing D1 receptors did not develop immunosuppression when subsequently injected with morphine. By comparison, rats pretreated with a compound (raclopride) that blocks D2 receptors did lose NK cell activity.

Moreover, D1 receptor activation in the shell of the NAc lowers NK cell activity even in the absence of morphine. Rats given no morphine but a test compound (SKF 38393) that activates D1 receptors demonstrated 35 to 39 percent less NK cell activity than a comparison group of rats injected with saline.

PATHWAY THROUGH THE BODY

Dr. Lysle and colleagues next turned their attention to the signaling chain that links D1 activity in the NAc to NK cell inhibition in other organs. The investigators focused on neuropeptide Y (NPY) as a likely candidate because it is released in the brain when sympathetic nerves are activated, is found at the nerves of the spleen, and interacts with receptors (Y1) in the membranes of white blood cells. "Most important in elevating NPY as a candidate, however, was other researchers' finding that it suppressed the ability of natural killer cells to attack cultured tumor cells," said Dr. Saurer.

The specificity of NPY's actions — affecting NK cells but not other white blood cells — is not surprising, added Dr. Lysle, because the brain generally seems to communicate with different immune system components in the body in very selective ways. As a result, he says, "Our team has identified the language for the suppression of natural killer cells, but other drugs of abuse and different immune system responses may speak distinct languages — ones that may be discovered in future research."

Source: NIDA Notes, Vol. 21, No. 6 (June 2008)

REFERENCES

Saurer TB, et al. Suppression of natural killer cell activity by morphine is mediated by the nucleus accumbens shell. *Journal of Neuroimmunology* 2996;173(1- 2):3-11.

Saurer TB, Ijames SG & Lysle DT. Neuropeptide Y Y(1) receptors mediate morphine-induced reductions of natural killer cell activity. *Journal of Neuroimmunology* 2006;177(1-2):18-26.

NATURAL KILLER CELLS ELIMINATE COMPROMISED CELLS

Natural killer (NK) cells constitute a rapid-response force against cancer and viral infections. These specialized white blood cells originate in the bone marrow, circulate in the blood, and concentrate in the spleen and other lymphoid tissues. When NK cells encounter cells that lack histocompatibility proteins, they attack and destroy them, thus preventing the cells from continuing to spread the virus or cancer. NK cells are distinguished from other immune system cells by the promptness and breadth of their protective response. Other white blood cells come into play more slowly and target specific pathogens — cancers, viruses, or bacteria — rather than damaged cells in general.

Review Course Offers Update on Addiction Science, Clinical Practice

ASAM's 2008 Review Course, which covers the core content of addiction medicine, is scheduled for the Westin O'Hare Hotel in Chicago, October 26th-28th. The course is preceded by special pre-courses organized by the Illinois Society of Addiction Medicine on Friday and Saturday, October 24th and 25th.

Dr. Edwin A. Salsitz

Dr. Karen Drexler

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

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

This year's course gives special attention to the use of newly available pharmacotherapies for alcohol and drug use disorders, as well as to emerging issues such as the diagnosis and treatment of aberrant medication use behaviors around opioid analgesics and other controlled substances.

SPECIAL SESSIONS: ***Understanding Addiction — Translating Science to Practice:*** How can individual practitioners access reliable information about current research? ***Challenges in Pain Management:*** How can addiction specialists help their primary care colleagues improve the care of all patients suffering from pain while minimizing the risk of addiction? ***Physician Impairment — The Scientific and Professional Challenge:*** With programs to assist impaired professionals under attack in the media, in some state legislatures, and in Congress, how can the interests in rehabilitating impaired physicians be balanced against the requirement to protect patients and the public? ***Ask the Faculty:*** Break-out sessions will allow participants to meet informally with faculty members to discuss topics of interest.

COURSE MATERIALS

ASAM's textbook, *Principles of Addiction Medicine, Third Edition*, is the basic reference text for the Review Course. Speakers will refer to and draw from this text often as part of their presentations. (*Principles* must be purchased separately: order from 1-800/844-8948; prices are $175 for ASAM members, $199 for nonmembers. Copies also will be available for purchase onsite.) As a supplement to *Principles*, participants in the Review Course will receive a Syllabus and CD-Rom with copies of speakers' slides and other information relevant to the topics to be covered. The Syllabus is a useful clinical reference and, for those who plan to sit for the Certification/Recertification Examination, provides advice on how to prepare and what to expect of the exam. The Syllabus will be shipped September 15, 2008, to all those who have registered for the Review Course by that date. Those whose registrations are received after October 13, 2008, can pick up their Syllabus on-site in Chicago at the ASAM Registration Desk.

LEARNING OBJECTIVES

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

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

CME CREDITS

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

REGISTRATION AND FEES

The Review Course registration fee is $400 for ASAM members; $475 for non-member physicians; $450 for non-physician professionals; $250 for residents (with documentation of status); $50 for medical students (with documentation of status). A one-day registration fee of $150 is also available. **Add a late registration fee of $50 for registrations submitted after October 13, 2008.** The conference hotel is The Westin O'Hare Hotel, 6100 River Road, Rosemont, Illinois (**847/698-6000**). For reservations, call the Westin O'Hare directly. To receive the conference rate of $159, reservations must be made on or before October 3, 2008. For reservations, dial: **1-800/WESTIN-1**.

QUESTIONS?

Contact Lisa Watson, CMP, at **301/656-3920** or **LWATSON@ASAM.ORG.**
ASAM REVIEW COURSE IN ADDICTION MEDICINE

ASAM REVIEW COURSE IN ADDICTION MEDICINE

Sunday, October 26 – Tuesday, October 28, 2008

WESTIN O'HARE HOTEL

CHICAGO

SATURDAY, OCTOBER 25, 2008

9:00 am – 9:00 pm
ISAM Pre-Course

5:00 – 7:00 pm
Registration opens

SUNDAY, OCTOBER 26, 2008

7:00 am – 5:00 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 9:00 am
Continental Breakfast

9:00 – 9:15 am
Welcome and Acknowledgements
Louis E. Baxter, Sr., M.D., ASAM President-Elect, and Course Co-Chairs Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM

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

10:15 – 10:30 am
Refreshment Break

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

11:45-1:00 pm
Lunch (Topic: Physician Impairment)

1:00 – 2:00 pm
Screening and Brief Intervention
Michael M. Miller, M.D., FASAM, FAPA

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

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Medical Comorbidities
Adam Gordon, M.D., M.P.H., FACP, FASAM.

4:15 – 5:15 pm
Pregnancy and Addiction
Marjorie Meyer, M.D., FACOG

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

5:30 – 7:00 pm
Dinner (on your own)

7:00 – 9:00 pm
Challenges in Pain Management
Theodore V. Parran, Jr., M.D., FACP

9:00 – 10:00 pm
Mutual Help Meeting

MONDAY, OCTOBER 27, 2008

7:00 am – 5:00 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 8:45 am
Continental Breakfast

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

9:00 – 10:30 am
Alcohol
Mark Willenbring, M.D.

10:30 — 10:45 am
Refreshment Break

10:45 – 11:45 am
Sedative-Hypnotics
Theodore V. Parran, Jr., M.D., FACP

11:45 – 1:00 pm
Lunch (Topic: Understanding Addiction)

1:00 – 2:00 pm
Non-Pharmacologic Therapies
Nichole Kosanke, Ph.D.

2:00 – 3:00 pm
Opioids
Edwin A. Salsitz, M.D., FASAM

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Opioid Agonist Therapy — Buprenorphine & Methadone
Edwin A. Salsitz, M.D.

4:15 – 5:15 pm
Twelve Step Programs
Lee Ann Kaskutas, Ph.D.

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

5:30 – 7:00 pm
Dinner (on your own)

7:00 – 9:00 pm
Ask the Faculty
Break-out sessions allow participants to meet informally with faculty members

9:00 – 10:00 pm
Mutual Help Meeting

TUESDAY, OCTOBER 28, 2008

7:00 am – 4:30 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 8:45 am
Continental Breakfast

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

9:00 – 10:30 am
Stimulants
Karen Drexler, M.D.

10:30 – 10:45 am
Refreshment Break

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

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

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

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

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Tobacco
Terry A. Rustin, M.D., FASAM

4:15 – 4:30 pm
Appreciations
Louis E. Baxter, Sr., M.D., FASAM

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

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

The Ruth Fox Donor Reception, which is held every year during the Med-Sci Conference to express ASAM's appreciation to the many members who support the Endowment Fund. This year's Reception was sponsored by Dr. & Mrs. Joseph E. Dorsey and Dr. Tommie F. Lauer. It was another very elegant and well attended event.

Dr. Schneider introduced the family of the Late James W. Smith, including his wife Barbara and their children Lynn, Lee, and Walter. Dr. Smith was a long-time leader in the addiction field and in ASAM, and a major donor to the Endowment Fund.

Dr. Lou Baxter and Dr. Mike Miller presented bronze medallions to: Herbert L. Malinoff, M.D., FASAM, Edwin A. Salsitz, M.D., FASAM, Richard G. Soper, M.D., J.D., FASAM and Martha J. Wunsch, M.D., FASAM. Silver medallions were presented to John P. Epling, M.D., FASAM, and Paul H. Earley, M.D., FASAM. A special framed award was presented to Tommie F. Lauer, M.D., FASAM for his many contributions to the Endowment and most recently his very generous bequest which places him in the Colleagues' Circle.

This year the Endowment Fund awarded seven scholarships, bringing the total number of scholarships awarded since 2002 to 43. Dr. Schneider introduced each of the recipients who gave a brief background of their experiences to date. They are Gregory Acampora, M.D., Lily Arora, M.D., Kathryn Hawk (a second-year med. student), Kristen Ochoa, M.D., Gregory Parada, M.D., John M. Raser, M.D., and Jose Vito, M.D.

The scholarships are but one example of the work supported by the Ruth Fox Memorial Endowment Fund, which was established to assure ASAM's continued ability to provide ongoing leadership in newly emerging areas of addiction medicine, to continue its commitment to educating physicians, to increasing access to care and to improving the quality of care.

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

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

Claire Osman
Director of Development

ASAM Staff & Consultants

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

Berit Boegli
Conferences &
Meetings Assistant
BBOEG@ASAM.ORG

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

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

Valerie Foote
Data Entry Operator
VFOOT@ASAM.ORG

Joanne Gartenmann
Consultant
JGART@ASAM.ORG

Tracy Gartenmann
Director of PCSS &
Buprenorphine Training
TGART@ASAM.ORG

Alexis Geier-Horan
Director,
Government Relations
Relations Assistant
AGEIER@ASAM.ORG

Gionne Graetz
Buprenorphine Training
& PCSS Manager
GGRAETZ@ASAM.ORG

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

Sandra Metcalfe
CME Consultant
SMETC@ASAM.ORG

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

Laura Kay-Roth
Executive Assistant
to the EVP/CEO
LKAY-ROTH@ASAM.ORG

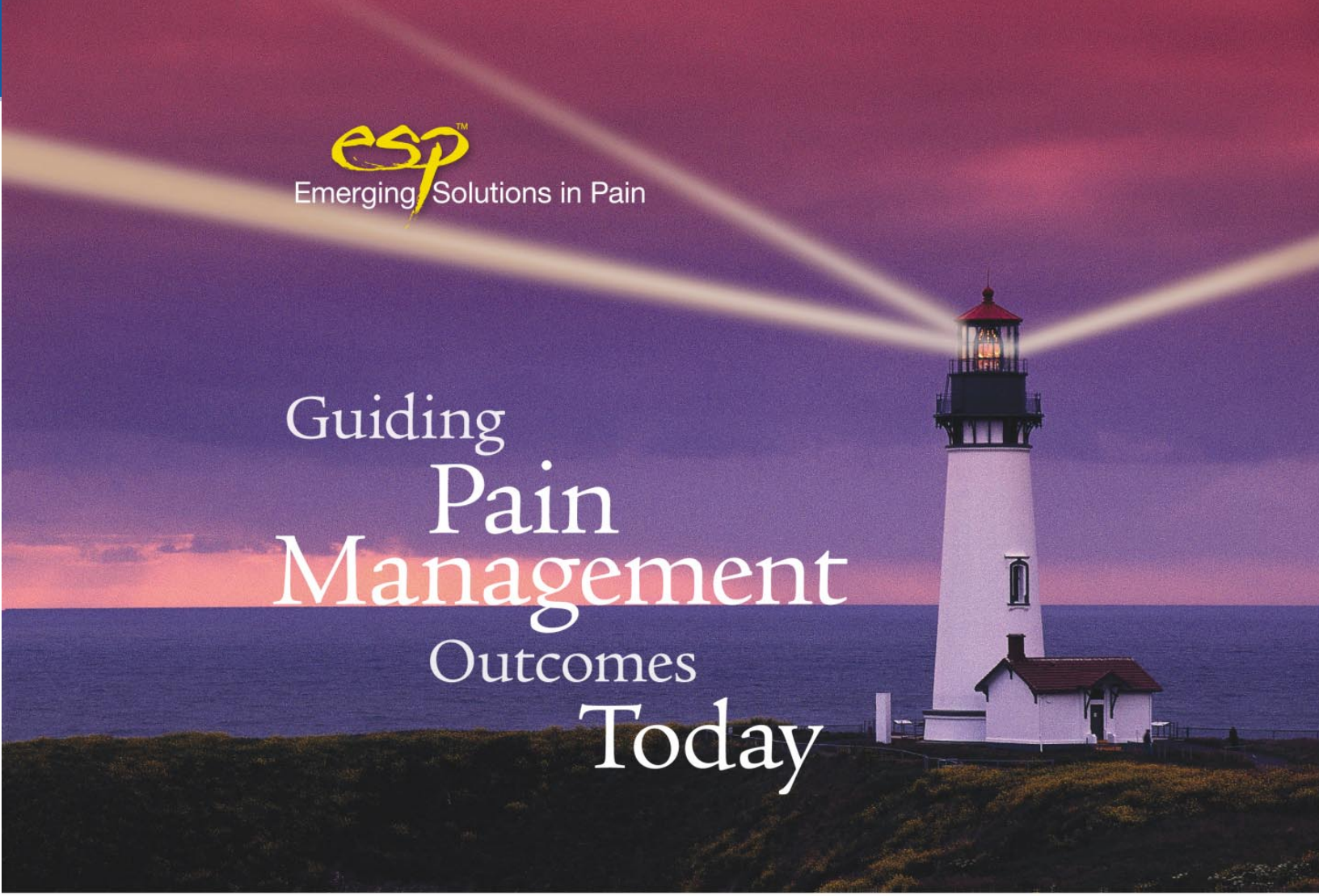
Noushin Shariate
Accounts Payable
NSHAR@ASAM.ORG

Lisa Watson, CMP
Director, Meetings
and Conferences
LWATSON@ASAM.ORG

Christopher Weirs
Director of Credentialing/
IT Manager
CWEIR@ASAM.ORG

Bonnie B. Wilford
Editor, ASAM News
210 Marlboro Ave.
Suite 31, PMB 187
Easton, MD 21601
Phone: 410/770-4866
Fax: 410/770-4711
BBWILFORD@AOL.COM

Except where indicated, all staff can be reached at ASAM's Headquarters Office,
4601 North Park Ave., Suite 101 Upper, Chevy Chase, MD 20814; phone **301/656-3920**; **EMAIL@ASAM.ORG**.



Emerging Solutions in Pain (ESP) is an ongoing **initiative that has been developed to address some of the most critical issues in pain management today.**

Enhance your learning through expanded multimedia features which include:

- Podcasting
- Video FAQs
- Accredited clinical case studies

The foundation of the website is the ESP Tool Kit, a multimedia collection of educational resources focusing on patient assessment for the risk of misuse, abuse and addiction, patient monitoring throughout the treatment plan and best practices for clinicians to help optimize patient care.

Try our newest features

- **Ask the Experts**
  Do you have challenging questions about pain management and addiction?
- **State Your Case**
  Submit your challenging case studies for review by ESP faculty.
- **Journal Club**
  A great way to increase your knowledge about timely peer-reviewed articles.
- **Scholarship Program**
  A wonderful opportunity for residents, fellows and registered nurses to attend a Leading Pain Management conference!

Visit **www.EmergingSolutionsinPain.com**

M·L·S
Medical Learning Solutions

Supported by an independent educational grant from Cephalon
deliver more

ASAM EVENTS

October 26 – 28, 2008
ASAM Review Course
in Addiction Medicine
Westin O'Hare Hotel
Chicago, Illinois
[21 Category 1 CME Credits]

December 5-7, 2008
Comprehensive MRO
Training Course
Washington, DC
[21 Category 1 CME Credits]

April 30, 2009
Ruth Fox Course for
Physicians
New Orleans, Louisiana
[8 Category 1 CME Credits]

April 30, 2009
Pain and Addiction:
Common Threads X –
New Orleans, Louisiana
[8 Category 1 CME Credits]

April 30-May 3, 2009
40th Annual Medical-
Scientific Conference
New Orleans, Louisiana
[22.5 Category 1 CME Credits]

October 22–24, 2009
ASAM Course on the
State of the Art in
Addiction Medicine
Hyatt Regency
Capitol Hill Hotel
Washington, DC
[21 Category 1 CME Credits]

OTHER EVENTS OF NOTE

September 4 – 7, 2008
Cape Cod Symposium
on Addictive Disorders
[Cosponsored by ASAM's
New England Chapters]
Hyannis, Massachusetts
For more information or
to register, visit
HTTP://WWW.CCSAD.COM
or phone Dee McGraw
at 616/475-4210

October 22-25, 2008
California Society of
Addiction Medicine's
Review Course
Newport Beach Marriott
Hotel & Spa
Newport Beach, California
For information or
to register, visit
HTTP://WWW.CSAM-ASAM.ORG

October 25, 2008
ISAM Pre-Course Review:
Pain Management
Westin O'Hare Hotel
Chicago, Illinois
[8 Category 1 CME Credits]
For more information or
to register, visit
HTTP://WWW.ISAM.ORG

November 6-8, 2008
32nd Annual National
Conference of the
Association for Medical
Education and Research in
Substance Abuse (AMERSA)
Hilton Embassy Row Hotel
Washington, DC
For more information or
to register, visit
HTTP://WWW.AMERSA.ORG

December 4-7, 2008
19th Annual Meeting
& Symposium of the
American Association for
Addiction Psychiatry (AAAP)
Boca Raton Resort & Club
Boca Raton, Florida
For more information
or to register, visit
HTTP://WWW.AAAP.ORG

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.

August is "Medicine Abuse Awareness Month"

The United States Senate has adopted a resolution declaring August "National Medicine Abuse Awareness Month." The measure, which was introduced by Senators Joseph Biden (D-DE) and Charles Grassley (R-IA), calls for community involvement and participation in efforts to educate parents about the dangers of adolescents' non-medical use of prescription and over-the-counter (OTC) medications.

Recent studies have underscored the extent of such misuse and abuse by young people. For example, some adolescents use large amounts of OTC cough compounds to obtain the active ingredient, dextromethorphan. Others engage in non-medical use of opioid analgesics, as well as stimulant medications used to treat ADHD.

Town hall meetings that focus on the problem have been scheduled during August in Seattle, Washington; San Antonio, Texas; and Miami, Florida. Organizations interested in hosting their own town hall meetings can access helpful materials at **WWW.DOSEOFPREVENTION.ORG.**