Volume 24, Number 4, Autumn 2009

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

See the complete program for ASAM's State of the Art Course, page 19.

www.asam.org

Agency Leaders to Address ASAM State of the Art Course

Leaders of the U.S. Food and Drug Administration, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Mental Health, the National Institute on Drug Abuse, the Center for Substance Abuse Treatment, and the Office of National Drug Control Policy will outline their agencie's agendas and priorities in addresses at ASAM's 2009 Course on the State of the Art in Addiction Medicine, which meets October 22-24th at the Hyatt Regency Capitol Hill Hotel in Washington, DC.

The State of the Art course focuses on cutting-edge research and the potential of such research to enrich the clinical practice of addiction medicine. As in the past, the course offers 7 themed sessions over three days, with each session featuring carefully selected lectures and audience interactions, supported by an extensive syllabus.

There is a $50 discount for registrations received by October 9th. To register, simply mail or fax the form on page 23, visit the ASAM website at WWW.ASAM.ORG, or register on site (on-site registration opens at 5:00 p.m. on Wednesday, October 21st).

ASAM Supports Proposed JCAHO Standards for SBIRT

Louis E. Baxter, Sr., M.D., FASAM, President of ASAM

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently released for public comment a list of proposed new hospital performance measures for screening, brief intervention, and referral to treatment (SBIRT) of patients for problems related to or exacerbated by alcohol, tobacco, and other drug use. According to Nancy Lawler, who is assistant project director and clinical lead for SBIRT at JCAHO, the SBIRT measures could become part of the JCAHO accreditation manual in late 2011 or 2012, assuming they survive review by JCAHO's advisory board, pilot testing and analysis, and are endorsed by the National Quality Forum, which helps set national health care performance standards and measures.

In urging ASAM and other field organizations to support the proposed measures, ASAM Award recipient and SBIRT pioneer Larry Gentilello, M.D., FACS, a professor of surgery at the University of Texas Southwestern Medical Center, said that adding the SBIRT measures to the hospital accreditation process could "do more to medicalize substance-abuse problems than all the urging and pleading we've undertaken for the past 25 to 30 years."

(Continued on page 4)

Health Care Reform is Focus of ASAM's Annual Legislative Day

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

Eileen McGrath, J.D.

ASAM members are urged to join their colleagues in meeting with members of Congress and key staff during the Society's 6th Annual Legislative Day, scheduled for October 21st, immediately preceding ASAM's State of the Art Course.

As members of Congress continue to debate health care reform, ASAM's goals are to ensure that (1) health care reform legislation is enacted this year, (2) addiction treatment benefits are part of any minimum benefits package; (3) education and training for addiction treatment professionals are part of workforce initiatives incorporated in the final bill; (4) parity – as defined in the 2008 Paul Wellstone and Pete Domenici Parity and Addiction Equity Act — is part of insurance reform.

The preliminary schedule for Legislative Day is as follows.

7:00 a.m. — Breakfast and orientation, Hyatt-Regency Capitol Hill Hotel

9:00 a.m. — Meetings with members of Congress and **5:00 p.m.** key staff, Capitol Hill

6:00 p.m. — Debriefing session, Hyatt-Regency Capitol Hill Hotel

ASAM's Government Relations Department and lobbying professionals will help to arrange meetings with members of Congress and their staffs and provide advocacy training.

For further information, contact Alexis Geier-Horan, ASAM's Director of Government Relations, at 301-656-3920, or check the "Legislative Day" box on the registration form found on page 23.

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

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

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

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

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

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

Dr. Regina Benjamin Named to Surgeon General Post

President Obama has announced his choice for surgeon general: Regina Benjamin, M.D., a 52-year-old family practitioner who has spent most of her career tending to the needs of poor patients in a Gulf Coast clinic in Alabama. "When people couldn't pay, she didn't charge them," the President said in making the announcement. "When the clinic wasn't making money, she didn't take a salary for herself." He termed Dr. Benjamin "a relentless promoter" of programs to fight preventable illness.

Dr. Benjamin cited the toll of preventable illness as the reason her family was not with her at the announcement: Her father died with diabetes and high blood pressure; her older brother and only sibling died at age 44 of an HIV-related illness; her mother died of lung cancer after taking up smoking as a girl; and her mother's twin brother could not attend because he is at home "struggling for each breath" after a lifetime of smoking.

"I cannot change my family's past, but I can be a voice to improve our nation's health for the future," she said.

Dr. Benjamin earned a bachelor's degree in 1979 from Xavier University of Louisiana, attended Morehouse School of Medicine from 1980 to 1982, and received a doctor of medicine degree from the University of Alabama at Birmingham in 1984. She completed her residency in family practice at the Medical Center of Central Georgia in 1987.

President Obama with Regina Benjamin, M.D.

Her medical training was paid for by a federal program, the National Health Service Corps, under which medical students promise to work in areas with few doctors in exchange for free tuition, one year of service for every year of paid tuition. In 1991, she earned a master's degree in business administration from Tulane University

In 1990, Dr. Benjamin founded the Bayou La Batre Rural Health Clinic in the fishing village of Bayou La Batre, Alabama, and has served as its CEO since. Like many of her patients, the clinic has suffered its own life-threatening challenges. It was heavily damaged by Hurricane Georges in 1998 and Hurricane Katrina in 2005. It also burned to the ground several years ago. But Dr. Benjamin rebuilt it after each setback and has continued to offer medical care to the village's 2,500 residents.

Her commitment to them has meant making house calls during the rebuilding, mortgaging her house and maxing out her credit cards, the President said, adding: "Regina Benjamin has refused to give up; her patients have refused to give up." Many of her patients are immigrants from Vietnam, Cambodia and Laos, who make up a third of Bayou La Batre's population and many of whom are uninsured. Dr. Benjamin said she has worked for years to scrape together the resources needed to keep the clinic doors open and found "it has not been an easy road. …It should not be this hard for doctors and other health care providers to care for their patients."

Dr. Benjamin has served as associate dean for rural health at the University of South Alabama's College of Medicine and as president of the Alabama Medical Association.

She was the first African-American woman to sit on the Board of Trustees of the American Medical Association, where she also chaired the AMA's Council on Ethical and Judicial Affairs.

The position of surgeon general, whose effectiveness is largely in its use as a bully pulpit, requires Senate confirmation.

Dr. Regina Benjamin holds advanced degrees in medicine and business administration.

COCAINE CONTAMINATION ALERT ISSUED

Drug Enforcement Administration data show that nearly a third of all cocaine seized in the U.S. is contaminated with levamisole, a veterinary medicine used to deworm livestock.

At least three deaths attributed to use of cocaine contaminated with levamisole have been reported in the U.S. and Canada, although the actual number may be higher. Contamination of some cocaine has been reported across the United States, Canada, and globally.

Federal officials say that levamisole most likely is added to cocaine during production outside the United States, although it is not understood why. Anecdotal reports suggest that some users believe levamisole enhances the effects of cocaine. It also severely weakens the immune system, suppressing the white cell count. The resulting condition is termed *agranulocytosis*. Individuals who snort, smoke, or inject crack or powder cocaine contaminated by levamisole can develop overwhelming, rapidly developing, life-threatening infections.

In Washington State, public health officials have issued a warning about the contaminated cocaine. They report that patients with agranulocytosi in Seattle required expensive hospitalization and treatment in intensive care.

ASAM Supports Proposed JCAHO Standards for SBIRT (continued from page 1)

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is seeking feedback on eight proposed process and outcome measures: Tobacco Use Assessment; Tobacco Use Treatment; Tobacco Use Treatment at Discharge; Tobacco Use Follow-up; Alcohol and Other Drug Use Screening; Alcohol and Other Drug Use and Dependence — Brief Intervention or Treatment; Alcohol and Other Drug Use and Dependence — Treatment Management at Discharge; and Alcohol and Other Drug Use and Dependence — Follow-up for Unhealthy Use and/or Disorders. Specifically, the proposed measures would require that:

1. All but specifically excepted patients* will be screened for excessive alcohol use, use of illicit drugs, misuse of prescription drugs, or tobacco use.
2. All patients with a positive screen receive a brief intervention.
3. All patients with a positive screen who are found to have be addicted to alcohol, tobacco or other drugs will have treatment initiated in the hospital or be referred to treatment at the time of discharge.
4. All patients will be contacted within two weeks after discharge from the hospitaland offered additional help as needed.

** For example, children under age 12, patients with terminal conditions who are admitted for comfort care only, and patients with dementia.*

FEEDBACK IS CRUCIAL

ASAM is formulating an organizational response, and also encourages individual members to comment on the proposal. The consequences of such feedback are enormous. According to JCAHO's Ann Watt, who is associate director of JCAHO's Center for Performance Measurement, "The present thinking regarding the draft measure…is that it will be offered to Joint Commission accredited hospitals as a set of core measures available for hospitals to choose in order to meet their performance measure accreditation requirement (most hospitals are required to collect and report data on four of 10 measures specified by JCAHO). [However] there has been some discussion as to whether reporting should be required on this set…."

Louis E. Baxter, Sr., M.D., FASAM

In other words, SBIRT performance measures — if implemented at all — could become one choice on a menu of indicators that hospitals can choose from (known as JCAHO's Oryx measures) to meet their accreditation requirements. Even that would be a significant step toward acceptance of SBIRT by the mainstream medical community. Listen to David Rosenbloom, president and CEO of the Center on Addiction and Substance Abuse at Columbia University: "Even if this is among the performance measures that hospitals can choose, it is a big deal," he says. "They constitute a remarkable and complete validation that tobacco, alcohol and drug addiction are chronic diseases that must be identified, treated, and followed after discharge in virtually all hospital patients. I think even the publication of the standards is a huge advance."

On the other hand, Eric Goplerud, Ph.D., co-chair of the Joint Commission's technical advisory group and director of Ensuring Solutions to Alcohol Problems, a project of the George Washington University Medical Center, advises that "the measures could become global and mandatory, but that decision has not been made and will be influenced by the strength of responses from the field to the initial descriptions of the measures."

COST, OUTCOMES DATA FAVOR ADOPTION

If adopted, the proposed measures would address some of the greatest unmet health care needs in U.S. hospitals. An estimated one in four hospital admissions is related to alcohol, tobacco, or other drug use. Broadly construed, the JCAHO measures could require that all admitted patients be screened for excessive alcohol use, use of illicit drugs, misuse of prescription drugs, or tobacco use; that those who screen positive receive a brief intervention; that those found to have a dependence problem get treated in the hospital or referred to treatment at discharge; and that follow-up activities be conducted within two weeks of discharge.

There also could be significant cost savings: experts have estimated that hospitals could expect to save $4 in health care costs for every $1 invested in SBIRT. It is for this reason that the Medicaid and Medicare programs now allow providers to seek reimbursement of SBIRT expenses. Also, recent research from the Center for Substance Abuse Treatment has found that SBIRT is "feasible to implement and the self-reported patient status at 6 months indicated significant improvements over baseline, for illicit drug use and heavy alcohol use, with functional domains improved, across a range of health care settings and a range of patients."

The pairing of alcohol and other drug screening with tobacco screening in the proposed JCAHO measures also could help win over skeptics. "Tobacco cessation interventions are so inexpensive that even if only the occasional patient stops smoking, it will more than pay for itself," according to Dr. Gentilello, who adds that the cost of 1,000 tobacco screenings is easily outweighed by the cost of treating one cancer patient.

Comments on the proposed performance measures will be accepted through September 30th, and many field groups and individual experts are expected to respond. To submit a comment, go to WWW.JCAHO.ORG and click on "comments.'

From the Joint Commission on Accreditation of Healthcare Organizations (JCAHO):

Candidate Measures for Assessing & Treating Tobacco, Alcohol, and Other Drug Use and Dependence — REQUEST FOR PUBLIC COMMENT

"In April 2009, The Joint Commission received funding from the Partnership for Prevention and the Substance Abuse and Mental Health Services Administration (SAMHSA) and their Center for Substance Abuse Treatment (CSAT) in the Department of Health and Human Services to develop a set of performance measures to address assessing and treating tobacco, alcohol, and other drug use and dependence for all hospitalized patients.

"The importance of this measure set cannot be emphasized strongly enough. More than 537,000 persons died as a consequence of alcohol, drug, and tobacco use, accounting for over 1 out of 4 deaths in the United States. Excessive use of alcohol and drugs is a source of enormous personal tragedy and results in a drain on the economy. Smoking-attributable health care expenditures are estimated at $96 billion per year and $97 billion in lost productivity. Nearly a quarter of one trillion dollars in lost productivity is attributable to substance use.

"Hospitalization provides an ideal opportunity to provide cessation assistance that may promote the patient's medical recovery and assist in controlling other health-related problems. Hospital-based research programs have repeatedly demonstrated that brief screening, counseling, and pharmacological treatments effectively reduce smoking and substance use, reduce substance use-related illnesses and injuries, and has been well accepted by patients and clinicians. Numerous case studies exist to demonstrate how hospitals have integrated tobacco and substance-use brief screening, counseling, and medical treatments into routine practice so that patient flow and medical services are not disrupted; and new billing codes for tobacco and substance use screening and treatment provide necessary financial support to hospitals delivering these services.

"This measure set is intended to broaden the scope of existing measures by enhancing and replacing the current National Hospital Quality Measures for Adult Smoking Cessation Advice/Counseling in the acute myocardial infarction (AMI-4), heart failure (HF-4), and Pneumonia (PN-4) measure sets.

"The Technical Advisory Panel (TAP) convened by The Joint Commission in late June 2009 sought to strengthen the currently endorsed smoking cessation and counseling measures, expand the population to all applicable patients, and broaden the scope of the measure set to include alcohol and other drug use and dependence.

"The 8 candidate process and outcome measures that resulted from the TAP meeting address the following aspects of care: screening/assessment, treatment which includes brief interventions and if applicable, medication, and follow-up after hospital discharge….

"Public comment, the first step in the measure development process, is now being solicited on these 8 candidate measures. Measures in this set do not target a specific diagnosis, but are broadly applicable to all hospitalized patients.

"Results of the public comment will be used develop detailed measure specifications and determine which measures should go forward for pilot testing….

"The implementation of these measures will assist the health care organization to identify opportunities to improve performance and provide an opportunity to positively impact morbidity, mortality, and healthcare costs associated with the use of tobacco, alcohol, and other drugs."

Studies Show SBIRT Saves Lives and Dollars

Screening, brief intervention and referral to treatment (SBIRT) for substance use disorders could save billions in health care costs if widely implemented as a component of national health care reform. But experts say that the programs need to be introduced in a systemic fashion to be effective and avoid overburdening physicians.

Various research studies have shown that SBIRT can cut hospitalization costs by $1,000 per person screened and save $4 for every $1 invested in trauma center and emergency department screening. A study from the State of Washington found that SBIRT reduced Medicaid costs by $185 per patient per month, according to Richard Brown, M.D., associate professor at the University of Wisconsin School of Medicine and Public Health. "All three studies showed that the savings occurred over the first 12 months," according to Dr. Brown.

The use of SBIRT programs is growing nationally but still faces some significant hurdles, including lack of funding; reimbursement and cultural issues; and UPPL laws, which allow health insurers in some States to deny payment when hospital care is related to injuries sustained in alcohol-related episodes, thus discouraging screening in trauma centers and emergency departments. However, a growing number of insurers have agreed to reimburse for SBIRT services, including the Federal Health Employees Benefit Plan, which covers 5.6 million federal workers. And in January 2009, Ohio became the 15th state to repeal its UPPL laws.

Advocates say that devoting even a few minutes to screening patients for alcohol and other drug problems in emergency departments, health clinics, employee assistance programs, and physicians' offices can identify at-risk patients and steer them into treatment before problematic substance use blossoms into a more serious health crisis.

Current literature on the effectiveness of SBIRT is summarized in a background paper prepared for a 2008 White House Conference on Medical Education in Substance Abuse. ASAM was officially represented at that conference by former President Larry Brown, Jr., M.D., FASAM. Numerous ASAM members helped to organize or participated in the meeting. To receive an electronic copy of the SBIRT summary, send an email to ASAMNews1@aol.com.

Research has shown that many screened patients cut down on their drinking simply because they were asked about their alcohol use; likewise, brief interventions have been shown to effectively reduce alcohol and other drug use. In primary care settings, only about 1 percent of patients screen positive and need formal treatment. The rate in emergency departments and trauma centers is around 3 percent)

Wisconsin has emerged as a national leader in SBIRT implementation: the latest state budget calls for reimbursement of screening and brief intervention services under the state's Medicaid plan, and Wisconsin insurers have broadly accepted SBIRT as a part of the treatment continuum, according to Dr. Brown, who also serves as the clinical director of the Wisconsin Initiative to Promote Healthy Lifestyles. SBIRT programs currently operate at 20 sites in the State, and Dr. Brown said he is optimistic that the programs will survive beyond the expiration of Wisconsin's Federal funding.

Noting that the U.S. spends at least $200 billion annually to treat problems related to alcohol and other drug use, Dr. Brown added that SBIRT is a natural fit for national health care reform. "It's a wonderful way to promote healthy behaviors and reduce health care costs," he said.

AMA Addresses Pharmaceutical Industry Involvement in Continuing Medical Education

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

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

At the annual meeting of the American Medical Association in June, the AMA's Council on Ethical and Judicial Affairs (CEJA) again brought forward a report on the pharmaceutical industry's financial sponsorship of continuing medical education programs. The report defined an ethical framework to guide professional practice with respect to such relationships.

Testimony on the report focused on the need to balance ethical and practical concerns. A number of medical organizations receive significant funding from the pharmaceutical industry to support their educational programs. Many delegates testified that such funding would not easily be replaced, particularly in the current economic climate. As a result of this testimony, the House of Delegates voted to return the report to the CEJA for further work.

A separate CEJA report dealt with the increasingly frequent situation in which physicians are employed by non-physician clinicians. In almost all States, the law requires that mid-level practitioners be supervised by a licensed physician. In such situations, the physician has both professional and legal responsibilities for the services provided under his or her direction and supervision. The new CEJA guideline states that it is unethical for a physician to supervise a non-physician practitioner who simultaneously employs the physician. Further, the guideline states that a physician in such an arrangement must give precedence to his or her ethical obligation to act in the best interest if the patient by exercising independent professional judgment, even if that places the physician at odds with the employer.

As a result of the complex legal and ethical issues raised by such situations, the CEJA found that physicians may supervise non-physician clinicians or be employed by non-physician clinicians, but cannot serve in both positions with the same clinician.

PRESCRIPTION MONITORING PROGRAMS

A resolution was brought forward recommending that States have the flexibility to require opioid treatment programs (OTPs) to report their dispensing of methadone to State prescription monitoring programs, or PMPs.

Your ASAM team (including Drs. Mike Miller, Don Kurth and myself) testified that, while this seems reasonable on its face, we had concerns that it would give law enforcement agencies access to data that is protected by Federal confidentiality statutes. Others voiced concerns that many PMPs do not have interoperability, and thus cannot exchange data with PMPs in adjoining States. In response to these concerns, the resolution was referred to the AMA Board of Trustees for study of the entire topic.

AMA AND THE WHITE HOUSE

As reported in the Summer issue of ASAM NEWS, the highlight of the House of Delegates meeting was the appearance by President Barack Obama. The President pulled no punches, clearly iterating his intent not to cap liability and hinting at some degree of equivalence between nurse practitioners and physicians.

But he also recognized the importance of working with physicians as he moves forward with health reform plans — something previous Administrations have failed to understand. Despite the fact that the AMA now counts only 17 percent of practicing physicians as members, it is clear that the AMA is understood by the White House to be the *de facto* voice of American Medicine.

The AMA has reciprocated, sending its highest elected officials to White House meetings on health care reform and other health topics. An example is a press release issued by the AMA to mark President Obama's signing of the law authorizing the Food and Drug Administration to regulate tobacco products. Titled "AMA Stands with President Obama at Historic Bill Signing on Tobacco Regulation: Family Smoking Prevention and Tobacco Control Act Promotes Disease Prevention and Healthy Lifestyles," the statement by AMA President J. James Rohack, M.D., read in part: "As long-time advocates for strong regulation of the tobacco industry, the AMA is honored to stand with President Obama today as he signs the historic tobacco law. Today's historic bill signing is a victory for public health over Big Tobacco.

"More than 400,000 Americans die needlessly every year as a direct result of tobacco use. The actions resulting from this new law may make people think twice before picking up a cigarette. The sad truth is that tobacco-related deaths are the number one preventable cause of death in the U.S. Physicians are working not only to treat diseases like cancer and heart disease that result from tobacco use, but to prevent them from occurring in the first place.

"The new law represents an important break from the past, as it signifies broad acceptance that nicotine is a drug harmful to people's health. Tobacco companies will now have to disclose ingredients and use stronger warning labels….

"With this bill signing, President Obama has again demonstrated his commitment to disease prevention and healthy lifestyles, both of which are vital parts of the overall health reform the AMA is working for this year."

MEDICAL MARIJUANA REPORT

The AMA Council on Science and Public Health is continuing work on a report that addresses potential medical applications of marijuana.

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

American Bar Association Calls on Senators to Include Parity for Mental Health and Addiction in Health Care Reform Bill

The American Bar Association has called on the Senate Finance Committee to include in its health care bill the relevant provisions of PL 110-343, the "Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008." The ABA is asking for parity for mental health and addiction in all health care plans covered by the new legislation. Currently, the provisions only apply to certain employer-sponsored plans.

In a letter sent yesterday to the Senate Finance Committee, the ABA noted that "it is estimated that 22.6 million Americans needed treatment for a substance use problem in the past year, and only 18 percent of those needing substance use treatment received it. Providing parity in benefits for the treatment of these disorders on a par with benefits provided for other medical and surgical problems would make an enormous difference in the treatment of millions of Americans who desperately need it," the letter said.

A full copy of the letter, signed by ABA Governmental Affairs Office Director Thomas M. Susman, can be accessed at http://www.abanet.org/poladv/letters/healthlaw/2009sep14_paritys_l.pdf.

British Medical Association Urges Ban on Alcohol Ads

Citing an alarming rise in alcohol consumption and drinking-related illness and death, the British Medical Association (BMA) has called for a ban on all types of alcohol advertising in Great Britain. A new BMA report says that the alcohol industry spends billions of dollars on advertising each year, including an increasing amount of money on sports sponsorships. The report called voluntary industry marketing guidelines "ineffective." The BMA report also called for government to set minimum prices for alcoholic beverages in order to control consumption. (About one-third of the British adult population drinks in excess of recommended guidelines.)

In issuing the report, Dr. Vivienne Nathanson, the BMA's head of science and ethics. said, "The BMA is not anti-alcohol. As doctors, our focus is to ensure that individuals drink sensibly so they do not put their health and lives in danger."

With its report, the BMA joins forces with the Royal College of Physicians, which in February 2007 issued a call for a complete ban on alcohol advertising. At that time, the College cited a rising tide of alcohol –related problems in the U.K., where the number of alcohol-related deaths has doubled in the past 15 years.

Disputing the problems cited by the two medical organizations, a spokesperson for the U.K. Department of Health said the current approach to alcohol prevention is working: And Jeremy Beadles, chief executive of the U.K. Wine and Spirit Trade Association, said the BMA proposals would cost jobs.

Save the Impaired Physician Programs!

To the Editor:

For the last 25 years, I've avidly read every ASAM publication, like ASAM News. As always, the latest issue (Summer 2009) had lots of bland but valid clinical, political and organizational news. Unlike most current ASAM literature that ignores the problem, it even had one brief reference by President Baxter to a topic I hold dear. He said: "I intend to continue to advocate for treatment of addicted health care professionals."

It motivates me to write with urgency because it is not working in my State. . . . For the past two years, the most populous State in the Union – California – has had NO diversion program for impaired physicians. . . . The Medical Board of California now defers to the Attorney General's office, which pursues the only course of action it is qualified to pursue: legal and punitive approaches. (I should point out that nurses, dentists and lawyers in the State have excellent diversion programs in place.) . . . .

It's time for ASAM leadership to exploit any and all "Bully Pulpits" by being candid about all aspects of physicians' addiction treatment, and to take steps to force those States (such as California) that have clear legal mandates to provide rehabilitation for addicted physicians to start doing so, and to point out the ethical imperatives physicians should feel toward all patients.

I'm not at all oblivious to the fact that ASAM and other medical organizations feel they have other, more pressing social and legal issues to face in running their respective groups. However, taking care of sick colleagues is an ethical challenge. . . . There's no better time to deal with our profession's enabling and codependence. Please help in this intervention. Sincerely, David Breithaupt, M.D.(ret), FACP, FASAM

Dr. Breithaupt lives in San Jose, California. He can be reached at DLBMLB@COMCAST.NET.

FDA Acts to Prevent Overdoses of Darvon, Other Propoxyphene Compounds

The U.S. Food and Drug Administration has announced that it will take several actions to reduce the risk of overdose in patients using analgesics such as Darvon and Darvocet that contain propoxyphene. The actions were taken because of data linking propoxyphene to fatal overdoses.

Propoxyphene, which has been on the market since 1957, continues to be widely prescribed for mild to moderate pain. The most frequently reported side effects include lightheadedness, dizziness, sedation, nausea, and vomiting.

In its announcement, the FDA said it is requiring manufacturers of propoxyphene-containing products to strengthen the label, including the boxed warning, to give greater emphasis to the potential for overdose when using these products. Manufacturers also will be required to provide patients with a medication guide that stresses the importance of using the drugs as directed.

Propoxyphene manufacturers must submit the requested safety labeling changes to the FDA within 30 days, or to provide a reason why they do not believe such changes are necessary. If they do not submit new language, or if the FDA disagrees with the language the companies propose, the Food, Drug and Cosmetic Act provides strict timelines for discussions regarding the changes. At the end of those discussions, the FDA may issue an order directing the labeling changes as deemed appropriate to address the new safety information.

In addition, the FDA announced a new safety study of heretofore unanswered questions about the effects of propoxyphene on the heart at higher-than-recommended doses. Findings from the study, as well as other data, could lead to additional regulatory action, the announcement said.

To further evaluate the safety of propoxyphene, the FDA plans to work with other Federal agencies, including the Centers for Medicare & Medicaid Services and the Veterans Health Administration, to study how often elderly persons are prescribed propoxyphene instead of other analgesics, as well as differences in the safety profiles of propoxyphene compared to other drugs.

In a warning to physicians, Janet Woodcock, M.D., director of the FDA's Center for Drug Evaluation and Research, said "Physicians need to be aware of the risk of overdose when prescribing these drugs. They should carefully review patient histories and make appropriate treatment decisions based on the warnings and directions stated within the drug's label. Prescribers and patients should be aware of propoxyphene's potential risks when used at doses higher than those recommended. Therefore, the FDA is requiring manufacturers to provide more information to help physicians and patients decide whether propoxyphene is the appropriate pain therapy."

At the same time it announced the new safety activities, the FDA denied a citizen petition from the group Public Citizen, which had requested a phased withdrawal of propoxyphene. In its response to Public Citizen, the FDA said that despite serious concerns about propoxyphene, the benefits of using the medication for pain relief at recommended doses outweigh the safety risks at this time. The FDA also noted that it plans to further evaluate the safety of propoxyphene and will take additional regulatory action if necessary.

Details of this decision can be found at: HTTP://WWW.FDA.GOV/DRUGS/DRUGSAFETY/POSTMARKETDRUGSAFETYINFORMATIONFORPATIENTSANDPROVIDERS/UCM170268.HTM.

ONDCP Campaign Focuses On Methamphetamine

The White House Office of National Drug Control Policy (ONDCP) has launched a new anti-methamphetamine ad campaign. The campaign includes public service announcements (PSAs) that can be customized for local communities.

The campaign focuses on preventing methamphetamine use and raising awareness about treatment and recovery. The target audience is young adults ages 18 to 34, as well as family and friends of persons who may be using methamphetamine. This young adult target was specifically chosen because rates of methamphetamine initiation and use are highest in this age group.

ONDCP will run TV, billboard, radio, print, and online advertising between September and November in states with the highest rates of methamphetamine use, as well as a small group of Midwestern states with high levels of methamphetamine laboratory seizures and incidents. Radio and Internet ads also will run in all states during the same time period.

At the conclusion of the campaign in November, many of the ads will be available as free, customizable PSAs for use by local community organizations and government offices. The television advertisements will be available as free customizable PSAs in early 2010.

Free resources currently available at WWW.METHRESOURCES.GOV include a series of "Life After Meth" posters, as well as ads specifically targeted to the Native American community. Details about ordering these resources and requesting customization are available on WWW.METHRESOURCES.GOV in the "Anti-Meth Campaign" section of the site.

SAMHSA: Updated Treatment Directory Available

A new, updated guide to finding local addiction treatment programs is now available from the Substance Abuse and Mental Health Services Administration (SAMHSA). The "National Directory of Drug and Alcohol Abuse Treatment Programs 2009" provides information on thousands of alcohol and drug treatment programs in all 50 states, the District of Columbia, Puerto Rico, and five U.S. territories.

The Directory includes a nationwide inventory of public and private alcohol and other drug treatment programs and facilities that are licensed, certified, or otherwise approved by agencies in each state. The Directory is organized in a state-by-state format for quick reference to more than 11,000 community treatment programs.

Information includes levels of care offered, special programs for adolescents, persons with co-occurring mental disorders, individuals living with HIV/AIDS, and pregnant women. Inform also is provided on forms of payment accepted, special language services available, and whether methadone or buprenorphine therapy is offered.

The updated directory complements SAMHSA's internet-based "Substance Abuse Treatment Facility Locator" — an online service that is updated regularly. The National Directory of Drug and Alcohol Abuse Treatment Programs is available on the Web at HTTP://FINDTREATMENT.SAMHSA.GOV/. Print copies can be obtained free of charge from SAMHSA's Health Information Network by phoning 1-877-SAMHSA-7 (1-877-726-4727).

National Drug Threat Assessment Tracks Rise in Opioid Deaths

Gil Kerlikowski, Director of National Drug Control Policy, recently released a report on the diversion and abuse of prescription drugs. The *National Prescription Drug Threat Assessment* (NPDTA) was prepared by the National Drug Intelligence Center (NDIC) in conjunction with the Drug Enforcement Administration (DEA). It synthesizes reports and data from law enforcement and public health officials to evaluate the threat posed by the distribution, diversion, and abuse of controlled prescription drugs in the United States.

The report concluded that non-medical use of prescription drugs is a serious threat to public health and safety. According to the report, unintentional deaths involving prescription opioids increased by 114 percent between 2001 and 2005, while treatment admissions for opioid addiction increased 74 percent in the same period.

In examining trends over time, the report says that in the general population, non-medical use of controlled prescription drugs was stable from 2003-2007, with 7 million Americans ages 12 and older reporting non-medical use of prescription drugs in the preceding month. However, the trend line escalated among young adults ages 18 to 25. From 2003-2007, approximately six percent of that age group reported non-medical use in the preceding month.

Among all prescription medications, the report says that opioid analgesics are the most widely diverted and abused, with one in five new drug abusers initiating their use with opioids.

Among all prescription medications, the report says that opioid analgesics are the most widely diverted and abused, with one in five new drug abusers initiating their use with opioids. The report estimates that diversion and abuse of controlled prescription drugs cost public and private medical insurers an estimated $72.5 billion per year.

In discussing the report's findings, Gil Kerlikowske, Director of National Drug Control Policy, observed that "Diversion and abuse of prescription drugs are a threat to our public health and safety….In 2006… drug-induced deaths in the United States exceeded firearm-injury deaths and ranked second only to motor vehicle accidents as a cause of accidental death. The law enforcement and health care communities must work together to help address prescription drug abuse, addiction, and the public safety consequences of diversion." Other key findings in the report were:

DRUG-RELATED MORBIDITY AND MORTALITY:

Emergency room visits for non-medical use of opioid analgesics increased 39 percent from 2004 to 2006. Treatment admissions for prescription opioids increased 74 percent from 2002 to 2006. Nearly one third of individuals who began abusing drugs in the past year reported their first drug was a prescription drug, and 19 percent report that it was a prescription opioid.

PRESCRIPTION DRUG DIVERSION:

Diverted prescription medications often are more readily available than heroin in illicit drug markets. Opioids are the most commonly diverted drug. Diversion methods include prescription drug fraud, theft, rogue Internet pharmacies, and gifts or theft from friends and relatives.

REGIONAL VARIATIONS:

Although rates of diversion and abuse are highest in the Eastern U.S., violent and property crimes associated with prescription drug diversion and abuse have increased in all regions of the United States over the past 5 years.

The full report can be accessed online at HTTP://WWW.USDOJ.GOV/NDIC/PUBS33/33775/33775P.PDF.

Intensity of Response to Alcohol Predicts Risk for Alcoholism

Individuals who show relatively little reaction to alcohol (defined as "low response" or LR) are at greater risk of developing alcohol use disorders (AUDs), according to the authors of a study that examined the influence of LR. The researchers found that LR is a unique risk factor for AUDs across adulthood. "If a person needs more alcohol to get a certain effect, that person tends to drink more each time they imbibe," explained Marc A. Schuckit, M.D., Director of the Alcohol Research Center at the Veterans Affairs San Diego Healthcare System, professor of psychiatry at the University of California, San Diego, and corresponding author for the study. "Other studies we have published have shown that these individuals also choose heavy drinking peers, which helps them believe that what they drink and what they expect to happen in a drinking evening are 'normal'," Dr. Schuckit added. "This low LR, which is perhaps a low sensitivity to alcohol, is genetically influenced," he said.

Dr. Schuckit and colleagues examined 297 men participating in the San Diego Prospective Study, who were initially tested for their level of reaction to alcohol when they were 18 to 25 years old. Each reported his family history of AUDs, typical drinking quantity, age of onset of alcohol use, body mass index, and initial age at recruitment for the study. AUDs were evaluated at 10-, 15-, 20-, and 25-year follow-ups.

Results showed that a low LR to alcohol predicted AUD occurrence over the course of adulthood, even after controlling for the effects of other robust risk factors. In short, LR is a unique risk factor for AUDs across adulthood. Dr. Schuckit explained that a low LR at age 20 was not simply a reflection of being a heavier drinker at age 20, and it was not an artifact of an earlier onset of drinking. Dr. Schuckit said, "We showed that a low LR at 20 predicts later heavy drinking and alcoholism even if you control for all these other predictors of alcohol problems at age 20." He added that the study's method of examination — establishing multiple predictors at age 20, revisiting participants about every five years, and securing a response rate of about 94 percent — strongly show that LR is consistent and powerful in predicting alcoholism.

"Because alcoholism is genetically influenced, and because a low LR is one of the factors that adds to the risk of developing alcoholism, if you're an alcoholic, you need to tell your kids they are at a four-fold increased risk for alcoholism. If your kid does drink, find out if they can 'drink others under the table' and warn them that that is a major indication they have the risk themselves. Keep in mind, however, that the absence of a low LR doesn't guarantee they won't develop alcoholism, as there are other risk factors as well," Dr. Schuckit said.

However, according to Dr. Schuckit, the news is not all bad. He concluded, "We are looking for ways to identify this risk early in life and to find ways to decrease the risk even if you carry a low LR…so there is hope for the future."

SOURCE: Trim RS, Schuckit MA & Smith TL (2009). The relationships of the level of response to alcohol and additional characteristics to alcohol use disorders across adulthood: a discrete-time survival analysis. Alcoholism: Clinical and Experimental Research (ACER). 33(9):1562-1570.

Implantable Naltrexone for Opioid Dependence

Naltrexone is a long-acting opioid antagonist whose oral formulation is approved in the U.S. for the treatment of opioid dependence. However, its usefulness in addiction treatment has been hampered by poor adherence.

To determine whether naltrexone pellets implanted subcutaneously would reduce craving and opioid self-administration, Norwegian researchers conducted an open-label randomized trial comparing naltrexone implants with usual care (i.e., referral to aftercare services) among 56 adults with opioid addiction. All participants had completed an abstinence-oriented inpatient treatment program, and all had passed an oral naltrexone challenge. Outcomes for participants in the two groups were assessed at 6 months.

Patients who were randomized to receive implantable naltrexone reported heroin use on an average of 18 days, compared to use on an average of 37 days reported by patients in the control group. The implantable naltrexone group reported an average of 37 days on which any opioid (including methadone or buprenorphine) was used, compared to an average of 97 days reported by the control group. Hair analysis, conducted in 43 of the 56 patients, was concordant with self-report in 86 percent of the cases.

Patient reports also showed that polydrug use, injection drug use, and craving were lower in the naltrexone group compared with controls; however, no statistically significant differences in overdose, depression, criminal activity, outpatient treatment attendance, and use of alcohol or nonopioid drugs were found.

One overdose death occurred in each treatment group. Implants were removed from three patients in the naltrexone group (one due to site infection, one due to site pain, and one due to diarrhea). None of the study subjects attempted to remove the implants.

SOURCE: Kunøe N, Lobmaier P, Vederhus JK et al. (2009). Naltrexone implants after inpatient treatment for opioid dependence: randomised controlled trial. British Journal of Psychiatry *194(6):541–546.*

Alcohol, Other Lifestyle Factors, and Mortality

Although nontraditional risk factors explain much of the survival advantage associated with moderate alcohol use, moderate drinkers maintain their survival advantage over abstainers or heavy drinkers even after adjustment for such factors. However, a recent study found that some, but not all, of the beneficial effects of moderate alcohol intake on total mortality may be related to other lifestyle factors.

To determine whether the survival benefit associated with moderate alcohol use remains after accounting for nontraditional risk factors such as socioeconomic status (SES) and functional limitations, researchers analyzed data from 12,519 participants in the Health and Retirement Study, a nationally representative study of U.S. adults aged 55 and older. Participants were asked about their alcohol use, activities of daily living, mobility, SES, psychosocial factors (depressive symptoms, social support, and importance of religion), age, sex, race and ethnicity, smoking, obesity, and comorbid conditions. The outcome measure was death during the four-year follow-up period.

Moderate drinkers (1 drink per day) had a markedly more favorable risk factor profile, with higher SES and fewer functional limitations. After adjusting for demographic factors, moderate drinking versus no drinking was associated with 50% lower mortality (odds ratio [OR], 0.50).

When the results were adjusted for smoking, obesity, and other comorbidities, the protective effect was slightly attenuated (OR, 0.57). When all risk factors (including functional status and SES) were adjusted for, the protective effect was markedly attenuated but remained statistically significant (OR, 0.72).

After calculating a propensity score for alcohol intake to provide more precise estimates of confounding, moderate drinking versus no drinking resulted in an OR for mortality of 0.62. Overall, the estimated mortality risk for moderate drinkers was 28 percent lower than that of nondrinkers after traditional multivariable adjustment, and 38 percent lower after a sophisticated analytic approach was used for better control of confounding factors.

SOURCE: Lee SJ, Sudore RL, Williams BA et al. (2009). Functional limitations, socioeconomic status, and all-cause mortality in moderate alcohol drinkers. Journal of the American Geriatric Society *57(6):955–962.*

Initiating Acamprosate During Alcohol Detox Is Not Beneficial and May Be Harmful

Acamprosate is an FDA-approved treatment for alcohol dependence that typically is initiated after patients have achieved abstinence. There have been no clinical trials comparing the results when acamprosate is initiated during alcohol detoxification versus after detoxification.

In this exploratory trial, researchers randomly assigned 40 alcohol-dependent patients to either acamprosate (1998 mg per day) or placebo during outpatient detoxification of 5-14 days, followed by a 10-week rehabilitation phase during which all subjects received acamprosate and weekly counseling. Results of the trial showed:

- Thirty-four patients (85%) completed the detoxification phase. There was no difference in detoxification completion rates between groups.
- Patients in the placebo group had better results on 5 of 7 secondary measures during detoxification (withdrawal symptoms, amount of oxazepam prescribed, duration of detoxification, number of heavy drinking days, and number of drinks per drinking day), although these differences were not statistically significant.
- During the rehabilitation phase, patients who had been treated with acamprosate during detoxification had a higher percentage of heavy drinking days (30% versus 11%) and more drinks per drinking day (8.1 versus 4.7) than patients in the placebo group.
- There was no significant difference between groups on secondary measures during the rehabilitation phase (Addiction Severity Index score, Penn Alcohol Craving Scale score, and Hamilton Rating Scale scores for depression and anxiety).

SOURCE: Kampman KM, Pettinati HM, Lynch KG, et al. (2009). Initiating acamprosate within-detoxification versus postdetoxification in the treatment of alcohol dependence. Addict Behav. *34(6–7):581–586.*

Half of U.S. Prisons Fail to Adequately Treat Addiction

Opiate agonist therapy (OAT) with methadone or buprenorphine is available in only about half of all federal and state prison systems, and just 23 states provide referrals to addiction treatment at the time inmates are released, according to new research. This is despite the fact that both the World Health Organization and the U.S. Centers for Disease Control and Prevention recommend that prisoners be offered OAT.

For the study, investigators from Miriam Hospital, Brown University, and the Center for Prisoner Health and Human Rights surveyed the medical directors of all 50 state corrections systems as well as the District of Columbia, and their counterparts in the federal prison system. They found that 55 percent of systems offer methadone to some patients, while 45 percent offer post-release linkages to community-based addiction treatment programs. Only 14 percent of prison systems provide buprenorphine, while 29 percent link to post-release buprenorphine treatment.

Most health officials at prison systems that didn't offer OAT said they preferred drug-free detoxification, while others cited security concerns. Significant numbers also admitted ignorance about the efficacy of methadone and buprenorphine in treating addiction. "Our interviews with prison medical directors suggest that changing these policies may require an enormous cultural shift within correctional systems," said lead author Amy Nunn, Ph.D., of Brown University. "Improving correctional policies for addiction treatment could dramatically improve prisoner and community health as well as reduce both taxpayer burden and reincarceration rates," she added. The study was published in the journal Drug and Alcohol Dependence.

Alcohol Abuse, Overeating, Depression Often Intertwine in Young Women

Excessive alcohol use can relate to overeating and depression in young women, according to a study published in the September/October issue of the journal *General Hospital Psychiatry*.

"Anyone who has been touched by depression, obesity or alcoholism knows that these disorders on their own can be devastating. When they're combined, these disorders become more costly, more difficult to treat and more impairing," said Carolyn McCarty, Ph.D., lead author and a research associate professor at the University of Washington and Seattle Children's Research Institute.

In the study. researchers surveyed 393 men and 383 women at ages 24, 27 and 30 about their weight, alcohol use and symptoms of depression within the preceding year. They found that women who had alcohol use disorders at age 24 were more than three times as likely to be obese at age 27, compared to women who did not. In addition, women who were obese at age 27 were more than twice as likely to be depressed at age 30, and women who were depressed at age 27 had an increased risk of alcohol disorders at age 30. For young men, the disorders did not appear to have similar connections over time.

"When you look across time, alcohol use and obesity predicted later depression. The big picture here is that these disorders, though they're different in manifestation and symptoms, appear to be related for some groups of women." Dr. McCarty said. Although she said more research is needed to understand why these disorders are more closely related in women than in men, Dr. McCarty suggested that women might be more likely to ruminate on problems in response to stress, which could increase the likelihood of developing depression, eating disorders and substance use disorders. Different biological pathways in the brain also might play a role, she said.

"From a clinical or health care provider perspective, when you think about what to do about one of these problems, you have to think about what to do about the other," said Gregory Simon, M.D., a psychiatrist and researcher at the Group Health Center for Health Studies in Seattle. "Being overweight is the norm among people who are depressed, so when helping people with depression, you've got to think about how their weight is related." Simon had no affiliation with the study.

SOURCE: McCarty CA, Kosterman R, Mason WA et al. (2009). Longitudinal associations among depression, obesity and alcohol use disorders in young adulthood. General Hospital Psychiatry *Sep-Oct; 31(5):442-450.*

Identifying Impaired Drivers Not Simple, Reports Suggest

One well-known and often deadly consequence of alcohol intoxication is impaired driving. Yet a recent review of the literature found that it is difficult for even trained observers to fully identify "intoxication," given that so many factors contribute to it. The study examined the very definition of intoxication, as well as methods designed to prevent impaired driving.

"It is important to understand and recognize intoxication because of the risk for injury that results from it," said John Brick, Ph.D., lead author and executive director of Intoxikon International. "Understanding and recognizing an intoxicated person can help us make decisions about allowing a person to drive, accepting a ride from someone, or cutting off a drinker." The review addressed the following key points:

Terminology. "Obvious intoxication," as defined in some courts, is not always the same as "visible intoxication."

"While most people would use these terms interchangeably to mean that someone was clearly drunk," said Dr. Brick, "laws in some states differentiate between the terms. For example, in some states 'obvious' intoxication means that if someone has consumed a large number of drinks, it should be obvious that they are intoxicated and not capable of driving. Other state laws define 'visible' intoxication as specific types of behavior, such as trouble walking, slurred speech and other common signs of alcohol intoxication. Thus, it is possible to have a unique legal situation where someone is *obviously* intoxicated, but not *visibly* intoxicated based on specific legal definitions."

Metabolism. In most people, reliable signs of intoxication are present by casual observation at a blood alcohol concentration (BAC) of 150 mg/dl or more, even in most tolerant individuals. At a BAC of less than 150 mg/dl, signs of visible intoxication are not reliably present in most drinkers, and the likelihood of identifying signs of impairment is less than chance.

"This presents a particular challenge to preventionists," Dr. Brick cautioned. "For example, how do you intervene or make an informed decision about driving with someone if they do not appear visibly intoxicated? People who are too impaired to drive are not typically staggering, slurring their speech, or presenting gross signs of intoxication."

Unfortunately, there is no easy way to determine how someone can reach a BAC of 150 mg/dl, he added. "A very small woman drinking rapidly could attain a BAC of 150 mg/dl with only four standard drinks, whereas a large man might require 10 or 12 such drinks, again depending on how long they were drinking and other scientific factors," he said. "While these analyses can be calculated scientifically based on specific individuals and circumstances, for general purposes it may be better to focus on observable signs of intoxication."

Strategies: Drink counting can be a useful prevention approach in some cases. In situations where exceptionally tolerant individuals do not show signs of visible intoxication even though they are very intoxicated, the only way to know if they are intoxicated might be to count drinks, Dr. Brick explained.

"Although helpful in some cases, this is not without difficulty because you do not know how much the person consumed before they started drinking at your restaurant or party," he added. "Also, if you have a policy that allows a certain number of drinks per hour, for example, you may rely on counting rather than paying attention to behavior, and end up over-serving. Drink counting is also problematic in a busy bar, restaurant, or social gathering…and drink sizes can vary widely." He said there is a need for further research to establish a reasonable maximum number of drinks to be served, coupled with training to identify signs of intoxication.

Implications: Summing up, Dr. Brick said: "Our review is important for scientists, law enforcement and the legal community, and particularly everyday people. We want readers to know that just because someone who has been drinking does not look visibly intoxicated it does not mean they are not impaired to drive. Similarly, if after drinking someone is showing one or more signs of visible intoxication such decreased inhibitions, doing or saying things they would not if sober, or psychomotor impairment, showing trouble walking, standing, or slurred speech, or cognitive impairment, as in easily confused, or impaired memory, judgment and mental tasks, then that person is probably well above the legal definition of intoxication in the US and probably has a BAC in excess of 150 mg/dl. Their risk for a serious accident is also very high."

While prevention efforts have become more sensitive to drinking and driving, he said, establishing "intoxication" has also become more dependent on special tests, such as those used by police, and not available to the general public. "Ultimately," he said, "if there is uncertainty as to whether someone is intoxicated, it is better to err on the side of caution, terminate service, and arrange for alternate transportation."

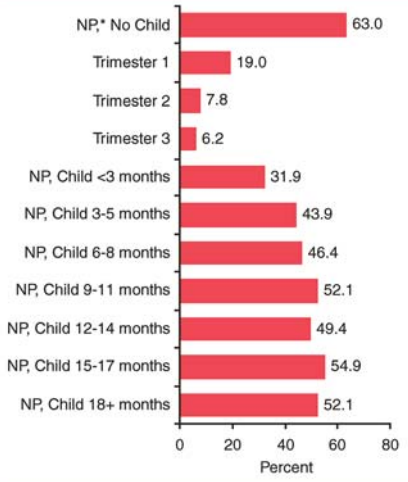
SOURCE: Brick J & Erickson CK (2009). Intoxication is not always visible: An unrecognized prevention challenge. Alcoholism: Clinical and Experimental Research *(ACER). 33(9): 1489-1507.*

Survey Finds Lower Rates of Substance Use by Pregnant Women, But Rapid Resumption of Use After Pregnancy

Women's use of alcohol, cigarettes, and illicit drugs during pregnancy can lead to poor pregnancy outcomes and behavioral and development problems in offspring. Nevertheless, a sizeable proportion of women in the first trimester of pregnancy were past month users of alcohol, cigarettes, or marijuana, and one in seven women used cigarettes in the second or third trimester. In addition, many women appear to resume use of alcohol, tobacco and other drugs after childbirth. The resumption appears to be rapid, given the high rates of such use among mothers of infants under 3 months old compared with women in the second or third trimesters of pregnancy.

Data from the National Household Survey on Drug Use and Health (NSDUH), released by the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration (SAMHSA), show that approximately one in five women used alcohol and/or cigarettes and 5% used marijuana during their first trimester of pregnancy. Substance use decreased among women in their second and third trimesters of pregnancy, suggesting that many women abstain from substance use once they know they are pregnant.

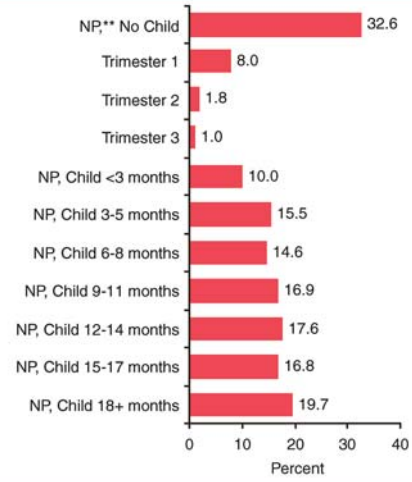
Figure 1. Women's (Aged 18 to 44 Years) Past Month Alcohol Use Rate by Pregnancy Trimester and Age of the Youngest Child in Household: 2002 to 2007



* NP = Nonpregnant

Source: 2002 to 2007 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

Figure 2. Women's (Aged 18 to 44 Years) Past Month Binge Alcohol Use* Rate by Pregnancy Trimester and Age of the Youngest Child in Household: 2002 to 2007

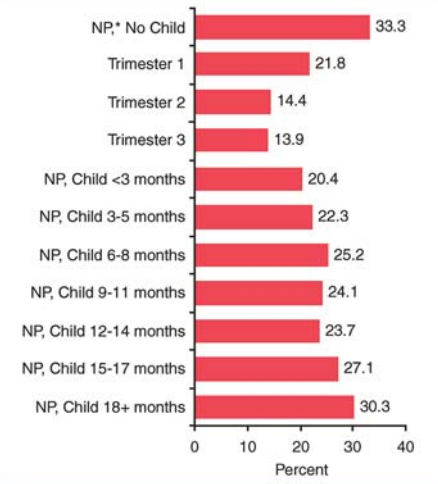


* Binge alcohol use is defined as drinking five or more drinks at the same time or within a couple of hours on at least 1 day in the past 30 days.

**NP = Nonpregnant

Source: 2002 to 2007 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

Figure 3. Women's (Aged 18 to 44 Years) Past Month Cigarette Use Rate by Pregnancy Trimester and Age of the Youngest Child in Household: 2002 to 2007

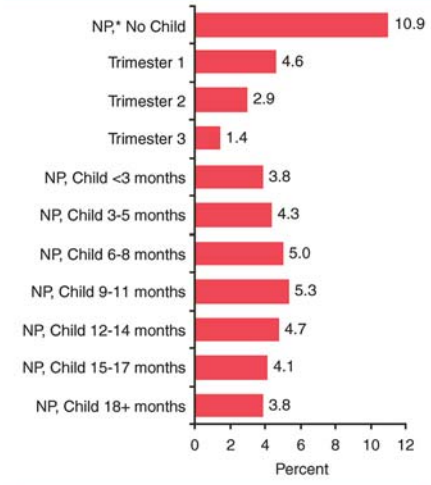


* NP = Nonpregnant

Source: 2002 to 2007 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

Non-pregnant women with children younger than three months old in the household had much higher rates of substance use in the preceding month than did women in their second and third trimesters, suggesting a rapid resumption of substance use following childbirth. Combined 2002 to 2007 data showed that past month alcohol use among women aged 18 to 44 was highest for those who were not pregnant and who did not have children living in the household (63 percent; see Figure 1). The rate was comparatively low for those in the first trimester of pregnancy (19 percent; see Figure 2) and even lower for those in the second (7.8 percent) or third (6.2 percent) trimesters. Similar patterns were seen across the four subgroups for past month binge alcohol use (Figure 2), cigarette use (Figure 3), and marijuana use (Figure 4).

Figure 4. Women's (Aged 18 to 44 Years) Past Month Marijuana Use Rate by Pregnancy Trimester and Age of the Youngest Child in Household: 2002 to 2007



* NP = Nonpregnant

Source: 2002 to 2007 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

The study's authors suggest that "effective interventions for women to further reduce substance use during pregnancy and to prevent postpartum resumption of use could improve the overall health and well-being of mothers and infants."

SOURCE: Adapted from the Substance Abuse and Mental Health Services Administration, "Substance Use Among Women During Pregnancy and Following Childbirth," The NSDUH Report, *May 21, 2009.*

SAMHSA:
Aging "Boomers" Continue Illicit Drug Use

Persons aged 50 to 59 who reported use of illicit drugs within the past year has nearly doubled…

Many "baby boomers" (Americans in the generation born between 1946 and 1964) are continuing to use illicit drugs as they grow older, causing the rate of illicit drug use to go up within the 50 to 59 year old age segment of the population. According to a new analytical publication produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), persons aged 50 to 59 who reported use of illicit drugs within the past year has nearly doubled, from 5.1 percent in 2002 to 9.4 percent in 2007, while rates among all other age groups remained the same or declined.

An Examination of Trends in Illicit Drug Use among Adults Aged 50 to 59 in the United States is the first in a series of new scientific reports being published by SAMHSA's Office of Applied Studies. The reports will provide detailed analyses of important substance abuse and mental health issues.

"These findings show that many in the Woodstock generation continue to use illicit drugs as they age," said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. "This continued use poses medical risks to these individuals and is likely to put further strains on the nation's health care system — highlighting the value of preventing drug use from ever starting."

The report analyzes many aspects of this phenomenon, including the types of illicit substances involved, as well as the demographic and behavioral factors associated with higher rates of use in this population segment.. The data used in the analysis come from a variety of sources, including 16,656 respondents aged 50 to 59 who participated in the National Surveys on Drug Use and Health from 2002 through 2007.

The full report is available on the Web at HTTP://OAS.SAMHSA.GOV/. For related publications and information, visit HTTP://WWW.SAMHSA.GOV/.

Adolescents Undertreated for Addiction, Study Finds

Only about 10 percent of adolescents who need help for problem drug or alcohol use actually enter treatment, according to a new study by the Substance Abuse Policy Research Program (SAPRP) of the Robert Wood Johnson Foundation. The study attributed the poor treatment access to a lack of adolescent-only services in the Nation´s treatment system. It also found that very few of the available treatment programs for adolescents received high marks for quality.

"We have known that out of 1.4 million teens needing help for substance use disorders, one-tenth…get treatment, said lead author Hannah Knudsen, Ph.D., of the University of Kentucky. "Part of this treatment gap may be driven by the limited availability of adolescent-only treatment services. Less than one-third of addiction programs in the U.S. have a specialized program for adolescents."

Investigators found wide variations in quality among adolescent-only programs. Knudsen analyzed nine "domains" of quality, including factors such as whether families are encouraged to be involved in the treatment process and whether programs offer a comprehensive array of services. She found that only a small number of programs scored high in each domain. The average for the national random sample of 154 treatment programs was a medium score for overall quality.

In addition, the data suggest that some treatment programs mix adolescents and adults. This practice does not conform to the recommendations of the federal Center for Substance Abuse Treatment (CSAT). Dr. Knudsen said such situations can create problems because of the developmental differences between adolescents and adults. For example, adolescents typically need services that are tailored to their stage of cognitive development.

Ruth Fox Memorial Endowment Fund

Dear Colleague:

In 1991, the Fund began to solicit donations from ASAM members. Indeed, it was the commitment and support of ASAM members that helped the Endowment reach its first million dollars in March 1992.

The goal of the Endowment Fund is to assure ASAM's continued ability to realize its mission of providing ongoing leadership in the field of Addiction Medicine and to continue its commitment to educating physicians, increasing access to care, and improving the quality of care. With your professional and financial support, ASAM and the Fund will achieve this goal.

For example, the interest income from the Endowment Fund once again supported the 2009 Ruth Fox Memorial Endowment Scholarship Program. As in earlier years, the program offered scholarships to physicians-in-training, allowing them to attend ASAM's Annual Medical-Scientific Conference in New Orleans.

Please continue to support the Endowment Fund so that we can continue to offer such scholarships in the future. For information about making a pledge, contribution, bequest, or memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman at 1-800/257-6776 or 1-718/275-7766. She welcomes your calls. Or email Claire at ASAMCLAIRE@AOL.COM.

Also, please let us know if you have included the Endowment Fund in your estate plans so that we can acknowledge your generosity. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

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

Claire Osman
Director of Development

ASAM Staff & Consultants

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

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

Jennifer Brownell
Consultant, Strategic Partnerships & Product Development
jrownell@ASAM.ORG

Gionne Graetz Celebi
Manager, Strategic Partnerships & Product Development and PCSS
GGRAETZ@ASAM.ORG

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

Valerie Foote
Data Entry Operator
VFOOT@ASAM.ORG

Joanne Gartenmann
Consultant
JGART@ASAM.ORG

Tracy Vilella Gartenmann
Director, Strategic Partnerships & Product Development (SPPD) and PCSS
TGART@ASAM.ORG

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

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

Sandra Metcalfe
CME Consultant
SMETC@ASAM.ORG

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

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

Noushin Shariate
Accounts Payable
NSHAR@ASAM.ORG

Leslie Strauss
Exhibits Manager, Conferences
LSTRAUSS@ASAM.ORG

Angela Warner
Senior Consultant, Strategic Partnerships & Product Development
AWARNER@ASAM.ORG

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

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

Darlene Williams
Pain & Addiction Program Manager and SPPD Program Assistant
DWILLIAMS@ASAM.ORG

Bonnie B. Wilford
Editor, ASAM News
210 Marlboro Ave.
Suite 31, PMB 187
Easton, MD 21601
Phone: 410/770-4866
Fax: 410/770-4711
ASAMNEWS1@AOL.COM

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

ASAM's 2009 Course on The State of the Art in Addiction Medicine — NEW THERAPEUTIC PARADIGMS

OCTOBER 22-24, 2009

HYATT REGENCY CAPITOL HILL HOTEL, WASHINGTON, DC

COURSE DIRECTOR: Frank Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse.

CO-CHAIRS: Markus Heilig, M.D., Ph.D., Chief of the Laboratory of Clinical Studies, and Clinical Director, Division of Intramural Clinical and Biological Research, National Institute on Alcohol Abuse and Alcoholism.

Robert A. Lubran, M.S., M.P.A., Director, Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Edwin A. Salsitz, M.D., FASAM, Assistant Professor of Medicine, Albert Einstein Medical Center, and Department of Medicine, Beth Israel Medical Center, New York City.

Bonnie B. Wilford, M.S., Executive Director, Coalition on Physician Education in Substance Use Disorders (COPE), Yale University School of Medicine, Easton, MD.

Stephen A. Wyatt, D.O., Medical Director, Dual Diagnosis Unit, Middlesex Hospital, Middlesex, Connecticut.

GOALS AND ORGANIZATION: The goal of ASAM's 2009 State of the Art Course is to present the most up-to-date information on the science of addiction and the practice of addiction medicine. To attain this goal, program sessions will focus on the latest research into the causes, prevention and treatment of addictive disorders, and will translate the research findings into clinically useful knowledge. The course also provides an opportunity for participants to interact with outstanding experts from across the U.S. and abroad.

Each of the seven sessions of the course is organized around a specific area of new scientific knowledge. Within each session, an expert faculty will provide concentrated reviews of recent scientific advances. In the discussion period that concludes each session, audience and faculty will jointly consider how to synthesize the research findings to improve clinical practice and patient care.

WHO SHOULD ATTEND? ASAM's 2009 State of the Art Course is designed specifically for the physician or other health care professional who seeks an advanced level of knowledge about recent breakthroughs in understanding and treating addiction and co-occurring disorders.

Topics to be addressed include:

Session 1. Cognition in Addiction. Presenters will examine the neuropharmacology of cognition and cognitive deficits in addicted patients; brain imaging in predicting relapse; the use of brief cognitive-behavioral therapy for patients with limited cognition and other strategies for cognitive remediation in addicted patients.

Session 2. Anxiety and Addiction. Presenters will discuss the neuroscience of anxiety disorders and the relationship between stress and anxiety; preclinical research on the neurobiology of PTSD and anxiety; PTSD, alcohol and drug use, and suicide risk in returning military personnel; psychotherapies for anxiety; and strategies for treating anxiety disorders in alcohol- and drug-dependent populations.

Session 3. Current Controversies in Addiction Medicine. Presenters will address policy and clinical perspectives on medical marijuana, snus, kratom, and other agents that advocates consider "harm reduction" strategies.

Session 4. Food as a Process Addiction. Presenters will describe the evidence for overlapping neural circuits in addiction and obesity; recent studies that combine evidence from imaging and genetics to predict vulnerability to weight gain; current treatment strategies for food-related disorders; and the Robert Wood Johnson Foundation's new initiative on eating disorders and obesity.

Session 5. Medication-Assisted Treatment: The Safety-Efficacy Paradox. Presenters will review the evidence regarding cardiac arrhythmias and Torsades de Pointes in patients being treated with methadone; suicidality in patients receiving pharmacotherapies for smoking cessation; pharmacotherapies for alcohol dependence; diversion and abuse of buprenorphine; and the FDA's new Risk Evaluation and Mitigation Strategies (REMS) and the implications of these new requirements.

Session 6. Buprenorphine: New Insights and Targeted Treatment Strategies. Presenters will examine the implications of the Prescription Opioid Addiction Treatment Study (POATS); the use of buprenorphine in the treatment of adolescents; indications and contraindications to the use of buprenorphine in treating pregnant women; combining psychosocial and pharmacotherapies; and current research into injectable probuphine as a potential alternative to buprenorphine.

Session 7. The Role of Gender in Addiction Risk and Treatment. Presenters will examine the evidence for gender-specific addiction risk; the special risks of substance abuse in LGBT populations (particularly the connection between methamphetamine use and rising rates of HIV); and domestic violence as a risk factor for alcoholism.

LEARNING OBJECTIVES: At the conclusion of the State of the Art Course, participants should be able to:

- Discuss the current evidence for clinical approaches to treatment of substance use and co-occurring disorders in various settings.
- Describe the uses of new therapies for addiction, as well as the most beneficial combinations of pharmacologic and non-pharmacologic approaches.
- Understand the factors to be considered in balancing the safety and efficacy of various treatment interventions.

To enhance the learning experience, every course registrant will receive a print syllabus and access to copies of the speakers' PowerPoint slides and related materials.

Agency Leaders to Deliver Keynote Addresses

Participants in the State of the Art Course will have an opportunity to hear directly from the heads of the principal Federal agencies involved in addiction research, prevention, treatment, and policy through a series of keynote addresses. Typically, these officials use the addresses to discuss their agencies' current research portfolios and plans for future research concentrations and other initiatives. The State of the Art Course is one of the few venues to bring these luminaries together in a single event. At press time, the following agency directors had been invited to participate at the dates and times shown:

Eric Broderick, D.D.S., M.P.H., Acting Administrator, Substance Abuse and Mental Health Services Administration *(address scheduled for Friday, October 23rd at 8:45 a.m.)*

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (*address scheduled for Saturday, October 24th at 11:30 a.m.*)

Ken Thompson, M.D., Associate Director for Medical Affairs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration *(address scheduled for Thursday, October 22nd at 1:15 p.m.)*

A. Thomas McLellan, Ph.D., Deputy Director, Office of National Drug Control Policy, Executive Office of the President, The White House *(address scheduled for Thursday, October 22nd, at 12:00 noon*)

Joshua Sharfstein, M.D., Deputy Director, U.S. Food and Drug Administration *(address scheduled for Friday, October 23rd, at 12:00 noon*)

Nora D. Volkow, M.D., Director, National Institute on Drug Abuse, National Institutes of Health *(address scheduled for Thursday, October 22nd at 8:45 a.m.)*

Kenneth R. Warren, Ph.D., Acting Director, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health *(address scheduled for Friday, October 23rd at 1:15 p.m.)*

Program to Focus on Treatment Safety and Efficacy, Promising Strategies

The goal of ASAM's 2009 State of the Art Course is to present the most up-to-date information on the science of addiction and the practice of addiction medicine. To attain this goal, program sessions will focus on the latest research into the causes, prevention and treatment of addictive disorders, and will translate the research findings into clinically useful knowledge. The course also provides an opportunity for participants to interact with leading scientists and clinical experts from the U.S. and abroad.

Each of the course's seven sessions is organized around specific areas of scientific discovery. Within each session, an expert faculty will present concentrated reviews of recent scientific advances. In the discussion period that concludes each session, audience and faculty will jointly consider how to synthesize the research findings to improve clinical practice and patient care.

Welcome and Overview of the Course

Thursday, October 22, 2009
8:30 a.m. to 8:45 a.m.

Presiding: ASAM President Louis E. Baxter, Sr., M.D., FASAM, Executive Medical Director, Professional Assistance Program of New Jersey, and Clinical Professor of Medicine, University of Medicine and Dentistry of New Jersey.

Course Director Frank Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse.

Session 1: Cognition in Addiction

Thursday, October 22, 2009
8:30 a.m. to 12:00 noon

Moderator: Frank Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse

Keynote Address: Nora D. Volkow, Ph.D., Director, National Institute on Drug Abuse

Presentations:

The Neuropharmacology of Cognition *(Trevor W. Robbins, Ph.D., FRS, Professor of Cognitive Neuroscience and Experimental Psychology and Head of Department, University of Cambridge, Cambridge, England)*

Cognitive Deficits in Addicted Patients *(Barbara Sahakian, Ph.D., F.Med.Sci., Professor of Clinical Neuropsychology, Department of Psychiatry, University of Cambridge School of Clinical Medicine and Addenbrooke's Hospital, Cambridge, England)*

Brain Imaging in Predicting Relapse *(Martin P. Paulus, M.D., Laboratory of Biological Dynamics and Theoretical Medicine, University of California San Diego)*

Brief CBT for Patients with Limited Cognition *(Effie Aronovich, Ph.D., Department of Genetics, Cell Biology and Development, Center for Genome Engineering, University of Minnesota, Minneapolis, Minnesota)*

Strategies for Cognitive Remediation in Addicted Patients (*William Fals-Stewart, Ph.D., Professor, School of Nursing, University of Rochester, Rochester, NY)*

Session 2. Anxiety and Addiction

Thursday, October 22, 2009
1:15 to 5:00 p.m.

Moderator: Stephen A. Wyatt, D.O., Medical Director, Dual Diagnosis Unit, Middlesex Hospital, Middlesex, Connecticut.

Keynote Address: Ken Thompson, M.D., Associate Director for Medical Affairs, Center for Mental Health Services.

Presentations:

The Neuroscience of Anxiety Disorders and the Relationship Between Stress and Anxiety *(George Koob, Ph.D., Professor and Chair, Division of Clinical Psychopharmacology, The Scripps Research Institute, La Jolla, California)*

Preclinical Research on the Neurobiology of PTSD and Anxiety *(Speaker to be announced)*

PTSD, Alcohol and Drug Use, and Suicide Risk in Returning Military Personnel (*Kathleen T. Brady, M.D., Ph.D., Professor and Director, Clinical Neuroscience Division, and Associate Dean, Clinical and Translational Research; Director, South Carolina Clinical and Translational Research Institute, University of South Carolina)*

Psychotherapies for Anxiety *(Speaker to be announced)*

Treating Anxiety Disorders in Drug-Dependent Populations *(Robert L. DuPont, M.D., President, Institute for Behavior and Health, Rockville, Maryland)*

Session 3. Current Controversies in Addiction Medicine

Thursday, October 22, 2009
7:00 to 9:00 p.m.

Moderator: Frank Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse

Presentations:

Policy and Clinical Perspectives on Medical Marijuana *(Ethan Nadelmann, Ph.D., Executive Director, Drug Policy Alliance, New York City)*

Snus, Kratom, and Other Agents Proposed as "Harm Reduction" Strategies *(Edward W. Boyer, M.D., Associate Professor of Emergency Medicine, and Director of Toxicology, and Director, Toxicology Fellowship, Department of Emergency Medicine, University of Massachusetts Medical School, Worcester, Massachusetts)*

Session 4. Food as a Process Addiction

Friday, October 23, 2009
8:30 a.m. to 12:00 noon

Moderator: Edwin A. Salsitz, M.D., FASAM, Assistant Professor of Medicine, Albert Einstein Medical Center, and Department of Medicine, Beth Israel Medical Center, New York City.

Keynote Address: Eric Broderick, D.D.S., M.P.H., Acting Administrator, Substance Abuse and Mental Health Services Administration

Presentations:

Evidence for Overlapping Neural Circuits in Addiction and Obesity *(Gene-Jack Wang, M.D., Chair, Medical Department, Brookhaven National Laboratory, Upton, New York)*

Combining Evidence from Imaging and Genetics to Predict Vulnerability to Weight Gain *(Eric Stice, Ph.D., Oregon Research Institute, Eugene, Oregon)*

Neuroimaging and Food Advertising *(Kathryn Montgomery, Ph.D., Professor, School of Communications, American University, Washington, DC)*

Current Treatment Strategies for Food-Related Disorders *(Mark S. Gold, M.D., Donald R.. Dizney Eminent Scholar and Distinguished Professor, University of Florida College of Medicine & McKnight Brain Institute; Departments of Psychiatry, Neuroscience, Anesthesiology, Community Health & Family Medicine; Chairman of the Department of Psychiatry, University of Florida, Gainesville, Florida)*

Hunger as Addiction *(Alain Dagher, M.D., Associate Professor, Montreal Neurological Institute, McGill University, Montreal, Ontario, Canada)*

Session 5: Medication-Assisted Treatment: The Safety-Efficacy Paradox

Friday, October 23, 2009
1:15 to 5:00 p.m.

Moderator: Markus Heilig, M.D., Ph.D., Chief of the Laboratory of Clinical Studies, and Clinical Director, Division of Intramural Clinical and Biological Research, National Institute on Alcohol Abuse and Alcoholism.

Keynote Address: Kenneth R. Warren, Ph.D., Acting Director, National Institute on Alcohol Abuse and Alcoholism.

Presentations:

Evidence Regarding Cardiac Arrhythmias and Torsades de Pointes in Patients Being Treated with Methadone (*Marc N. Gourevitch, M.D., Dr. Adolph and Margaret Berger Professor of Medicine, and Professor of Psychiatry and Director, Division of General Internal Medicine, New York University Langone Medical Center, New York City; and Mori J. Krantz, M.D., Associate Professor of Medicine, Division of Cardiology, University of Colorado School of Medicine, and Director, Colorado Prevention Center, Denver Health Medical Center, Denver, Colorado)*

Suicidality in Patients Receiving Pharmacotherapies for Smoking Cessation *(John R. Hughes, M.D., Professor, Department of Psychiatry, University of Vermont College of Medicine, Burlington, Vermont)*

Pharmacotherapies for Alcohol Dependence — What Are the Risks? *(Dominic A. Ciraulo, M.D., Professor of Psychiatry and Psychology, Boston University, and VA Outpatient Clinic, Boston,* Massachusetts)

Buprenorphine Diversion and Abuse *(Edward W. Boyer, M.D., Associate Professor of Emergency Medicine, and Director of Toxicology, and Director, Toxicology Fellowship, Department of Emergency Medicine, University of Massachusetts Medical School, Worcester, Massachusetts)*

Implications of the FDA's New Risk Evaluation and Mitigation Strategies (REMS) *(Ellen Fields, M.D., M.P.H., Clinical Team Leader, DAARP/Center for Drug Evaluation and Research, U.S. Food and Drug Administration, Silver Spring, Maryland)*

Session 6. Buprenorphine: New Insights and Targeted Treatment Strategies

Saturday, October 24, 2009
8:30 a.m. to 12:00 noon

Moderator: Robert A. Lubran, M.S., M.P.A., Director, Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Keynote Address: H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, Center for Substance Abuse Treatment

Presentations:

Implications of the Prescription Opioid Addiction Treatment Study (POATS) *(Roger D. Weiss, M.D., Professor of Psychiatry and Clinical Director, Alcohol and Drug Abuse Treatment Program, Belmont, Massachusetts)*

Use of Buprenorphine in the Treatment of Adolescents *(George E. Woody, M.D., Director, CRE Team on Addictions/MIRECC, Philadelphia Veterans Affairs Medical Center, and Treatment Research Institute, University of Pennsylvania, Philadelphia, Pennsylvania)*

Indications and Contraindications to the Use of Buprenorphine in Treating Pregnant Women *(Marjorie C. Meyer, M.D., Director, Opiate Treatment Program During Pregnancy, and Associate Professor, Ob/Gyn, University of Vermont, Burlington, Vermont)*

Combining Psychosocial and Pharmacotherapies (*Kathleen M. Carroll, Ph.D., Professor of Psychiatry, Division of Substance Abuse/MIRECC ,Yale University School of Medicine, New Haven, Connecticut)*

Current Research into Injectable Probuphine as a Potential Alternative to Buprenorphine *(Walter Ling, M.D., Professor of Psychiatry and Director, Integrated Substance Abuse Programs, Department of Psychiatry & Biobehavioral Sciences, David Geffen School of Medicine at UCLA, Los Angeles, California)*

Session 7. The Role of Gender in Addiction Risk and Treatment

Saturday, October 24, 2009
1:15 to 3:15 p.m.

Moderator: Frank Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse.

Presentations:

Evidence for Gender-Specific Addiction Risk *(Cora Lee Wetherington, Ph.D., Coordinator, Women & Gender Research, National Institute on Drug Abuse, Bethesda, Maryland)*

Special Risk Factors for Substance Abuse in the LGBT Population *(Steven Shoptaw, Ph.D., Professor, Department of Family Medicine, David Geffen School of Medicine at UCLA, Los Angeles, California)*

Domestic Violence as a Risk Factor for Alcoholism *(Speaker to be announced)*

Current Clinical Guidelines *(Eric C. Strain, M.D., Professor, JHB Psychiatry Substance Abuse Programs, and Medical Director, Behavioral Pharmacology Research Unit, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland)*

Wrap Up, Acknowledgements, and Adjournment

Saturday, October 24, 2009
3:00 to 3:15 p.m.

Presiding: ASAM President Louis E. Baxter, Sr., M.D., FASAM, and Course Director Frank Vocci, Ph.D.

HOTEL AND TRAVEL INFORMATION

HOTEL: The State of the Art Course will be held at the Hyatt Regency Capitol Hill Hotel, 400 New Jersey Avenue, NW, Washington, DC 20001 (phone 202/737-1234; fax 202/737-5773). Hotel check-in time is 3:00 p.m. Check-out time is 12:00 noon. Features and amenities are listed on the hotel's website at HTTP://WASHINGTONREGENCY.HYATT.COM/HYATT/HOTELS/INDEX.JSP.

A limited number of rooms are being held at the conference rate of $239 single or $264 double (rates are subject to local taxes). Reservations should be made no later than Wednesday, September 30, 2009. To receive the conference rate, call the Hyatt reservations department at 1-800/233-1234 or phone the hotel directly at 202/737-1234 and tell the reservation agent that you are attending the ASAM State of the Art Course.

TRAVEL FROM LOCAL AIRPORTS:

From/to Ronald Reagan National Airport: Taxis are available outside the baggage claim area. The fare is approximately $14-$18 (10-20 minutes). One-way fare on the Super Shuttle is approximately $14. Reservations may be made by calling 800-BlueVan (1-800/258-3826) or online at WWW.SUPERSHUTTLE.COM.

From/to Dulles International Airport: Taxis are available on the lower level of the terminal, outside baggage claim. Taxi fare is approximately $60 to $80 (50-60 minutes). One-way fare on the Super Shuttle is approximately $29.

From/to Baltimore/Washington (BWI) Airport: Taxis are available on the lower level of the terminal, outside baggage claim. The one-way fare is approximately $63 (60 minutes). The MARC train offers weekday commuter service from the BWI station to Union Station, which is within 3 blocks of the hotel. The MARC fare is approximately $6 one way.

AMTRAK, MARC, AND METRO: MARC commuter trains run from Baltimore's BWI station to Union Station (weekdays only). For those traveling by local transit (Metro), use the Red Line and exit at the Union Station stop.

Union Station is within 3 blocks of the hotel. Follow the exit signs to the front of Union Station. Take E Street (between the semi-circle of flags) to the intersection of E Street, NW and New Jersey Avenue, NW. The hotel will be directly in front of you.

Taxis are available at the main entrance to Union Station. The fare to the hotel is approximately $5.50, with rush-hour surcharges possible.

DRIVING DIRECTIONS:

From Points North: Take I-95 South to exit 22B (Baltimore-Washington Parkway South). Exit onto Route 50 West toward Washington, then exit onto New York Avenue. Stay on New York Avenue for approximately four miles. Make a left onto North Capital Street, proceed for approximately one mile. Make a right turn onto E Street and proceed for one block. Make a left turn onto New Jersey Avenue. The hotel is on the right.

From Points South: Take I-95 North to I-395 toward Washington. As you pass over the Potomac River, stay in one of the middle lanes. At the end of the bridge, veer right and continue to follow signs for I-395 North. Proceed for approximately one mile, then take the exit for US Senate/D Street/I-395 North. Stay in the right lane as you go through two tunnels. In the second tunnel, take the exit for D Street. Make a right turn onto D Street at the stoplight at the end of the tunnel. Go to the second traffic light and turn left onto New Jersey Avenue. The hotel is on the left.

From Points West: Take I-66 East or Route 50 toward Washington to the Theodore Roosevelt Bridge. Exit onto Constitution Avenue. Follow Constitution Avenue toward the U.S. Capitol. A few blocks before the Capitol, make a left onto Louisiana Avenue and proceed for two blocks. Make a left onto New Jersey Avenue. The hotel is one block ahead on the left.

From the Northwest (via I-270): Take I-270 South toward Washington. Keep right to exit onto the I-270 Spur South toward I-495 South in the direction of Washington/Northern Virginia (the I-270 Spur becomes I-495/Capital Beltway). Take exit 43 to the George Washington Memorial Parkway toward Washington. Follow the GW Parkway until it merges with I-395 North toward Washington. Take the exit for U.S. Senate/D Street/I-395 North. Stay in the right lane as you go through two tunnels. In the second tunnel, take the D Street exit. Make a right at the light at the end of the tunnel onto D Street. Go to the second traffic light and turn left onto New Jersey Avenue. The hotel is on the left.

PARKING: The Hyatt Regency Capitol Hill Hotel offers valet parking to conference attendees at the following hourly rates: less than 1 hour, $20; 1-2 hours, $25; 2-10 hours, $28; and 10-24 hours, $41. Self-parking is not available at the hotel; however, a public garage is located across the street from the hotel's main entrance.

GETTING AROUND TOWN: For assistance in planning your travel, contact the hotel's concierge, or visit HTTP://WWW.WMATA.COM/default.cfm for complete maps, schedules and trip ideas.

CONTINUING EDUCATION CREDITS

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.

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

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

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

SAVE $50…Register By October 9th!

To qualify for the special rates shown below, registrations must be received by Friday, October 9, 2009. On-site and late registrants are welcomed, but will be charged $50 in addition to the amounts shown. The registration fee includes the course syllabus and other reference materials, continental breakfast, and refreshment breaks.

Full payment must accompany each registration. Checks and money orders in U.S. funds drawn on a U.S. bank will be accepted. Visa and MasterCard are accepted as well. *(ASAM does not accept purchase orders as a form of payment.)* Students, residents, fellows and interns must provide documentation of full-time status in their respective categories with their registration forms.

REGISTRATION FEES:

- ❑ ASAM Member ..... $ 475
- ❑ Nonmember Physician ..... $ 530
- ❑ Nonphysician Professional ..... $ 480
- ❑ Resident, Fellow, or Intern* ..... $ 200

(with proof of status)*

- ❑ Student* ..... $ 100
- ❑ Daily Registration ..... $ 200
  - ❑ Thursday, October 22nd
  - ❑ Friday, October 23rd
  - ❑ Saturday, October 24th

Name: _____

Degree and Title: _____

Organization: _____

Street Address: _____

City/State/Zip Code: _____

Email: _____

Phone: _____ Fax: _____

❑ Check enclosed Credit Card: ❑ Visa ❑ Mastercard

Card Number: _____ Exp. Date: _____

Signature: _____

❑ **Send me information about registering for ASAM Legislative Day.**

Register Today!

Make checks payable to: "ASAM 2009 State of the Art Course."

MAIL the Completed Registration Form with Payment To:
ASAM 2009 State of the Art Course, PO Box 80139, Baltimore, MD 21280-0139.

Or complete the credit card information and FAX the Registration Form to:
ASAM Conference Department at **301/656-3815**.

ONSITE REGISTRATION: The onsite Registration Desk will be open at the following hours:

Wednesday, Oct. 21st ..... 5:00 p.m.-8:00 p.m.
Thursday, Oct. 22nd ..... 7:00 a.m.-5:00 p.m.
Friday, Oct. 23rd ..... 7:00 a.m.-5:00 p.m.
Saturday, Oct. 24th ..... 7:00 a.m.-5:00 p.m.

TAX DEDUCTION INFORMATION: IRS regulations permit an income tax deduction for educational expenses. To be deductible, your expenses must be for education that (1) maintains or improves skills required in your present job; or (2) serves a business purpose and is required by your employer or by law or regulations, to keep your present salary, status, or job. (The IRS recommends that you keep a daily record of expenditures in accordance with this regulation.) Registrants are advised to consult their tax advisors.

PERSONS WITH DISABILITIES OR DIETARY RESTRICTIONS: Persons who require special accommodations should indicate them on the registration form and return it by October 1, 2009, so that we may accommodate your needs.

ASAM Conference Calendar

ASAM EVENTS

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]

December 4-6, 2009
Comprehensive MRO Course: Toxicology Testing and the Physician's Role in the Prevention and Treatment of Substance Abuse
Washington, DC
[18 Category 1 CME Credits]

April 15, 2010
Ruth Fox Course for Physicians
San Francisco Marriott
San Francisco, California
[8 Category 1 CME Credits]

April 15, 2010
Pain & Addiction: Common Threads
San Francisco Marriott
San Francisco, California
[8 Category 1 CME Credits]

April 15-18, 2010
41st Annual Medical-Scientific Conference
San Francisco Marriott
San Francisco, California
[21 Category 1 CME Credits]

OTHER EVENTS OF NOTE

October 22, 2009
Making Liability and Risk More Manageable:
Risk Management and Patient Safety in Outpatient Methadone Treatment
University of Illinois at Chicago, Chicago, Illinois
View the program or register online at WWW.IRETA.ORG

October 23-24, 2009
Managing Chronic Pain While Keeping the "Control" in Controlled Substances
Sponsored by the Vermont Dept. of Health, the Vermont Medical Society, and the Brattleboro Retreat, with support from CSAT
Hampton Inn Conference Center
Colchester, Vermont,
and at multiple Webinar sites
[4 Category 1 CME credits]
For more information or to register, email JKELLIHER@BRATTLEBORORETREAT.ORG or phone 802/258-4359

November 5-7, 2009
33rd National Conference of the Association for Medical Education and Research in Substance Abuse (AMERSA)
DoubleTree Bethesda Hotel
Bethesda, Maryland
View the program or register online at HTTP://WWW.AMERSA.ORG/CONFREG.ASP

December 3-6, 2009
American Academy of Addiction Psychiatry 20th Annual Meeting and Symposium
Hyatt Regency Century Plaza
Los Angeles, California
View the program or register online at HTTP://WWW2.AAAP.ORG/MEETINGS-AND-EVENTS or phone AAAP at 401/524-3076

February 7-10, 2010
12 International Conference on Treatment of Addictive Behaviors
The Eldorado Hotel, Santa Fe, New Mexico
View the program or register online at HTTP://CASAA.UNM.EDU

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.

REGISTER NOW for the 2010 ABAM Certification Exam

Certification is recognized throughout the world as signifying excellence in the practice of Addiction Medicine. It demonstrates that a physician has met rigorous standards through intensive study, assessment, and evaluation. Certification is designed to assure the public that a medical specialist has successfully completed an approved educational program and an evaluation, including a secure examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality patient care.

The next Certification Exam will be offered by the American Board of Addiction Medicine (ABAM) on December 11, 2010. The 2010 Certification Application is posted on ASAM's website (WWW.ASAM.ORG) and on ABAM's website (WWW.ABAM.NET). The sites also contain information about eligibility to sit for the examination, fees and deadlines.