Spring 2009 Volume 24, Number 1

ASAM News

Newsletter of The American Society of Addiction Medicine

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ASAM at Work for You:

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For a look at President Obama's views on addiction and treatment, as well as key federal health appointees, see page 3.

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Parity Legislation Passes Congress, Signed Into Law

After a 12-year struggle, the House and Senate have enacted legislation requiring parity in health coverage for mental health and addiction care. The Paul Wellstone and Pete Domenici Mental Health and Equity Act of 2008 passed the House on October 3rd as part of the $700 billion financial bailout package, two days after the Senate voted a similar bill. President Bush quickly signed the measure into law.

"I'm ecstatic," said David Wellstone, who has lobbied for the legislation since his father Paul's death in a plane crash. "To have my dad's legacy be this law is a great thing," he added.

Another Minnesotan, Republican Rep. Jim Ramstad, has sponsored similar legislation for years, bucking his own party's opposition. Rep. Ramstad, who is retiring, said: "It has been 12 long years, but it's worth every minute of the effort." He called passage of the bill his most important legislative achievement. *(For more on parity, see page 18.)*

ASAM Members Elect New Officers, Members of the Board of Directors

ASAM members have chosen the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Regional Directors. In balloting completed December 1, Donald J. Kurth, M.D., M.B.A., FASAM, was chosen President-Elect, C. Chapman Sledge, M.D., FASAM, was elected Secretary, and Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA, was named Treasurer.

Those elected Regional Directors are Marc Galanter, M.D., FASAM (Region I); David R. Pating, M.D. (Region II); John P. Femino, M.D., FASAM (Region III); Jeffrey A. Berman, M.D., FASAM (Region IV); J. Ramsay Farah, M.D., M.P.H., FAAP (Region V); Herbert Malinoff, M.D. (Region VI); John P. Epling, Jr., M.D. (Region VII); Marvin D. Seppala, M.D. (Region VIII); Raju Hajela, M.D., M.P.H., FASAM (Region IX); and Richard G. Soper, M.D., J.D., FASAM (Region X).

The newly elected officers and Regional Directors will be installed at the Annual Business Meeting during the Society's 2009 Medical-Scientific Conference in New Orleans. At that time, Louis E. Baxter, Sr., M.D., FASAM, will assume the Presidency of ASAM and Michael M. Miller, M.D., FASAM, FAPA, will become Immediate Past President. Profiles of the new officers and directors appear on pages 7-14 of this issue of **ASAM News**.

Eileen McGrath, J.D

ASAM Wins NIDA Grant

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

In this era of austerity, it is difficult to win federal grants. However, thanks to the extraordinary leadership of ASAM's own Marc Galanter, M.D., FASAM, the National Institute on Drug Abuse has awarded ASAM a grant for advancing the scientific input to the Society's annual Medical-Scientific Conference. The grant, which is funded for $125,000 over five years, focuses primarily on inviting speakers and young investigators to join with ASAM in our research mission.

Jag Khalsa, Ph.D., chief of NIDA's Medical Consequences Branch, is the government's project officer for the award. In discussing the importance of the project, Dr. Khalsa said, "We at NIDA regard ASAM as one of our most valuable resources for research and education. This project will solidify the working relationship between our Institute and the medical addiction treatment community."

Dr. Galanter deserves great credit for conceptualizing the grant application and leading the team that saw it through to completion. He was ably assisted by Lisa Watson, ASAM's Director of Meetings and Conferences.

Many of our members are not fully acquainted with the central role that NIDA and its sister agency, the National Institute on Alcohol Abuse and Alcoholism, have played in advancing the frontiers of addiction research. NIDA is the federal focal point for research on drug abuse and addiction. It was established in 1974 and became part of the National Institutes of Health in 1992 (with ASAM member Robert L. DuPont, M.D., as its first Director). The Institute is divided into four divisions, one for epidemiology, services, and prevention research; two for basic and clinical neuroscience and behavioral research; and a fourth on pharmacotherapies and medical consequences of drug abuse. It operates with a budget of over $1 billion annually, and has been particularly active in medications development, including buprenorphine and its current work on antibody-based vaccines for stimulants and nicotine dependence. NIDA also has a long history in supporting HIV-related research and is active in biomedical research training.

In addition, support from NIDA and from NIAAA were instrumental in establishing teaching on addiction in medical schools with their joint Career Teacher Program, dating back to the 1970s. Both institutes currently have extensive programs in research training. Both Dr. Khalsa from NIDA and Mark Willenbring, M.D., from NIAAA, participate in ASAM's Medical-Scientific Conference Program Committee, and have been instrumental in introducing new research into our Med-Sci Program.

The project funded by the NIDA grant has three specific aims. The first is to foster multidisciplinary collaboration among U.S. and international health care professionals in both basic and clinical science. This will increase ASAM's ability to invite overseas experts to our Med-Sci conferences — an important opportunity, given the fact that there is a growing body of research emerging from international investigators, particularly in the European Union. The second goal is to encourage young researchers and clinicians to enter the field of addiction clinical research.

This will allow ASAM to increase travel grants, introduce instruction in grant writing, and develop a support network to promote research among members of ASAM who have recently completed training. This is important because of an acknowledged need, among our leadership as well as in the federal government, for developing a strong cadre of physician researchers in our field. Finally, the grant will allow for more opportunities for physicians and other health care professionals already involved in research to sharpen their skills and experience a greater range of presentations at our annual meetings.

Altogether, this funding places ASAM in the ranks of a limited number of professional research organizations, like the Congress on Problems of Drug Dependence, that receive NIDA support for their annual meetings. We thank NIDA for its vote of confidence, Dr. Galanter for his visionary leadership, and look forward to moving forward in this important partnership.

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

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Obama Policies Favor Prevention, Treatment

Based on his legislative record, Barack Obama has not previously been deeply involved in drug policy questions. Yet William Cope Moyers, vice president of external affairs at Hazelden, says he has "never been more hopeful that addiction treatment will begin to get the attention it deserves."

As a one-term senator, Mr. Obama compiled relatively little legislative history on addiction issues, but he made a number of public statements on aspects of drug policy, and his cornerstone campaign document, the Blueprint for America, includes a number of positions and statements related to alcohol, tobacco and other drug use.

President Barack Obama

BLUEPRINT FOR CHANGE

Noting that health care reform is a high priority of the new administration, Mr. Moyers said it is "imperative that the President and Congress include addiction and treatment in whatever reform ultimately evolves," adding that "There will be a lot of issues on the table; let's just hope that not just addiction but treatment and recovery will be on the agenda."

Indeed, the Obama campaign's Blueprint for America includes a pledge to sign a universal health care plan by the end of his first term as president. "The benefit package will be similar to that offered through the Federal Employees Health Benefits Program (FEHBP), the plan members of Congress have," the Blueprint states. "The plan will cover all essential medical services, including preventive, maternity and mental health care." (The FEHBP requires parity coverage of addictive disorders, although this is not explicitly mentioned in the Obama document.)

The Blueprint cites the need to spend more money on disease prevention and pledges support for rural communities, including a promise to combat methamphetamine. "Obama has a long record of fighting the meth epidemic," according to the Blueprint. "As President, he will continue the fight to rid our communities of meth and offer support to help addicts heal. "

Tom Coderre, national field director for Faces and Voices of Recovery, praised then-Senator Obama's support of addiction parity legislation and noted that he also supported the Second Chance Act of 2007, which provides support for ex-offenders re-entering society. Expansion of drug courts was a high priority in the Obama campaign's civil rights agenda. "Obama will give first-time, nonviolent offenders a chance to serve their sentence, where appropriate, in the type of drug rehabilitation programs that have proven to work better than a prison term in changing bad behavior," the Blueprint states.

Among the campaign's military priorities was a pledge to improve mental health treatment for troops and veterans suffering from combat-related mental health problems. "Veterans are coming home with record levels of combat stress, but we are not adequately providing for them," according to the Blueprint.

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Obama Announces Key Health Appointments

As this issue of **ASAM News** went to press, the following appointments had been officially announced by the White House, but none of the designees had been confirmed by the Senate.

Department of Health and Human Services: President Obama has announced his intention to nominate Kansas Governor Kathleen Sibelius as Secretary of Health and Human Services. In that role, she will work with Democrats and Republicans alike in efforts to cut costs, expand access, and improve the quality of health care for all Americans.

As a popular Democratic governor in a Republican state, Gov. Sibelius has proved her ability to garner support from both sides of the aisle. She also served as Kansas Insurance Commissioner from 1994 to 2002, during which time she earned a reputation for standing up to the health insurance companies.

White House Office of Health Reform: Nancy-Ann DeParle, an expert on health care and regulatory issues, will serve as Counselor to the President and Director of the White House Office for Health Reform. Ms. DeParle also has been commissioner of the Department of Human Services in Tennessee and, in the Clinton Administration, handled budget matters for federal health care programs and oversaw the Medicare and Medicaid programs.

In announcing the appointments of Gov. Sibelius and Ms. DeParle, President Obama said, "If we are going to help families, save businesses, and improve the long-term economic health of our nation, we must realize that fixing what's wrong with our health care system is no longer just a moral imperative, but a fiscal imperative. Health care reform that reduces costs while expanding coverage is no longer just a dream we hope to achieve — it's a necessity we have to achieve."

Office of National Drug Control Policy: Seattle Police Chief Gil Kerlikowske is President Obama's choice to head the Office of National Drug Control Policy (ONDCP).

In a White House ceremony, Vice President Joseph Biden — who helped create ONDCP — said Chief Kerlikowske "brings a lifetime of experience working on drug policy issues…. He understands that combating drugs requires a comprehensive approach that includes enforcement, prevention and treatment."

Chief Kerlikowske echoed the Vice President's call for a "coordinated comprehensive national drug strategy," stating, "It's an incredibly complex problem, and it requires prosecutors and law enforcement, courts, treatment providers, and prevention programs to exchange information and to work together."

Chief Kerlikowske's nomination won praise from a broad range of advocates and officials, including Los Angeles Police Chief William Bratton, Partnership for a Drug-Free America President Steve Pasierb, Police Executive Research Forum President Chuck Wexler, and advocates for drug policy reform.

Unlike his recent predecessors, the Director will not serve as a

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

Medical Staff Credentialing for Addiction Specialists

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

When physicians practice on hospital medical staffs or managed care panels, they must be granted privileges to perform specific preventive, diagnostic or therapeutic procedures or processes. In addiction medicine, we perform consultations and diagnostic examinations of inpatients and outpatients; we manage intoxication, withdrawal and the chronic disease of addiction; we provide counseling for individuals and families and prescribe medications as indicated; and we supervise multidisciplinary teams of clinicians. And, as has been highlighted by a flurry of recent activity, we screen for the presence of substance use disorders and provide brief interventions, and refer diagnosed individuals to specific addiction treatment services (screening, brief intentions, and referral to treatment, or SBIRT).

It is not uncommon for hospital medical staffs and managed care provider panels to have a requirement that members be board-certified by an ABMS-recognized specialty board. In the case of addiction medicine, there is no ABMS-recognized specialty board except for the subspecialty of addiction psychiatry, but roughly half of ASAM members are non-psychiatrists. Moreover, over 99% of ASAM-certified addiction medicine specialists were at one time certified by an ABMS-recognized specialty board, but many physicians now specializing in addiction medicine have not maintained re-certification in their original specialty. Thus, in many communities, the physician most skilled in managing patients with substance related disorders is an ASAM-certified addiction medicine specialist who is not currently board-certified by an ABMS-recognized board. Such physicians sometimes face barriers in receiving or maintaining credentials on hospital medical staffs and managed care provider panels.

The American Medical Association has unequivocal policy on this topic: the AMA states that board certification is one way, but not the only way, of identifying/assuring quality in a physician. ASAM-certified physicians who encounter barriers to medical staff membership through requirements for board certification (which always is interpreted to mean "an ABMS-recognized board") should bring this AMA policy to the attention of local authorities.

The ASAM certification credential has widespread credibility and recognition throughout the Nation; the ASAM website describes what ASAM certification is and how widely it is recognized. For example, it might be effective to call on an ASAM-certified colleague from another city (an "expert" having been defined as someone from out of town, who travels with slides!) who may be better able to overcome resistance to granting medical staff privileges or membership on a managed care panel.

Another approach is to work with a hospital's Medical Executive Committee and/or hospital/clinic/network Credentials Committee to establish a Department of Addiction Medicine or to define a specific set of credentials for the practice of addiction medicine within the medical staff/provider panel. (This approach was adopted by Meriter Hospital in Madison, Wisconsin, to allow for both hospitalists and locum tenens physicians to join the medical staff and provide care to addiction patients, even if they are not board-certified by an ABMS-recognized board.)

Physicians should use all available tools to advocate vigorously for themselves whenever they confront discrimination based on lack of awareness of the content of addiction medicine, the clinical skill set of an addiction medicine specialist, and the ASAM examination/certification process. To do so serves the highest interests of our patients and our profession.

AMA Acts Favorably on Issues Supported by ASAM

Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA, ASAM's Representative to the AMA House of Delegates, and Michael M. Miller, M.D., FASAM, FAPA, President of ASAM

ASAM was well represented at the December 2009 meeting of AMA's House of Delegates by ASAM's Delegate Dr. Stu Gitlow and — attending his first AMA meeting — ASAM's Alternate Delegate and President-Elect, Dr. Don Kurth. In addition, ASAM's President, Dr. Mike Miller — a member of the Wisconsin Medical Society delegation — represented ASAM at the Section Council on Preventive Medicine and joined the Chair of the APA's Delegation, Dr. Jack McIntyre, in addressing the House of Delegates to thank the House for its forward-looking policies dating back 50 years, when the AMA declared that alcoholism is a disease, as well as through its policies on parity, which insist that addiction be included with mental health in any parity legislation.

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

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

Drs. McIntyre and Miller thanked the AMA specifically for its advocacy on behalf of mental health and addiction parity in enactment of H.R.1424. In response to a Resolution from the Minnesota Delegation, the AMA House voted to direct AMA staff to post informational materials on the AMA website to inform physicians and patients about the benefits afforded to them through the adoption of this landmark payment reform legislation.

From ASAM's perspective, the major achievement of the December meeting was adoption, by unanimous consent, of a report of the Council on Science and Public Health titled "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction." The report commits the AMA to work with relevant national medical specialty societies to develop CME programming and practice guidelines on nonmedical use of prescription medications. In line with the AMA's new focus on creating products that are of practical use to individual physicians in clinical practice, the AMA staff has been charged to devise a consensus screening tool that will help physicians assess the risk of addiction in any patient under consideration for long-term prescribing of opioids, psychostimulants, benzodiazepines, and other pharmaceuticals that are subject to misuse, diversion, or addiction.

Other items adopted by the AMA House include:

* A landmark CSAPH report on "Global Climate Change and Human Health," which addresses what physicians need to know about how health conditions are likely to evolve as the climate changes.
* A Report by the Council on Medical Service on "Comparative Effectiveness Research," which outlines principles that should guide the creation of any federal centralized Comparative Effectiveness Research entity that would fund, set standards for, and serve as a repository for CER.
* A report from the AMA Board of Trustees on the concept of "One Fee, One Number," which calls for registration by the federal Drug Enforcement Administration to be linked to a particular physician rather than a practice site, so that the same DEA number can be used at all sites and in multiple states, wherever a physician may practice.
* A report from the AMA Board of Trustees entitled "Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters."
* A resolution from the AMA's Organized Medical Staff Section suggesting that a set of model medical staff bylaws be adopted to encompass policies for addressing disruptive/abusive behavior by members of the medical staff, and to shield physicians from inappropriate/unfair accusations of abusive behavior. This Resolution asks for the creation of a Report from the AMA that would update previous AMA definitions, focus on objectively describable behaviors, and abandon the term "disruptive physician," as well as assuring that physicians have appropriate due-process mechanisms to appeal when accused of exhibiting abusive behaviors. The President of the Federation of State Physician Health Programs, ASAM member Dr. Louis Sanchez, joined the AMA President and dozens of other physicians in presenting more than an hour of testimony on this topic before the Reference Committee. The resolution adopted by the House of Delegates includes a proposal for the AMA to work with the Joint Commission on a new set of standard definitions and terms in this area. A related matter deals with the new Joint Commission standard in the Leadership chapter of the JCAHO accreditation manuals, LD.03.01.01, and directs the AMA to ask the Joint Commission to delay by one year the implementation of this new standard until issues regarding terminology can be worked out. Model Medical Staff Bylaws language regarding a Code of Conduct for members of the organized medical staff, which addresses potentially disruptive/abusive behavior, also was proposed.

A number of other items also are of interest to ASAM members:

- The topic of e-prescribing of controlled substances was brought before the AMA House, and existing AMA policy on this topic was reaffirmed.
- The topic of so-called "medical marijuana" and proposals to change the Schedule I status of marijuana plant products under the federal Controlled Substances Act was brought before the

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AMA Acts Favorably *continued from page 5*

AMA House by the AMA Medical Student Section. A Resolution from the Washington State delegation asked that the AMA support efforts to stop criminal prosecution and other enforcement actions against physicians who are acting in accordance with that state's "medical marijuana" laws. Testimony involved a parade of individuals from outside the AMA House of delegates, each of whom provided an anecdote regarding a patient or patients who responded well to use of marijuana. Further testimony focused on the well-known risks of marijuana and the fact that, although the risk is likely to be low for a patient with a terminal illness, it is not likely to be low when the drug is diverted for use by others. The CSPH report describes fairly strong evidence that controls currently in place for controlled substances have failed to effectively stop access by those who should not have such substances. The House referred these matters to the AMA Council on Science and Public Health, with a request that the council prepare a full report with recommendations. (Dr. Gitlow is a member of that Council and will have an opportunity to weigh in on the report.)

- The California delegation presented a resolution addressing the fact that in California, when a hospital medical staff implements a "summary suspension" of a physician's privileges, this information is immediately publicly disseminated, before the physician is afforded any of the rights of due process contained in the medical staff bylaws or any confirmation of the validity of the concern by the California board of medicine. The California resolution asks that a review of such action by a state licensing board should be conducted and completed before any public disclosure or automatic referral to the National Practitioner Data Bank. The Reference Committee Report addresses the broader topic of efforts to make public the data in the NPDB, and the House agreed that this matter needs prompt action; the House referred this matter to the AMA Board of Trustees for their consideration and prompt decision.
- Another California resolution asked that the AMA adopt the definitions found in the "Joint Principles of Patient-Centered Medical Home," which were jointly developed by the AAFP, the AAP, the ACP and the AOA. There was much discussion of this concept, and the AMA President presented to the Section Council on Preventive Medicine the AMA Public Policy Statement on this topic. The House did vote to adopt the "Joint Principles" in order to create a common set of terminology as the AMA Council on Medical Service completes its work on a detailed Report on PCMH for presentation to the AMA House in 2009.
- Yet another California resolution asked that the AMA "take all appropriate steps to seek federal regulatory and/or statutory changes to strengthen a medical staff's right to self-governance to ensure that the medical staff as a whole is responsible for the patient care, patient safety, and the quality of care delivered in the hospital, and that the Medicare program enforce the 'conditions of participation' in Medicare that relate to the autonomous status of the organized medical staff." This resolution was adopted.
- A resolution was presented by the AMA's Organized Medical Staff Section to the full House, asking for a clarification of the title of "doctor" in the hospital environment. This responds to the fact that many health professions have created doctoral degree programs in discipline in which a bachelor's or master's degree previously was the terminal degree. The resolution was adopted by the House.
- A resolution by the Florida delegation regarding Maintenance of Certification (MOC) requirements established by the member boards of the ABMS was adopted.
- A resolution from the AMA's Minority Affairs Consortium was introduced, asking the House to reaffirm the AMA's policies on HIV infection and to support the CDC in its efforts to evaluate the effectiveness of existing HIV prevention programs directed to minority populations. The resolution was adopted.

REASONS TO JOIN THE AMA

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

Membership in the AMA continues to falter, and the percentage of physicians paying full dues is now under 20% of all who are eligible. For ASAM to retain its seat in the AMA's House of Delegates, our Society must have a specific percentage of our members who also are members of the AMA. In the past, ASAM has fallen below the required percentage and been placed on probation, but we argued effectively that the required percentage should change to more closely reflect the AMA membership percentage in general. This move succeeded and the new percentage was approved. The result: ASAM is safe for now as a member of the House of Delegates, which has been critical in our members' quest for professional recognition.

However, we're on the edge, so please don't look at this as your chance to drop your AMA membership. In fact, we could use a little breathing room, so I'd urge those of you who aren't now AMA members to reconsider. The AMA has been a strong ally of ASAM for many years, working alongside us in seeking parity for addictive disease and developing policies with us on addictive substances and addiction in general. ***Please join!***

PROFILE: *Dr. Baxter is Next President of ASAM; His Goals Include Making Parity Real*

Daniel Meara

It sometimes — though rarely — happens that trying circumstances are met by an individual whose abilities and temperament are tailored precisely to the test. So it is with the incoming president of the American Society of Addiction Medicine, Dr. Louis E. Baxter, Sr., of New Jersey. His tenure will begin amid obvious constraints but also with enormous opportunities, not the least being that ASAM will have no small say in refining the rules and regulations that govern the new federal parity law.

Dr. Baxter, who heads New Jersey's Professional Assistance Program, has considerable expertise in addiction medicine and has won the respect of the field. Perhaps as important in such uncertain times is his deep reservoir of optimism, which readily comes across in meeting him, as does his modest manner. He recognizes this as a momentous time and embraces it, noting "It is the first time in history that addiction medicine can promote itself with evidence-based practices." Science, he stresses, now "underscores addiction as a disease."

Dr. Louis E. Baxter, Sr., MD, FASAM

He remembers a time when that was not the case, when addiction treatment was slighted as "merely talk therapy." Now that addiction and mental illness treatment "have the same underpinnings" as other medical specialties — with scientific data confirming "addiction as a brain disease" — he is confident about the field's future in spite of the threats presented by the feeble economy.

Developments in the science of addiction medicine will, Dr. Dr. Baxter says, play an important part as he and others strive to "make the parity bill real." It will fall to Dr. Baxter and others to ensure that regulations are written in such a way that they protect patients. He is prepared to wrangle with the details that he understands are the devil in the bill and also to negotiate with those who don't want to see any more money spent on treatment. The details to be hashed out include who gets to define the conditions insurers cover as well as who determines authorization and utilization of services. Because most health plans operate on a calendar year, the law will go into effect January 1, 2010.

Among the key details in the parity negotiations and more generally will be treating addiction as a chronic disease. Dr. Baxter occasionally delivers a lecture on this subject. In his talk, he contrasts the treatment of diabetes and addiction. When a diabetic is diagnosed, he has his blood sugar brought into balance with insulin, which Dr. Dr. Baxter calls the detox part of his treatment. From there on, the patient is educated about his disease, learns to control his own blood levels, and meets periodically with a physician. Treatment is a life-long commitment. When addicted patients begin treatment, too often they go through detox but the disease management component goes wanting. In his lecture, Dr. Baxter notes that when addiction patients enter a true continuum of care — including occasional meetings with a doctor, preferably an addiction specialist — the outcomes are better than those seen with other chronic illness.

In addition to the evidence-based practices and improved and measured treatment outcomes, Dr. Baxter notes that the field has made great gains with pharmacotherapy. For alcohol dependence, he said naltrexone, while not a cure for alcoholism, is "a tool with which we can assist patients to help them maintain recovery." He also cited the benefits of buprenorphine, which "attenuate the effects of withdrawal." He also pointed to other promising developments in pharmacotherapy.

Another development that feeds Dr. Dr. Baxter's optimism is the formation of the American Board of Addiction Medicine. He hopes that through this board, more doctors will specialize in addiction medicine. He said the residencies and fellowships now available should help bring more doctors into the field. Furthermore, the new parity law should make addiction medicine more attractive to medical students, in that it will be possible for them to earn a living in the field.

As for addiction being included in a universal health care plan, Dr. Baxter said ASAM and other stakeholders are working to include it in any proposals. This effort comes at time when "health care dollars are being highly scrutinized," Dr. Baxter noted. Nonetheless, he said he is heartened that we are now in an environment in which "decisions are based on science, not ideologies."

ASAM's upcoming conference in New Orleans clearly has stirred the enthusiasm of its President-Elect. A special plenary session will focus on the new parity law. The agenda also includes an introduction to addiction medicine and its history. Among the hot topics to be covered are treatment of adolescents, urine drug testing, and reimbursement. The National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse will present new findings on alcoholism and drug addiction.

Through the years, Dr. Baxter has invested considerable time and effort in New Jersey's Professional Assistance Program, which promotes treatment of impaired physicians and other health care personnel. He said the program is growing in numbers, which he sees as a good thing, although not everyone agrees. The way Dr. Baxter sees it, the fact that more physicians and other medical professionals are coming into treatment means that more patients are being protected from practitioners who could be impaired. He adds that the 700 professionals currently enrolled in the program are well below the estimated 2,600 who need help.

In describing how he will lead ASAM, Dr. Baxter says, "I intend not to be a micro-manager; I will let experts do what experts do." He adds that he will use "the richness of experience we have." Dr. Baxter's leadership style, coupling a light touch with profound understanding, are likely to make the next two years at ASAM an extraordinary time for addiction medicine, whatever the obstacles.

***Daniel Meara** is the Public Information Officer of the National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ). This article originally appeared in NCADD-NJ's publication,* Perspectives, *and is reprinted with the permission of the New Jersey NCADD.*

THE OFFICE OF
PRESIDENT-ELECT

Newly Elected ASAM Leaders to Take Office in April

The following Officers and Regional Directors will be installed at the Annual Business Meeting on May 1st during ASAM's Annual Medical-Scientific Conference in New Orleans. At that time, Louis E. Baxter, Sr., M.D., FASAM, will assume the Presidency of ASAM and Michael M. Miller, M.D., FASAM, FAPA, will become Immediate Past President. All of the officers serve two-year terms (2009-2011).

Donald J. Kurth, M.D., M.B.A., FASAM

RANCHO CUCAMONGA, CALIFORNIA

Biographical Sketch: I was born in New England, raised in New Jersey, and attended Columbia University in New York City for college and medical school. While at Columbia, I received a Scholarship Abroad to study at Oxford University in England. I trained at Johns Hopkins and UCLA and settled in southern California

I have long been committed to the treatment of addictive disease, not just at a clinical level, but at the level of research, education, and public policy as well. I have served as a member of the Board of Governors of Daytop Village in New York since 1975. After completing medical school at the College of Physicians and Surgeons of Columbia University, I trained at Johns Hopkins and UCLA, becoming Board Certified in Emergency Medicine in 1987.

During this period I also served as a physician volunteer for the Flying Samaritans (providing free medical care to poverty areas in Baja, Mexico) and founded the Free Pediatric Immunization Clinic in my own hometown. I have broad ranging experience in both the private and the public sectors, having served as President of the Chamber of Commerce as well as being publicly elected as Finance Committee member and later President of the $36 million per year regional water district (Cucamonga County Water District). In 1993 I also received the Small Business Person of the Year Award from the United States Small Business Administration.

I currently serve as Mayor of the City of Rancho Cucamonga, a suburban community with a population of 150,000. For the past 10 years, I have served as Chief of Addiction Medicine at Loma Linda University Behavioral Medicine Center. My time is split between patient care, teaching, research, and finishing up my M.B.A. My love, of course, is advancing our specialty and developing public policies to improve access to addiction treatment for our patients. Board certification for Addiction Medicine must be our next goal. My hobbies are wilderness rafting and spending time with my bride, Dee.

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.

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.

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.

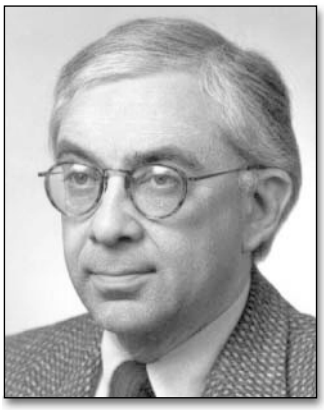
As an organization and a medical specialty, we can sit tight, not take on these new activities, not take any risks, and ASAM likely would gradually diminish in scope and importance to the field. Or we can push for the advocacy and acceptance that are critical to our patients and our members, doing so 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.

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.

DIRECTOR OF REGION II (CALIFORNIA)

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.

ALTERNATE DELEGATE

Edwin A. Salsitz, M.D., FASAM

ALTERNATE DELEGATE

Peter Banys, M.D.

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.

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 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.

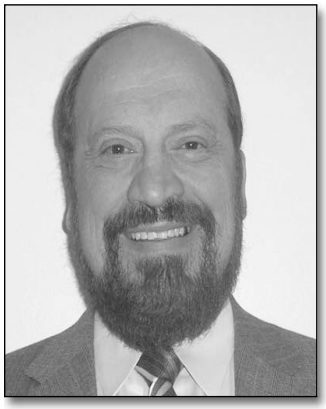
ALTERNATE DELEGATE
Ken Freedman, M.D., M.B.A., FACP, FASAM

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

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.

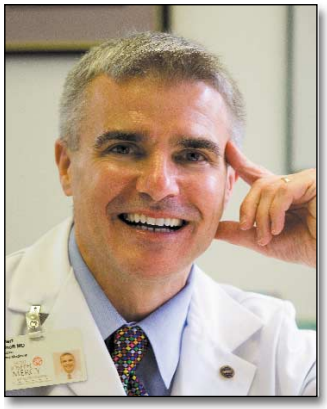
How do you feel your election would benefit ASAM and the field of addiction medicine? At the Regional level, my focus will be to strengthen the chapters' legislative efforts and to enhance membership recruitment and development.

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.

DIRECTOR OF REGION VI
(IA, IL, IN, MI, MN, WI)

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.

ALTERNATE DELEGATE
Gary D. Helmbrecht, M.D.

ALTERNATE DELEGATE
Dora D. Dixie, M.D.

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.

DIRECTOR OF REGION VIII
(AK, AZ, CO, HI, ID, MT, ND, NM, NV, OR, SD, UT, WA, WY)

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.

ALTERNATE DELEGATE
Howard C. Wetsman, M.D.

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

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.

DIRECTOR OF REGION X
(AL, FL, KY, MS, TN, Puerto Rico, Virgin Islands)

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.

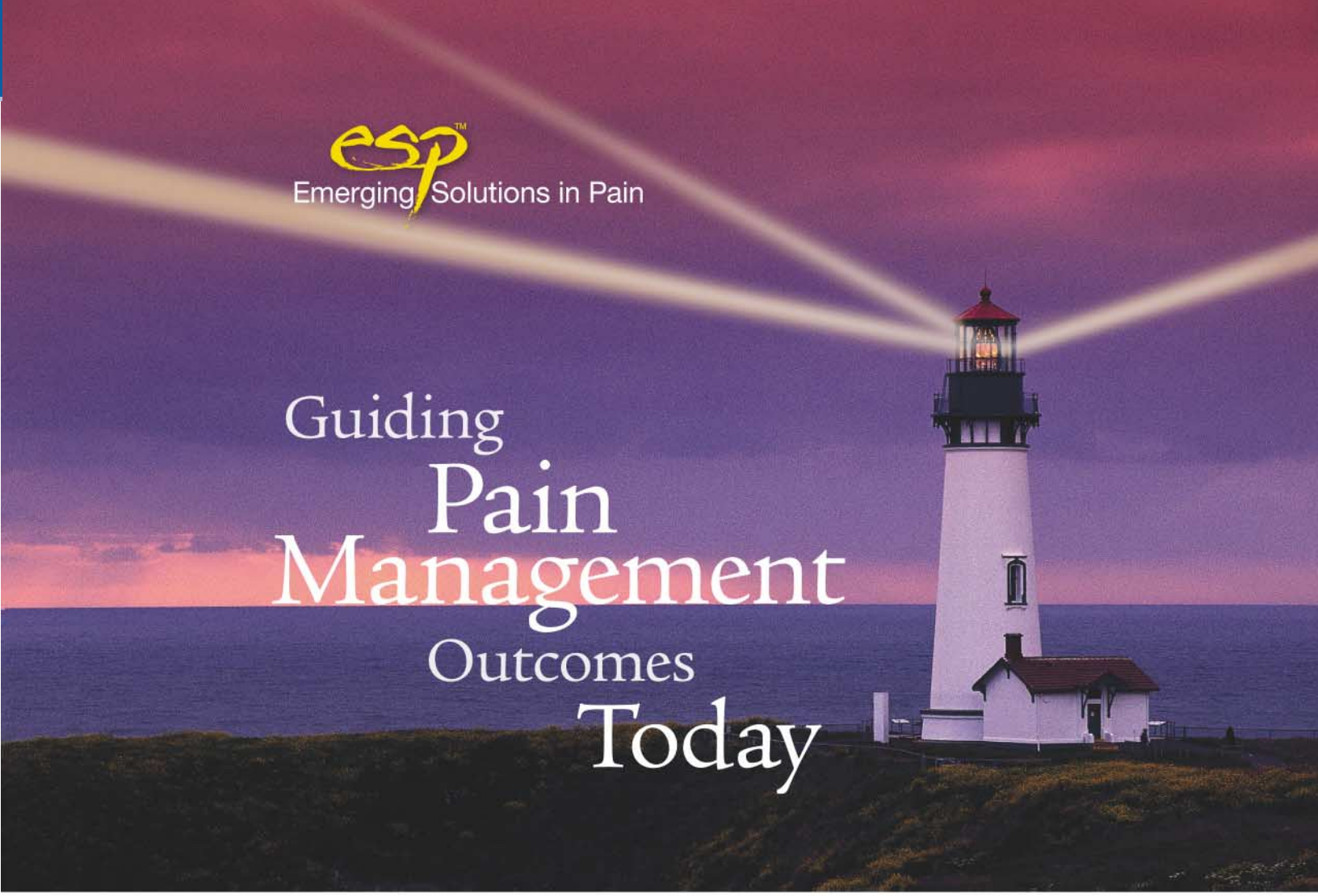
Within addiction medicine, I have:

- 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.

ALTERNATE DELEGATE
David C. Marsh, M.D., CCSAM

ALTERNATE DELEGATE
Bernd Wollschlaeger, M.D., FAAFP, FASAM



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MONITORING THE FUTURE
Survey Shows Mixed Results

There are signs that the recent decline in adolescent marijuana use has stalled, although the downward trend in cigarette and alcohol use continues, according to the 2008 Monitoring the Future (MTF) Survey. The survey — now in its 33rd year — is a series of classroom surveys of 8th, 10th and 12th graders, conducted by researchers at the University of Michigan under a grant from the National Institute on Drug Abuse (NIDA).

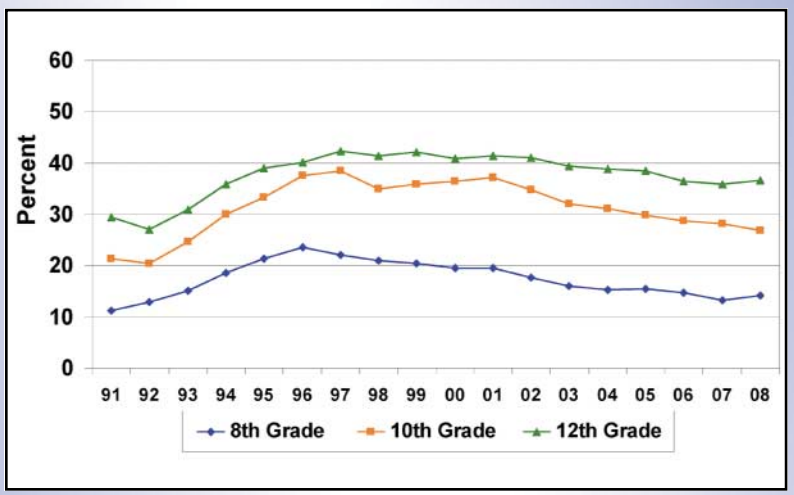
The current survey indicates that marijuana use among 8th, 10th and 12th graders, which has shown a consistent decline since the mid-1990s, appears to have leveled off, with 10.9% of 8th graders, 23.9% of 10th graders, and 32.4% of 12th graders reporting use within the preceding year. Heightening the concern over this leveling off in use is the finding that, compared to the 2007 data, the proportion of 8th graders who perceived smoking marijuana as harmful and the proportion disapproving of its use have declined.

The 2008 MTF survey indicates a continuing high rate of prescription drug abuse among adolescents, with little change seen in the past six years. Nearly 10% of 12th grade students reported non-medical use of Vicodin in the preceding year, while 4.7% reported abuse of Oxycontin. In fact, seven of the top 10 drugs reported by 12th graders in the 2008 survey were prescribed medications or over-the-counter agents.

There are some bright spots, including data showing that cigarette smoking is at the lowest rate in the history of the MTF survey. And there continues to be a gradual decline in alcohol use across all grade levels, with a significant decline from 2007 to 2008 among 10th graders on all measures of use (lifetime, past year, past month, daily, and binge drinking). Nevertheless, tobacco and alcohol use by adolescents remain at alarmingly high levels: more than one in ten high school seniors report that they use cigarettes daily and 5.4% report that they smoke more than a half pack a day. While alcohol use continues a slow downward trend, close to 25% of 12th graders report that they had five or more drinks in a row sometime in the two weeks prior to the survey.

Overall, 46,348 students from 386 public and private schools in the 8th, 10th and 12th grades participated in the 2008 survey. The MTF survey has measured drug, alcohol, and cigarette use and related attitudes in 12th graders nationwide since 1975; 8th and 10th graders were added to the survey in 1991. Survey participants report their drug use behaviors across three time periods: lifetime, past year, and past month. The survey has been conducted since its inception by investigators at the University of Michigan. Additional information on the Monitoring the Future Survey, as well as comments from NIDA Director Nora Volkow, Ph.D., can be found at HTTP://WWW.DRUGABUSE.GOV/DRUGPAGES/MTF.HTML

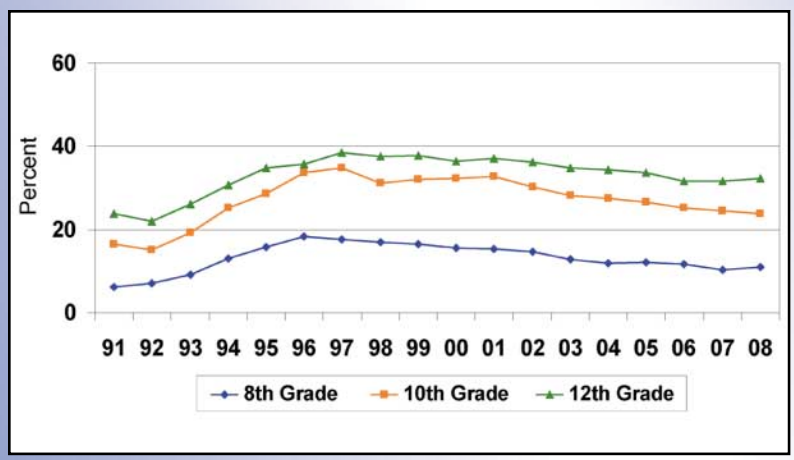
Percent of Students Reporting Any Illicit Drug Use in Past Year, by Grade



SOURCE: University of Michigan, 2008 Monitoring the Future Study

Downward Trend in Marijuana Abuse Slows

Percent of Students Reporting Use of Marijuana in Past Year, by Grade



SOURCE: University of Michigan, 2008 Monitoring the Future Study

ASAM's 40th Annual Med-Sci Conference
Opens April 30th in New Orleans

The Hilton New Orleans Riverside Hotel is the site of ASAM's 40th Annual Medical-Scientific Conference, where addiction experts from around the world will gather for a program rich in scientific symposia, clinical courses and workshops, and research papers and poster sessions. (View the complete Med-Sci program or register online at WWW.ASAM.ORG.)

The conference — which welcomes ASAM members as well as non-member researchers, educators, and clinicians — is preceded on April 30th by the Ruth Fox Course for Physicians and the annual course on *"Pain and Addiction — Common Threads X: Lessons from Katrina."*

The Annual Business Meeting and Breakfast will be gaveled to order Friday, May 1st, at 7:30 a.m. by ASAM President Michael M. Miller, M.D., FASAM, FAPA. Early risers will be rewarded with a buffet breakfast, to be served from 7:15 a.m., courtesy of The Christopher D. Smithers Foundation. The business meeting affords an opportunity for members to offer their views on ASAM's needs and priorities. It also marks the official installation of Dr. Louis E. Baxter, Sr., as ASAM's President, Dr. Donald J. Kurth as President-Elect, Dr. C. Chapman Sledge as Secretary, Dr. Stuart Gitlow as Treasurer, and new members of ASAM's Board of Directors (see pages 7-14).

The official opening session of the Conference at 9:00 a.m. Friday features an address by Marc Galanter, M.D., FASAM, Director of the Division of Alcoholism and Drug Abuse at the New York University School of Medicine, who is the 2009 recipient of the R. Brinkley Smithers Distinguished Scientist Award. Dr. Galanter will deliver the award lecture on "Spirituality, Social Affiliation, and Alcoholics Anonymous: Broadening the Base of Empirical Medicine." Other distinguished speakers invited to address the opening plenary are Ting Kai-Li, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism, and Nora D. Volkow, M.D., Director of the National Institute on Drug Abuse.

On Saturday, the day begins with the Public Policy plenary session, which begins at 8:00 a.m. This year's topic is "The Campaign for Parity." The plenary features a keynote

address by Nancy H. Nielsen, M.D., Ph.D., President of the American Medical Association.

Also on Saturday, the ASAM Awards Luncheon, set for 12:15 to 2:00 p.m., honors outstanding individuals have made notable contributions to the Society and to addiction medicine. A traditional highlight of the luncheon is the John P. McGovern Award on Addiction and Society, established in 1997 to honor an individual who has made highly meritorious contributions to public policy, treatment, research, or prevention and who has increased our understanding of the relationship of addiction and society. The award is sponsored by an endowment from the John P. McGovern Foundation. This year's recipient is Congressman Patrick J. Kennedy, in recognition of his tireless efforts on behalf of parity for mental health and addiction treatment. *(The Awards Luncheon is an extra fee event; business attire is requested.)*

NEW MEETING SCHEDULE

In a departure from past Med-Sci Conferences, the ASAM Board of Directors will meet at 6:00 p.m. Monday, April 27th and all day Tuesday, April 28th. All ASAM Committee and Council Meetings will take place on Wednesday, April 29, 2009.

MUTUAL HELP MEETINGS

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

Continuing Education Credits Available

Accreditation Council for Continuing Medical Education (ACCME). The American Society of Addiction Medicine is accredited by the Accreditation Council for continuing medical education to sponsor continuing medical education for physicians.

American Medical Association (AMA). The American Society of Addiction Medicine designates this continuing medical education activity for a maximum of 20 credit hours in Category 1 toward the AMA Physician's Recognition Award. The Ruth Fox Course for Physicians and Pain and Addiction: Common Threads X each have been designated for an additional 8 credit hours. Each physician should claim only those hours of credit that he/she actually spent in the activity.

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

National Association of Alcoholism and Drug Abuse Counselors (NAADAC). ASAM has been approved as a National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Education Provider, #152. Those who are applying for NAADAC credit should report their hours directly to NAADAC.

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

First Step Toward Federal Parity Mandate Realized

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

Most Americans know October 3, 2008, as the date of passage of the Emergency Economic Stabilization Act — the financial system "bail-out" bill. By a lopsided vote of 263 to 171, the House followed the Senate in allocating $700 billion to stabilize our economy. But those of us in ASAM and many other addiction and mental health care organizations felt affirmation and a sense of completion, because the bill that actually was introduced in the Senate and sent to the President on October 3 was the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, with the Emergency Economic Stabilization Act becoming an amendment to it!

For more than a decade, advocates have worked ceaselessly for the passage of "parity;" that is, legislation that requires insurers to offer the same benefits for mental health and substance use conditions as for other medical disorders. TheWellstone-Domenici Act mandates that insurance plans have the same financial requirements and the same benefit limitations for mental health and substance use services as for medical and surgical care. Specifically, this means that deductibles, co-pays, co-insurance, and out-of-pocket expenses; visit and day limitations; and in-network and out-of-network benefits must be the same. Managed care firms are required to disclose their medical necessity criteria. Insurance plans can opt out of the mandate for one year if costs rise by more than 2% in the first year of implementation or 1% in succeeding years. Small firms that employ 50 or fewer persons are exempt.

Passage of the Wellstone-Domenici Act signals that the mental health and substance use care fields are coming of age. Most Americans now recognize that mental and substance use conditions are illnesses like any others, and need to be considered as such by the insurance industry and care providers. Legislators also have come to understand this. All of us in these fields know and appreciate that the dividends will be better care and improved quality of community life for care recipients.

Insurance parity also can serve to move the important agenda of integration with primary care. The mechanism seems very straightforward: Insurance parity will promote care equity between specialty and primary care in integrated care settings. Care equity will empower our efforts to develop a consumer-directed medical home that encompasses specialty and primary care. An urgent need exists to accomplish this goal. Thus, the full benefits of the Wellstone-Domenici Act are likely to continue unfolding over the next decade.

Our past success must stoke rather than dampen our future efforts to gain the attention of public policy makers. New challenges do await us. Parity will improve the care of those who already have health insurance coverage, but it will do nothing to address the problems of those who have no health insurance at all. Of the approximately 47 million Americans without health insurance, fully one-third have mental health or substance use conditions. Furthermore, fully one-third of those with mental health or substance use conditions have no insurance — double the national rate of uninsurance for all groups.

Less than four months ago, a new Congress and administration entered Washington. Keeping national health care reform on their agenda will be a major challenge, as they confront monumental economic problems, the protracted wars in Iraq and Afghanistan, and a very large federal deficit. Yet the Wellstone-Domenici Act energizes us to keep mental health and substance use care at the healthcare reform table as the national debate unfolds.

NEXT STEPS

Group health plans must comply with the federal parity law at the beginning of the plan year that begins one year after the legislation was signed. So for most this means January 1, 2010, as most plans are on calendar years. The law does not need to be re-passed by Congress annually as the 1996 parity law did (that law's "sunset" provisions have been eliminated as well).

Although parity is now the law of the land, that doesn't mean we in ASAM as advocates can take a breather. In a sense, the harder work is yet to come, because the more detailed work of interpretation is yet to come.

The U.S. Departments of Labor, Health and Human Services, and Treasury (specifically the IRS) now need to develop regulations — the nuts and bolts or operational details of any legislation.

- The federal government will need to provide guidance about the non-preemption of state parity laws. The federal parity law is stronger than most state parity laws, but potentially confusing situations will need to be addressed. For instance, in Pennsylvania the state requires health plans to offer at least 30 days of substance use treatment. It is unclear how this requirement will interact with the federal parity law, noting that the key question is whether the state law will interfere with the application of the federal law. Some Pennsylvania providers are wary of losing this "minimum" benefit written into state law.
- Clarification of those areas where federal guidance will be needed, is how parity will really come to life. For example, If a health plan has a $10 co-pay for primary care, $25 for specialty care, and $35 for physical therapy, what constitutes an equitable co-pay for mental health and substance use services?
- The federal government also will need to provide more clarification around the law's language allowing group health plans exemption from the parity requirements. Health plans covered by the law must comply with it for the first year. If they demonstrate that within the first six months of compliance their total plan costs increase by 2% or more due to parity, they can seek an exemption from the law for the next year. However, they then have to come back into compliance the following (third) year. If their total costs subsequently increase 1% or more because of parity, they can

seek an exemption for the next (fourth) year. Studies have found that parity tends to increase premiums by less than 0.5%.

Although regulations from the Departments of Labor, Treasury, and Health and Human Services are due by October 3, 2009, employers and insurers must comply with the law even if no regulations have been issued. As advocates help craft these policies, public education also will be important.

There is a tremendous need for education, both for people within our field plus the general public. ASAM answered the call to be involved as an organization in the legislative phase of this reform, and we worked with coalitions to achieve our results. Now, as we enter the regulation-writing phase, ASAM and others will need to stay involved. We can't let the traditional opponent of parity 'get their victory' in the back rooms where regulatory language is crafted.

Mental health and addiction parity provides an important component to our overall policy agenda. As our nation now turns its attention to overall health system reform, ASAM's Legislative Advocacy and Public Policy Committeesface an awesome opportunity. But starting the healthcare reform debates with parity as a given is a tremendous advantage

The Whole Health Campaign, a coalition of which ASAM is a member, brings together a range of mental health and substance use care interests. The WHC has begun working on principles that everyone in the field can agree to.

Another focus must be on bringing parity into Medicare, Medicaid, TriCare, and all government health insurance plans. A step forward was made in 2008 when the co-pay rates for mental health and addiction care under Medicare were placed at parity with co-pay rates for med-surg visits. But patients covered by Medicare and Medicaid do not have access to Level III (residential) addiction care as outlined in the ASAM Patient Placement Criteria, because of a regulation called the IMD (Institutions for Mental Disease) Exclusion. The 2008 Parity Bill promises to correct this situation. We must continue to fight for all our patients, regardless of who their third-party coverage is with.

The fight for parity has done a great job of unifying our field. I think we're at a time when we can get past some of the prior divisions within our field and see the benefit of working together, and hopefully we will then be able to craft some larger policy priorities and work to achieve those.

Our efforts have brought success. Let us continue to build our Society, the American Society of Addiction Medicine.

Dr. Soper is Chair of the ASAM Chapters Council and Co-Chair of the ASAM Member Involvement and Support Action Group (MISAG).

Med-Sci Conference *continued from page 17*

HOTEL AND CONFERENCE REGISTRATION

Conference Registration. Register for the conference online at WWW.ASAM.ORG. The deadline for receipt of advance registrations is Monday, April 6, 2009. Registrations received after that date will be processed as on-site registrations and will incur a late fee of $75. On-site registration will open from 5:00 to 7:00 p.m. on Wednesday, April 29th, and from 7:00 a.m. to 7:00 p.m. on Thursday, April 30th.

Hotel Reservations. The conference site is the Hilton New Orleans Riverside Hotel, Two Poydras Street, New Orleans, Louisiana. The Hilton is a short walk from everything — the French Quarter, or the Warehouse/Arts District. The hotel is connected to the Marketplace, which is home to 140 shops and restaurants.

A limited number of rooms are being held at the special conference rate of $234 single/double (add $30 per night for each additional person). To reserve a room, phone the Hilton New Hotel at (504) 561-0500 or 1-800-HILTONS. To receive the conference rate, tell the reservation agent that you are attending the "ASAM Medical-Scientific Conference." To secure your reservation online, use the following ASAM-Hilton webpage at HTTP://WWW.HILTON.COM/EN/HI/GROUPS/PERSONALIZED/MSYNHHH-SAM-20090424/INDEX.JHTML. Hotel space is limited, and reservations are on a first-come first-served basis. The hotel cannot guarantee conference rate and availability of rooms after April 6th. Make your reservations early!

Airline Reservations. The official ASAM travel agency is Protravel International. For assistance with your travel arrangements, phone Brenda Osborne at 1-800-854-4707 between 9:00 a.m. and 6:00 p.m. Pacific Time, or email her at BRENDA.OSBORNE@PROTRAVELINC.COM.

FY 2009 Omnibus Bill Expands Addiction Program Funding

Prodded by the Obama administration, the U.S. House and Senate finally completed the FY 2009 appropriations process by passing an Omnibus spending bill in early March (the 2009 fiscal year runs from October 1, 2008, to September 30, 2009). In the absence of Congressional authorization, most federal agencies and programs have been operating on a continuing resolution, which extended federal funding at FY 2008 levels until March 6, 2009.

The FY 2009 Omnibus bill includes funds for a number of federal agencies, including the Departments of Health and Human Services, Education, Justice and Labor. Funding for drug and alcohol prevention, treatment, recovery and research programs is included in the legislation. Most of these programs received increases under the Omnibus bill (see the Table). For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) received $3.33 billion, an increase of $100.9 million over FY 2008 levels and $309.9 million more than President Bush requested in his FY 2009 budget. The Substance Abuse Prevention and Treatment (SAPT) Block Grant received $1.7786 billion, a $19.8 million increase over FY 2008 funding levels. This amount is equal to the FY 2009 budget request.

SAMHSA's Center for Substance Abuse Treatment (CSAT) received $414.3 million, a $14 million increase over FY 2008 funding levels and $77.5 million more than the Bush administration's FY 2009 budget request. The Center for Substance Abuse Prevention (CSAP) received $201 million, a $6.88 million increase over FY 2008 levels and $43 million more than President Bush's FY 2009 budget request.

The National Institute on Drug Abuse (NIDA) received $1.033 billion, a $30.8 million increase over FY 2008 spending and $32 million over the Bush FY 2009 budget request. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) received $450.23 million, a $13.9 million increase over FY 2008 and $13.5 million over the FY 2009 budget request.

The chart below compares the FY 2008 appropriated levels to the FY 2009 levels contained in the Omnibus Appropriations Bill for programs of interest to our field. For the full text of the FY 2009 Omnibus bill, go to: HTTP://WWW.RULES.HOUSE.GOV/111/LEGTEXT/111_OMNI2009.HTM.

FY 2009 Omnibus Appropriations Bill	FY 2008 Appropriated[1]	FY 2009 Omnibus Bill (Requested)	Net Change
Financial Services Appropriations Act			
Drug-Free Communities Act (DFCA)	$90 million[2]	$90 million[3]	Level Funded
National Anti-Drug Media Campaign	$60 million	$70 million	+$10 million
High Intensity Drug Trafficking Areas	$230 million	$234 million	+$4 million
Labor, HHS, Education Appropriations Act			
Substance Abuse Prevention and Treatment Block Grant	$1.759 billion	$1.779 billion	+$20 million
Center for Substance Abuse Prevention (CSAP)	$194.1 million[4]	$201 million[5]	+$6.9 million
Center for Substance Abuse Treatment (CSAT)	$399.8 million	$414.3 million	+$14.5 million
National Institute on Drug Abuse (NIDA)	$1.001 billion	$1.033 billion	+$32 million
National Institute on Alcohol Abuse and Alcoholism (NIAAA)	$436.3 million	$450.2 million	+$13.9 million
State Grants Portion of the Safe and Drug Free Schools and Communities Program	$294.8 million	$294.8 million	Level Funded

Note: *All numbers are rounded up to the nearest million*

[1]*The FY 2008 numbers contained in the Labor, Health and Human Services and Education portion of the chart reflect the 1.75% across-the-board that was applied to these programs.*

[2]*Includes $2 million for National Community Anti-Drug Coalition Institute.*

[3]*Includes $2 million for the National Community Anti-Drug Coalition Institute.*

[4] *Includes $5.5 million for the Sober Truth on Preventing Underage Drinking Act, $4 million of which is for Community Based Coalition Enhancement Grants; $1 million is for the adult oriented media campaign; and $500K is for the Intergovernmental Coordinating Committee on the Prevention of Underage Drinking (ICCPUD).*

[5]*Includes $7 million for the Sober Truth on Preventing Underage Drinking Act, $5 million of which is for Community Based Enhancement Grants; $1 million is for the adult oriented media campaign; and $1 million is for the ICCPUD.*

CSAT Releases TIP on Depression in Addicted Persons

The Center for Substance Abuse Treatment has released a new Treatment Improvement Protocol (TIP) on *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery.* TIP 48 provides answers that substance abuse treatment counselors need when working with clients with depressive symptoms and substance use disorders. It addresses counseling approaches, cultural concerns, counselor roles and responsibilities, screening and assessment techniques, treatment planning and processes, and elements of continuing care.

Organized in three parts, TIP 48 provides vignettes of counseling sessions, descriptions of specific techniques, and an *online-only literature review*. It also provides program administrators with information about incorporating the management of depressive symptoms into their substance abuse treatment programs, complete with a systematic approach to designing and implementing a supportive infrastructure.

TIP 48 also marks a new approach to volumes in the TIPs series. Short and concise, TIP 48 focuses on how to perform relevant activities and target specific needs of substance abuse treatment counselors, program administrators, and clinical supervisors. This approach allows the materials in the TIP to be reviewed, discussed, and used as a training tool over a short period of time and with few or no additional resources required. The goal is to improve the delivery of substance abuse treatment services.

The TIP is available for download at HTTP://WWW.KAP.SAMHSA. GOV or may be ordered at no cost from SAMHSA's Health Information Network (SHIN) online at HTTP://WWW.SAMHSA.GOV/SHIN or by phone at 1-877-726-4727.

Ask for publication order number (SMA) 08-4353.

NIAAA Releases Update of Alcohol Policy Information

The Alcohol Policy Information System (APIS), a project of the National Institute on Alcohol Abuse and Alcoholism, has released an update of state-by-state alcohol policies. APIS is an online resource that provides detailed information on selected alcohol-related policies across the United States. The update covers the period January 2, 2007, through January 2, 2008.

In all, the update includes more than 35 changes in State alcohol policy statutes and regulations. Among the most significant are:

HEALTH POLICY:

- Four States (Illinois, Indiana, Maine, and Oregon) and the District of Columbia have adopted provisions that specifically prohibit insurers from denying payment for insurance benefits for losses due to intoxication of the insured (also referred to as UPPL laws — Uniform Accident and Sickness Policy Provision Laws). In all cases except Maine, laws that specifically permitted denial of insurance were repealed. Seven States and D.C. have enacted prohibitions in the last several years.
- Colorado amended its health insurance parity law to require that insurance companies provide alcohol-related coverage. Previous law only required that insurers offer such coverage.

ALCOHOL AND PREGNANCY:

- Two states, Louisiana and Pennsylvania, adopted laws imposing reporting requirements on health professionals regarding suspicion or evidence of alcohol use or abuse by women during pregnancy. Louisiana's law applies to physicians, and Pennsylvania's law applies to health care providers.
- Two states, Louisiana and Alaska, adopted alcohol and pregnancy laws related to child abuse and child neglect. These laws pertain to clarification of rules of evidence of prenatal alcohol exposure in child welfare proceedings.
- Alaska adopted a law that provides priority access to substance abuse treatment for pregnant and postpartum women who abuse alcohol.
- Texas has adopted a mandatory warning sign law related to alcohol and pregnancy for on-sale retailers.
- Minnesota has adopted a civil commitment law for pregnant women who abuse alcohol. This brings to five the number of States with laws that either involuntarily commit a pregnant woman to treatment or involuntarily place a pregnant woman in protective custody of the State for the protection of a fetus from prenatal exposure to alcohol.
- Louisiana has adopted a criminal prosecution law pertaining to alcohol and pregnancy. These provisions prohibit the use of results of medical tests, such as prenatal screenings or toxicology tests, as evidence in the criminal prosecution of women who may have caused harm to a fetus or a child.

UNDERAGE DRINKING:

- Iowa and South Carolina adopted keg registration laws.
- Alaska adopted a law to impose criminal liability on those who host underage drinking parties, and Illinois and Kansas have strengthened their hosting laws.
- Oregon and Utah increased the applicable age of for their "use/lose" laws (Loss of Driving Privileges for Alcohol Violations by Minors) from 18 to 21, and South Carolina adopted a prohibition against Underage Consumption of Alcohol.

ALCOHOL AND MOTOR VEHICLES:

- Pennsylvania reduced its BAC limit for operators of recreational watercraft from 0.10 to 0.08 percent.
- Wyoming made its open container law applicable to all occupants of a vehicle, bringing its law into conformity with Federal standards.

Many of these changes are consistent with the goal of reducing underage drinking and its consequences as well as alcohol-related deaths and injuries in the general population.

Details on these policy developments are available at the APIS website, HTTP://WWW. ALCOHOLPOLICY.NIAAA.NIH.GOV/

Interactive "Video Doctor" Program Reduces Risk Behaviors

Positive Choice, an innovative computer-based counseling program funded by the National Institute on Drug Abuse, has been shown to sharply reduce sexual and drug risk behaviors among people living with HIV/AIDS. The program, designed and evaluated by the University of California, San Francisco, has been chosen by the Centers for Disease Control and Prevention (CDC), for inclusion in *The 2008 Compendium of Evidence-Based HIV Prevention Interventions*. To be included, programs must be scientifically proven to reduce HIV- or STD-related risk behaviors, or to promote safer behaviors. The 2008 Compendium is a single source of information that informs State and local HIV prevention programs about "what works" in preventing HIV infections and includes a total of 57 interventions.

An interactive risk assessment and risk reduction counseling program, Positive Choice uses a video doctor to simulate the ideal physician-patient risk counseling conversation, which provides a way to help patients talk with their health care providers. The program matches risk assessment responses to tailored interactive video clips. Following the counseling sessions, patients are prompted to discuss their risky behaviors with their health care provider. At the 3- and 6-month follow-ups, the researchers noted a significant reduction in illicit drug use and unprotected sex. Moderate reductions in substance use and casual sex partners also were observed.

The study results were published in the April 2008 issue of *PLoS One*. For more information about the program, visit: WWW.PLOSONE.ORG/ARTICLE/INFO%3ADOI%2F10.1371%2FJOURNAL.PONE.0001988.

STUDIES: *Physician Health Programs Set the Standard for Addiction Treatment*

Three new studies show that physicians who develop problems with alcohol and other drugs can be treated successfully and returned to medical practice with the help of special programs that couple treatment referral and monitoring with rapid responses to noncompliance. Previous studies have shown that in individual states, and on a small scale, the Physician Health Programs (PHPs) are effective. The current studies, however, involve the largest samples of physicians ever followed, over the longest periods of time.

In general, rates of illicit drug use are lower among physicians than in the general public. However, rates of prescription misuse are five times higher among physicians, according to a 2008 review published in the *Harvard Review of Psychiatry*. That study concluded that physicians' drug problems are related to occupational exposure and ease of access to drugs, coupled with high levels of stress and lack of early detection.

To address such problems, Physician Health Programs provide intensive, long-term case management and monitoring. The programs aim to save the lives and careers of addicted physicians, and to protect the public by addressing impairment among caregivers. They are also are an effective way to remove noncompliant doctors from the practice of medicine. "This isn't to cover it up; it's quite the opposite," said Temple University psychiatry chairman Dr. David Baron, who oversees the Pennsylvania PHP. "It allows for quality treatment and to make sure that we're still ensuring the safety of the public."

In a study published in the March 2008 issue of the journal *Substance Abuse Treatment*, Drs. Robert L. DuPont, A. Thomas McLellan, William L. White, L. J. Merlo and Mark S. Gold described an analysis of 904 physicians enrolled in 16 state Physician Health Programs between 1995 and 2001. The research was funded by the Robert Wood Johnson Foundation.

Of the physicians enrolled, 45% were mandated formally by a licensing board, hospital, malpractice insurer, or other agency. The rest were informally "mandated" by employers, families and colleagues. Physicians entering such programs generally sign agreements to abstain from use of alcohol or drugs, with penalties for violating such agreements including intensified treatment, being reported to their medical licensing boards, and/or surrender of their license to practice medicine.

Program measures included group and individual therapy, residential and outpatient programs, surprise workplace visits from monitors, and links to 12-Step programs such as Alcoholics Anonymous

and Narcotics Anonymous. Physicians who enrolled in the programs had to abstain from alcohol or other drugs, and were subject to random drug testing for five or more years. If tests showed signed of a return to substance abuse, swift action was taken: the errant physician was reported to the medical board, which could lead to loss of a medical license.

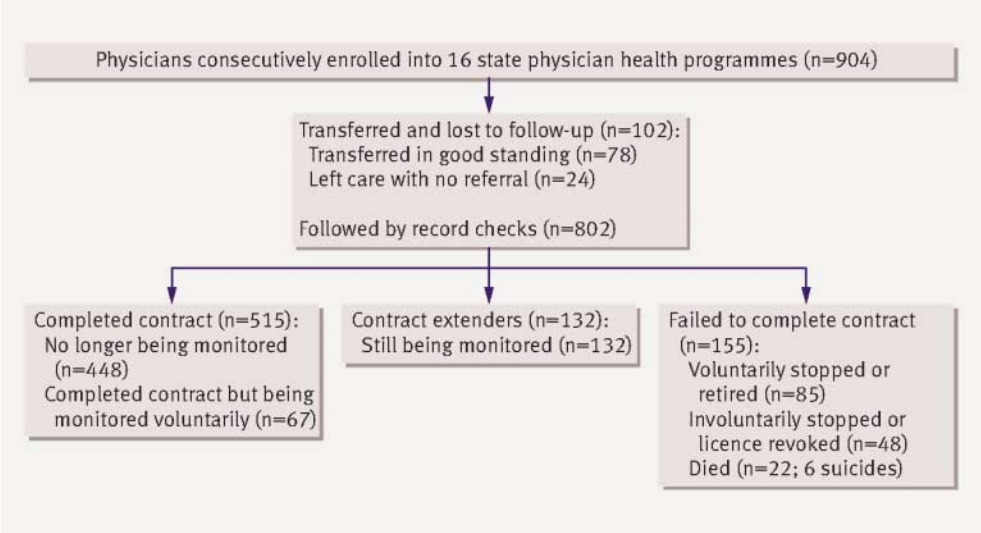
Patients received care not only for their addiction, but also for accompanying medical or psychiatric disorders. They paid for their treatment, drug tests and follow-up care. Mark Gold, M.D., chairman of psychiatry at the University of Florida College of Medicine and UFL's McKnight Brain Institute, noted that the approach used by the PHPs "should be a model for treatment of anyone with these diagnoses."

Of the 904 physicians enrolled in a PHP at the beginning of the study, 78% had no positive drug tests during five years of intensive monitoring. And five to seven years after starting treatment, 72% were actively practicing medicine, without drug abuse or malpractice. Of the others, 18% left medical practice, while others relapsed into drug use. Three percent of those who did not complete their programs had substance-related deaths or committed suicide.

Although the PHPs employed a variety of approaches, the researchers found that success was not related to specific therapists or modes of therapy, but rather to the long-term nature of the treatment. Still, the authors singled out some ingredients that successful programs had in common, including treatment extended over years — not weeks or months — and unambiguous success markers such as urine testing and return to work and normal family activities. The results were the same regardless of whether the drug of choice was alcohol, cocaine, prescription medications, or other substances.

"It's the idea of a carrot and a stick," explained Scott Teitelbaum, M.D., director of the Florida Recovery Center, which treats addicted physicians referred from around the country. "There's always a level of resistance — people never feel they need the level of care that's recommended. Someone might not agree with you, but if they want to practice medicine, they have to comply." Often, with the support of peers and growing realization that treatment is working, the physician-patients' motivations change from simply wanting to obey the rules to wanting to change their lives, Dr. Teitelbaum added.

Flow of Physicians Through Trial



Source: McLellan AT, Skipper GS, Campbell M, DuPont RL (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *British Medical Journal* 337;a2038, page 1.

Source: DuPont RL, McLellan AT, White WL, Merlo LJ, Gold MS (2009). Setting the standard for recovery: Physicians' Health Programs. *Journal of Substance Abuse Treatment* Mar;36 (2):159-71.

Related Articles: McLellan AT, Skipper GS, Campbell M, DuPont RL (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *British Medical Journal* 337;a2038.

Brewster JM, Kaufmann M, Hutchison S, MacWilliam C (2008). Characteristics and outcomes of doctors in a substance dependence monitoring programme in Canada: Prospective descriptive study. *British Medical Journal* 337;a2098.

Marshall EJ (2008). Doctors' health and fitness to practise: Treating addicted doctors. *Occupational Medicine* (London) Aug;58(5):334-40.

Although the PHPs employed a variety of approaches, the researchers found that success was not related to specific therapists or modes of therapy, but rather to the long-term nature of the treatment.

Findings On Methadone Metabolism May Enhance Patient Safety

Newly published research could significantly improve the safety of methadone, according to investigators at Washington University School of Medicine in St. Louis and the University of Washington in Seattle.

The research provides evidence that the body processes methadone differently than previously thought. Investigators believe those incorrect assumptions about methadone have been making it difficult for physicians to understand how and when the drug is cleared from the body and may be responsible for unintentional under- or over-dosing, inadequate pain relief, side effects and even death. Principal investigator Evan D. Kharasch, M.D., Ph.D., and his colleagues reported their findings in the March issue of the journal Anesthesiology and online in the journal Drug and Alcohol Dependence. Dr. Kharasch is an anesthesiologist and clinical pharmacologist at Washington University School of Medicine and Barnes-Jewish Hospital in St. Louis.

In addition to its role as a mainstay in the treatment of opioid addiction, methadone has found a growing use as an effective treatment for acute, chronic and cancer pain. For example, use of the drug for pain treatment rose 1,300 percent between 1997 and 2006. However, this increase in methadone use has been accompanied by an even greater increase in methadone-related adverse events, which have increased by approximately 1,800 percent, and methadone-associated deaths, which rose by more than 400 percent (from 786 to 3,849) between 1999 and 2004.

"Unfortunately, increased methadone use for pain has coincided with a significant increase in adverse events and fatalities related to methadone," notes Dr. Kharasch, adding that "The important message is that guidelines used by clinicians to direct methadone therapy may be incorrect."

The investigators wanted to understand how protease inhibitors interact with methadone. For years, the enzyme P4503A was believed to be responsible for clearing methadone from the body. But when healthy volunteers were given a low dose of methadone together with protease inhibitors that caused profound decreases in the activity of P4503A, there was no reduction in the clearance of methadone.

There were two reasons to study what happens to methadone when taken in combination with these drugs: First, HIV/AIDS patients may receive methadone for pain and, in some cases, for accompanying addictive disorders, along with one or more protease inhibitors. In addition, many protease inhibitors interact with the P4503A enzyme that long has been thought important to methadone clearance. In the new studies, Dr. Kharasch and his team looked at interactions among methadone, the P4503A enzyme in the intestine and liver and the protease inhibitors nelfinavir, indinavir and ritonavir.

The researchers gave study volunteers a combination of the protease inhibitors ritonavir and indinavir. Both drugs profoundly inhibited the actions of the enzyme. If that enzyme was responsible for methadone clearance, then inhibiting it should have caused methadone to build up in tissue stores. To the contrary, the researchers found no effect on methadone levels.'

Volunteers in the second study received the protease inhibitor nelfinavir. Again, the drug inhibited the action of the P4503A enzyme. That should have meant methadone concentrations would rise, but they actually decreased by half.

"For more than a decade, practitioners have been warned about drug interactions involving the enzyme P4503A that might alter methadone metabolism," Dr. Kharasch said. "The package insert says inhibiting the enzyme may cause decreased clearance of methadone, but our research demonstrates that P4503A has no effect on clearing methadone from the body. So the package insert appears to be incorrect, or certainly needs to be reevaluated, as do guidelines that explain methadone dosing and potential drug interactions."'

That can be dangerous, Dr. Kharasch explained, because a clinician may prescribe too much or too little methadone for patients taking drugs that interact with P4503A on the assumption that they also would influence methadone clearance. Too little methadone will not relieve pain. Too much can contribute to the unintentional build-up of methadone in the system, which can cause slow or shallow breathing and dangerous changes in heartbeat. Physicians could be unintentionally prescribing methadone incorrectly.

"The highest risk period for inadequate pain therapy or adverse side effects is during the first two weeks a patient takes methadone," Dr. Kharasch said. "If we can provide clinicians with better dosing guidelines, then I believe we will be able to better treat pain and limit deaths and other adverse events."

About a dozen related liver enzymes are part of the P450 family, and Dr. Kharasch believes another enzyme from that family may be the one actually involved in methadone metabolism and clearance. His laboratory is determined to identify the correct enzyme to limit over- and under-dosing of patients taking methadone, as a step toward improving addiction and pain treatment as well as patient safety. Currently, he's testing the related enzyme P4502B. Laboratory studies and preliminary clinical results indicate that P4502B may be involved, but Dr. Kharasch says more clinical research is needed.

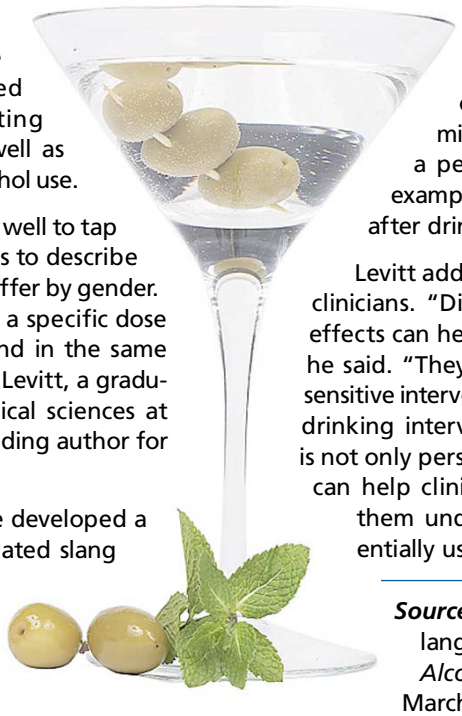
"The research also is important for the treatment of HIV/AIDS," he added. "Protease inhibitors can interfere with the activity of P4503A but increase the activity of P4502B. This paradox is highly unusual, and because these two enzymes metabolize so many prescription drugs, there are many potential drug interactions that we'll be able to understand better if we can get a better handle on how these pathways absorb drugs into the system and clear them from the body."

Dr. Kharasch's research was supported by grants from the National Institute on Drug Abuse and by an NIH grant to the University of Washington General Clinical Research Center.

Sources: Kharasch ED et al. Methadone metabolism and clearance are induced by nelfinavir despite inhibition of cytochrome P4503A (CYP3A) activity. *Drug and Alcohol Dependence,* 2009; DOI: 10.1016/j.drugalcdep.2008.12.009

Kharasch ED et al. Methadone Pharmacokinetics Are Independent of Cytochrome P4503A (CYP3A) Activity and Gastrointestinal Drug Transport. *Anesthesiology,* 2009; 110 (3): 660 DOI: 10.1097/ALN.0b013e3181986a9a.

The Language of Intoxication



The terms that drinkers typically use to describe alcohol's effects on them are quite different from the language used physicians and researchers, possibly limiting the effectiveness of screening questions as well as researchers' understanding of self-reported alcohol use.

New findings show that researchers could do well to tap into a wide spectrum of terms used by drinkers to describe their levels of intoxication; also, these tend to differ by gender. "There is tremendous variation in what effect a specific dose of alcohol will have in different individuals and in the same person on different occasions," explained Ash Levitt, a graduate student in the department of psychological sciences at the University of Missouri, as well as corresponding author for the study.

"As social and cultural animals, humans have developed a rich and diverse vocabulary of intoxication-related slang to describe the subjective states they are experiencing while drinking," said Levitt." However, alcohol researchers have largely ignored the language of intoxication." Instead, he added, researchers often rely on objective measures which, although critical to alcohol research, do not reflect individual subjective differences in drinking experiences.

Moreover, most studies in self-report research that do use subjective assessments, he said, rely on single-item subjective assessments of intoxication. For example, "How often in the past 30 days did you drink enough to get 'drunk?" or "On a 1-100 scale, how 'drunk' do you feel right now?" Even though "drunk" is the oldest English-language intoxication-related synonym currently used today, Levitt noted, individuals do not perceive "drunk" in the same way, and just because something is commonly used does not mean that there aren't better alternatives.

Researchers used a web-based approach to survey two different samples, n=290 (140 males, 150 females) and n=146 (73 males, 72 females), of university undergraduates who ranged in age from 17 to 24 years. Each participant was asked about their familiarity and usage of a number of intoxication-related words.

"We found that intoxication-related terms reflected either moderate or heavy levels of intoxication, and that 'drunk' reflected a level of intoxication somewhere between moderate and heavy," said Levitt. "Men tended to use heavy-intoxication words more than women, which were also relatively more forceful in their tone, such as 'hammered.' Women tended to use moderate intoxication words more than men, which were also relatively more euphemistic, such as 'tipsy.' This is similar to other gender differences in slang usage, for example, men 'sweat' and women 'glow.'"

Women's use of intoxication terms could have important public health and methodological implications, said Levitt, adding that "Their use of 'tipsy' reflected an average of four drinks over two hours, which actually meets binge-drinking criteria for women but not men. Therefore, women could be binge drinking while psychologically perceiving their level of intoxication as being 'tipsy' or relatively benign, as opposed to heavier levels of intoxication that would be described with less euphemistic terms, such as 'hammered' or 'wasted.' Such a perception could potentially mislead women, for example, to feel as though they are capable of driving after drinking because they are 'only tipsy'."

Levitt added that these findings also have implications for clinicians. "Discrepancies between objective and subjective effects can help the clinician assess tolerance and sensitivity," he said. "They could also aid in the development of gender-sensitive interventions. Previous research has shown that heavy-drinking interventions work best when individual feedback is not only personalized, but also gender-specific. Our findings can help clinicians improve these interventions by helping them understand which terms men and women differentially use."

Source: Levitt A, Sher KJ, Bartholow BD (2009). The language of intoxication: Preliminary investigations. *Alcoholism: Clinical & Experimental Research (ACER)* March; *33(3) 448-454.*

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.

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.

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

Your Recognition as a Specialist in Addiction Medicine

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

This is an important communication to all physicians who have been certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM).

Most of you know that while ASAM has been certifying individual physicians (more than 4,100 in 22 years), your Society also has expended considerable effort and resources to assist in the establishment of the American Board of Addiction Medicine (ABAM). Incorporation of ABAM in 2007 was the first official step toward seeking official recognition of Addiction Medicine as a medical specialty by the American Board of Medical Specialties (ABMS).

As the core part of ASAM 's certification process, the ASAM Certification/Recertification Examination is widely respected for the breadth and quality of the question items. Since 1992, the examination has been developed by the ASAM Examination Committee through a contract with the National Board of Medical Examiners (NBME). Most consider the ASAM examination to be of a level of quality and rigor equal to the examinations offered by member boards of the American Board of Medical Specialties.

Certification by the American Society of Addiction Medicine is cited in Federal and State statutes as a credential that entitles a physician to various rights and privileges. That is a tremendous value to those who have earned ASAM certification. The Society's aim is to pursue ABMS recognition in a manner that preserves the value of the existing ASAM certification. Thus, while the Recertification Examination will be administered by ABAM beginning in 2010, physicians who become Diplomates of ABAM will be able to say that he or she also is an "ASAM-certified physician " in order to meet all statutory language and the credentialing requirements of managed care panels.

Those of you who have earned ASAM certification can retain that status. Although ASAM no longer will certify physicians after it transfers the examination process to ABAM in 2010, it will maintain a roster of physicians who have been certified by ASAM, and those individuals will retain their status as ASAM-certified physicians. In addition, ASAM will add to its roster of ASAM-certified physicians the names of all those who are certified by ABAM, thus assuring that your ASAM certification will retain its value.

As your specialty society, ASAM always will have an interest in the activities of the independent specialty board in Addiction Medicine (ABAM). In fact, ASAM will be one of the sponsors of the application that ABAM submits to the ABMS.

When ABAM makes application to the ABMS to recognize Addiction Medicine, ASAM will advocate that all physicians who have earned ASAM certification should be recognized as having Diplomate status by an ABMS member board. ASAM also will advocate that non-onerous pathways be established to allow ASAM-certified physicians to become eligible for certification by an ABMS member board.

Your ASAM officers and the members of the Board of Directors encourage you to take advantage of the opportunity to become certified by ABAM now, before the date at which you would be required to obtain ASAM Recertification.

If you have questions about the process of becoming ABAM-certified, please contact ABAM at ABAM@GMAIL.COM If you have questions about the status of your ASAM certification, please contact Christopher Weirs, M.P.A., at 301-656-3920 or at CWEIR@ASAM.ORG

Obama Policies Favor Prevention, Treatment *continued from page 3*

OBAMA SAYS HE'LL ENGAGE PARENTS

In December 2007, the Partnership for a Drug-Free America (PFDFA) asked both Sen. Obama and Sen. McCain, "If you become President, how will you bolster efforts to reduce alcohol and drug abuse in communities throughout America?" and "A recent national survey found a significant decline in the number of parents talking to children about the risks of drugs and alcohol. If you become President, how will you encourage parents to engage with their kids on this health issue?"

The McCain campaign did not respond to the questions, but the Obama campaign did, citing the need for international cooperation on drug enforcement, expansion of drug courts, strengthening enforcement efforts aimed at methamphetamine, and supporting after-school programs. "I will promote healthy communities and work to strengthen our public-health and prevention systems," said Mr. Obama's response. "I will promote healthy environments, which would include restricted advertising for tobacco and alcohol to children and wellness and educational campaigns. I will increase funding to expand community-based preventive interventions to help Americans make better choices to improve their health."

Obama called parents "our first line of defense against alcohol and drug abuse," but said parents need more resources and information.

Candidate Obama called parents "our first line of defense against alcohol and drug abuse," but said parents need more resources and information. "My health care plan includes strengthening our public health and prevention infrastructures so that parents get the information they need about substance abuse, and guidance on how to talk about it," he said. "And my poverty plan calls for the creation of 'Promise Neighborhoods' in our cities that will support similar public-health initiatives."

He added, "Some parents are just not taking the time to engage with their kids on [the drug] issue," adding, "We need to tell parents to turn off the television, put away the video games, and spend some time providing the guidance our children so badly need and desire. Parents need to strike up a conversation with their kids and warn them against the perils of drug use…I've been quite open about my struggles as a young man growing up without a father in the home. I had to learn very early on to figure out what was important and what wasn't, and exercise my own judgment and in some ways to raise myself. Along the way, I made mistakes. And so I recognize the importance of parents talking to their children and actively engaging them on this issue, and will promote these values as President."

MARIJUANA, ALCOHOL POLICIES

On the subject of medical marijuana, Sen. Obama told a reporter during the campaign: "I have more of a practical view than anything else. My attitude is that if it's an issue of doctors prescribing medical marijuana as a treatment for glaucoma or as a cancer treatment, I think that should be appropriate because there really is no difference between that and a doctor prescribing morphine or anything else. I think there are legitimate concerns in not wanting to allow people to grow their own or start setting up 'mom and pop shops' because at that point it becomes fairly difficult to regulate."

During a primary debate, Mr. Obama said he was opposed to lowering the legal drinking age from 21 to 18. In other public statements, he has said he would consider strategies such as needle-exchange programs to fight the spread of HIV/AIDS and would support medical use of marijuana under certain conditions. "I think it is important that we are targeting HIV/AIDS resources into the communities where we're seeing the highest growth rates," he told *Politico* in a 2008 interview. "That means education and prevention, particularly with young people. It means that we have to look at drastic measures, potentially like needle exchange, in order to insure that drug users are not transmitting the disease to each other. And we've got to expand on treatment programs."

Source: *"Obama "Blueprint for America" and Curley B. Obama and McCain: Where They Stand on Addiction Issues. JoinTogether.com, June 2008.*

Obama Announces Key Health Appointments *continued from page 3*

member of the Cabinet, although ONDCP will remain a part of the Executive Office of the President and administration officials insist that the Director still will have direct access to the President.

Food and Drug Administration: Margaret (Peggy) Hamburg, M.D., is President Obama's choice to head the Food and Drug Administration. With nearly 11,000 employees and an annual budget of more than $2 billion, the FDA is charged with overseeing products that account for one-quarter of consumer spending in the United States, including prescription and over-the-counter medications, heart valves, stents and other medical devices, the blood supply, and food. In recent years the agency has been shaken by a series of failures, leading former officials, members of Congress, watchdog groups and various government reports to call for an infusion of strong leadership, money, technology and personnel — and perhaps a major restructuring.

Health advocates say Dr. Hamburg, 53, has the ability to restore competency to the agency. "It's a brilliant choice," said Harvey V. Fineberg, president of National Academy of Sciences Institute of Medicine. "She is a person who will have the public interest foremost in mind."

Dr. Hamburg graduated from Harvard Medical School and completed her training at the New York Hospital/Cornell University Medical Center, where her research focused on neuroscience and neuropharmacology. From 1986 to 1988, she served in the U.S. Office of Disease Prevention and Health Promotion, and from 1989 to 1990 was assistant director of the National Institute of Allergy and Infectious Diseases at NIH, where her work focused on AIDS research. In 1990, Dr. Hamburg became deputy health commissioner of New York City and was named health commissioner a year later. There, she created an aggressive tuberculosis control program and the country's first public health bioterrorism defense program. In 1997, she became assistant secretary for planning and evaluation at the Department of Health and Human Services in the Clinton administration, where she created a bioterrorism program.

Dr. Hamburg's principal deputy at FDA will be Joshua Scharfstein, M.D., now health commissioner of Baltimore. In that post, Dr. Sharfstein, 39, won national attention when he convinced the FDA in 2007 to restrict the use of over-the-counter cough and cold medications for young children. He successfully argued that government needed to limit their use in the face of mounting evidence that they can cause hallucinations, seizures, respiratory and heart problems, and that there was a lack of evidence that they work as intended. "Dr. Sharfstein has been recognized as a national leader for his efforts to protect children from unsafe over-the-counter cough and cold medications," the President said, "and he's designed an award-winning program to ensure that Americans with disabilities have access to prescription drugs." Dr. Scharfstein also has been a strong advocate for expanding access to buprenorphine to treat opioid addiction.

Some observers predict that the appointments of Drs. Hamburg and Scharfstein are part of an administration plan to split the FDA into two parts, with Dr. Hamburg heading a Food Safety Administration and Dr. Scharfstein at the top of a Federal Drug Administration.

Sources: *New York Times, Washington Post, Baltimore Sun, Atlanta Constitution, JoinTogether Online.*

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

The Ruth Fox Memorial Endowment Fund was established to assure ASAM's continued ability to provide ongoing leadership in newly emerging areas affecting the field of addiction medicine, to continue its commitment to educating physicians, to increasing access to care and to improving the quality of care. An important component of this mission is fulfilled each year when the recipients of the Ruth Fox Scholarships — an outstanding group of physicians in training — join us at ASAM's Annual Medical-Scientific Conference. The scholarships cover travel, hotel and registration expenses for recipients to attend the Med-Sci Conference and Ruth Fox Course, as well as one year's free membership in ASAM. In 2008, the Endowment Fund awarded seven scholarships, bringing the total number of scholarships awarded since 2002 to 43.

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 ASAMCLAIRE@AOL.COM. She welcomes your calls. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

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IN MEMORIAM: CHARLES S. LIEBER, M.D.

Dr. Charles S. Lieber, a former President of ASAM who upset scientific dogma by showing that alcohol in excess can cause cirrhosis despite an adequate diet, died March 1, 2009, of stomach cancer. He was 78 and lived in Englewood Cliffs, New Jersey. Dr. Lieber devoted much of his career to promoting alcohol research as a legitimate science, countering a prevailing perception that little could be done about alcoholism.

He made many of his fundamental findings on the toxic effects of alcohol at the Veterans Affairs Medical Center in the Bronx, New York. In a classic experiment in 1974, Dr. Lieber and a team of researchers reported that alcohol was toxic to the liver of baboons who had been fed the equivalent of a fifth of liquor every day for up to four years. The findings upset conventional medical belief that cirrhosis was due to the poor nutrition commonly linked to alcoholism, rather than to alcohol itself. In other experiments, Dr. Lieber deciphered some of the ways alcohol can affect the liver and showed that it could convert various compounds in the body to highly toxic ones. The findings are still debated, but they help explain why heavy drinkers and even some social drinkers seem more vulnerable to pain relievers like acetaminophen (Tylenol, for example), anesthetics and industrial solvents.

"He was a giant in his field, probably the most eminent in the world in alcohol and the liver," said Dr. Steven Schenker, another such expert, at the University of Texas Health Science Center at San Antonio. "His concepts put him under a lot of pressure, but he defended his positions brilliantly and gentlemanly in very heated discussions with some of the brightest scientists in the world," Dr. Schenker said in an interview with the New York Times.

Charles Saul Lieber was born in Antwerp, Belgium, on Feb. 13, 1931. In the buildup to war, he fled with his family to France and then to Switzerland, where a Swiss family rescued him from a refugee camp and sheltered him for four years. After World War II, he returned to Belgium, where, as an 18-year-old pre-med student, he had part of his stomach removed after nearly bleeding to death from an ulcer. He earned his medical degree in 1955 at the University of Brussels, where his ulcer led him to study factors causing such bleeding. He did research there until 1958, when he used a Belgian fellowship to study at the Boston City Hospital and Harvard Medical School.

In addition to his daughter Sarah, of Englewood Cliffs, New Jersey, Dr. Lieber's survivors include his wife, Dr. Maria Leo-Lieber; two daughters, Collette Lieber-Freid of Upper Saddle River, New Jersey, and Leah Lieber-Rafiy of Manhattan; two sons, Daniel, of Larchmont, New York, and Samuel, of Livingston, New Jersey; and six grandchildren.

IN MEMORIAM: THE REV. JOSEPH C. MARTIN

The Rev. Joseph C. Martin, whose lectures and films about addiction have been leading tools in recovery programs for more than 40 years, died March 9, 2009, of heart failure at his home in Havre de Grace, Maryland. He was 84.

Long considered one of the country's foremost educators on alcoholism, Father Martin's role in the addiction field started, he said, almost by accident. "That was in February 1972," Father Martin told a reporter in 1998. "I was a seminary teacher. I had no plans to go into alcoholism treatment. I had some notes I'd taken because of my own recovery, and I used them for a talk. The Navy filmed it, and that was 'Chalk Talk'." The title of the film came from the blackboard he used to illustrate points during the lecture. It became a classic in treatment programs around the country. By the end of his life, Father Martin had more than 40 motivational films to his credit. His book, *"Chalk Talks on Alcohol"* was published in 1982 and is still in print.

Those who heard Father Martin described him as a gifted speaker who was funny and sprinkled his talks with a sense of the absurd. "He seemed to believe that the discussion of alcoholism was too important to be taken deathly seriously," recalled one member of Alcoholics Anonymous, who heard Father Martin on several occasions over the years. "He thought that laughter was the best approach to reach the sick."

A native of Baltimore, Joseph Martin was born Oct. 12, 1924, and graduated from Loyola High School, where he was valedictorian. He later attended Loyola College before studying for the priesthood at St. Mary's Seminary and St. Mary's Roland Park in Baltimore. In 1948, he was ordained a priest of the Society of Saint Sulpice, whose mission is to train and educate seminarians.

He began his recovery from alcoholism in 1958 and marked his 50th year in recovery last year, along with his 60th anniversary as a priest. In the early 1980s, Father Martin and co-founder Mae Abraham, who began her recovery after hearing one of Father Martin's lectures, began raising funds to buy and renovate an estate located on the Chesapeake Bay near Havre de Grace. Father Martin's Ashley opened in 1983 and has since provided treatment to more than 40,000 people suffering from drug and alcohol addiction.

In 1991, Father Martin was invited by Pope John Paul II to participate in the Vatican's International Conference on Drugs and Alcohol. He traveled widely around the world to speak to Alcoholics Anonymous groups and to teach addiction counselors.

He is survived by a brother, Edward Martin, of Liburn, Georgia; two sisters, Frances Osborne and Dorothy Christopher, both of Baltimore; Mae and Tommy Abraham, with whom he lived for 30 years; and many nieces and nephews.

ASAM Conference Calendar

ASAM EVENTS

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

April 25-29, 2009
AATOD National Meeting:
Treatment and Recovery — People and Outcomes
Hilton New York Hotel
For more information or to register, visit HTTP://WWW.AATOD.ORG

May 7-8, 2009
Prescribing Opioids for Chronic Pain
Sponsored by the Illinois Society of Addiction Medicine, Illinois Dept. of Alcohol and Substance Abuse, and Illinois State Medical Society
May 7th at the Abraham Lincoln Hotel, Springfield, IL;
May 8th at the Westin O'Hare Hotel, Chicago, IL
5 Category I CME credits
For more information or to register, visit HTTP://ILSOCIETYOFADDICTIONMEDICINE.ORG/CONFERENCE.HTM

May 15, 2009
Prescribing Opioids for Chronic Pain
Sponsored by the New York Academy of Family Physicians
Rochester, New York
4 Category I CME credits
For more information or to register, visit HTTP://WWW.NYSAFP.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.

SPECIAL SESSIONS OPEN ASAM MEETING

The following social and educational events on Thursday evening, April 30th, kick off ASAM's Annual Medical-Scientific Conference in New Orleans:

Thursday, 5:00 - 6:00 p.m.
New Members' Welcome Reception
Sponsored by Loma Linda Univ. Behavioral Medicine Center, Redlands, CA

6:00 - 8:00 p.m.
Welcoming Reception and Opening of ASAM Exhibit Hall
Sponsored by the Louisiana Chapter of ASAM

7:00 - 9:00 p.m.
Chapters Council Meeting
In addition to the general meeting, individual chapters will meet throughout the Med-Sci Conference. See the ASAM Registration Desk for a schedule.

8:00 - 10:00 pm
Component Session I: AA in Vivo — Workshop in the Twelve-Step Recovery Action Group
Chair: Marc Galanter, M.D., FASAM
Speakers: Marc Galanter, M.D., FASAM; Penelope Ziegler, M.D.; Richard K. Ries, M.D.

Component Session II: Update on the ASAM Patient Placement Criteria
Chair: Marc J. Fishman M.D.
Speakers: David Mee-Lee M.D.; George Kolodner, M.D.

Component Session III: Moving Addiction Medicine into Family Medicine
Chair: Norman Wetterau, M.D., FAAFP, FASAM
Speakers: Richard Blondell, M.D.; Anthony Cloy, M.D.

Component Session IV: Opioid Agonist Treatment — Training, Clinical Practice and Policy Initiatives
Chair: Daniel P. Alford, M.D., M.P.H., FACP
Speakers: Andrew J. Saxon, M.D., Edwin Salsitz, M.D., FASAM; Adam J. Gordon, M.D., M.P.H., FASAM; Daniel Alford, M.D., M.P.H., FACP; Laura F. McNicholas, M.D., Ph.D.; John A. Renner, Jr., M.D., DFAPA

Component Session V: Public Policy in Addiction Medicine: Past, Present, and Future
Co-Chairs: Petros Levounis, MD, MA and Mark L. Kraus, MD, FASAM
Speakers: Mark L. Kraus, M.D., FASAM; Petros Levounis, M.D., M.A.; David E. Smith, M.D., FASAM; Louis E. Baxter, Sr., M.D., FASAM