Volume 25, Number 1, Winter 2009-2010

ASAM News

Newsletter of The American Society of Addiction Medicine

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ASAM at Work for You:

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www.asam.org

ASAM's Med-Sci Conference to Meet in San Francisco

Addiction medicine practitioners, educators and researchers will gather in San Francisco from April 15-18th for ASAM's 41st Annual Medical-Scientific Conference. The conference welcomes ASAM members as well as non-member physicians, nurses, psychologists, counselors, students and residents. It features three full days of clinical and scientific offerings, as well as ASAM's annual Business Meeting on Friday morning, April 16th.

The Med-Sci Conference is preceded by the Ruth Fox Course for Physicians and ASAM's course on Pain and Addiction — Common Threads, both scheduled for Thursday, April 15th. Educational activities conclude on Sunday, April 18th. All the events take place at the San Francisco Marriott Marquis Hotel.

For additional information or to register, visit the ASAM website at WWW.ASAM.ORG or contact ASAM's Department of Meetings and Conferences at 301-656-3920. Detailed information about the program will appear in the Spring issue of **ASAM News**.

New Edition of ASAM Textbook Wins 4-Star Review

A reviewer for Doody's Book Reviews™, which evaluates books and electronic products across a wide range of clinical specialty areas, has given the new 4th Edition of ASAM's textbook, *Principles of Addiction Medicine*, a rating of four stars (outstanding).

In his review, Michael Easton, M.D., of Chicago's Rush University Medical Center, calls the book an "excellent overview of the specialty of addiction medicine." He describes the book as suitable for all health care professionals, adding that "Each of the book's 14 sections is organized by senior editors who are well known experts in their areas. The first section on basic science is followed by sections reviewing pharmacology (opiates, stimulants, caffeine, nicotine, cannabinoids, hallucinogens and designer drugs, dissociatives, inhalants, and steroids); diagnosis and intervention (including special populations, emergency rooms, geriatrics and laboratory testing); management of withdrawal; psychosocial, behavioral, and pharmacological treatments (for alcohol, opioids, stimulants and nicotine); and self help groups. The book then turns to topics such as medical problems caused by alcohol and drugs and co-occurring psychiatric disorders, addiction and pain, children and adolescents, and ends with ethical, legal, and liability issues in addiction practice."

Doody's Book Reviews™ collects information on approximately 3,000 book and software titles each year from over 250 of the world's leading publishers of professional level healthcare publications. Expert reviews of about 2,000 of the titles each year are prepared by a network of more than 5,000 academically-affiliated healthcare professionals. The reviews are sent to more than 300,000 health care and health information professionals through a weekly e-mail service and personalized web pages. It is estimated more than 1,000,000 individuals worldwide regularly consult Doody's Book Reviews™.

Principles of Addiction Medicine, 4th Edition, was edited by Richard K. Ries, M.D., FAPA, FASAM; David A. Fiellin, M.D.; Shannon C. Miller, M.D., FASAM, FAPA, CMRO; and Richard Saitz, M.D., M.P.H., FACP, FASAM. Published by Lippincott Williams & Wilkins, the 1570-page hardcover volume is priced at $199 and can be ordered online at HTTP://WWW.LWW.COM/PRODUCT/?978-0-7817-7477-2.

Eileen McGrath, J.D.

2010 Promises Real Advances In Access to Addiction Treatment

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

The beginning of 2010 marks several important advances and opportunities to improve access to addiction treatment.

First, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Parity Act, which was passed and signed into law in 2008, took full effect on January 1. The Act eliminates discrimination by insurance companies and expands access to treatment for those who seek help for addiction to alcohol or other drugs and want coverage for their care through their employer-sponsored group health plans.

Thanks to the Wellstone Act, those plans are required to cover mental health and addiction care at the same level (at parity) with the benefits they offer for all other medical or surgical care, including out-of-pocket expenses, deductibles and co-pays.

Second, Congressional negotiators continue their efforts to reconcile the House and Senate versions of health reform legislation. While there are many differences to be resolved, coverage of addiction treatment does not appear to be one of them, as it is addressed in both the House and Senate measures. This is in sharp contrast to the last big health reform battle on Capital Hill — the Clinton administration's ill-fated effort to achieve universal coverage in 1993-94.

Carol McDaid of Capitol Decisions, who works with ASAM and other leading addiction organizations to shape Federal legislation, points out that agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of National Drug Control Policy (ONDCP) have been actively collaborating with addiction field representatives on health reform. As reported in **ASAM News**, SAMHSA issued a consensus statement calling for addiction and mental health services to be included in health reform and outlining a series of core principles for reform, while the Coalition for Whole Health has drafted legislative language reflecting the field's priorities.

Carol adds that because of the recent battle for passage of the parity law, the arguments in favor of covering addiction treatment are still fresh in lawmakers' minds. In fact, data clearly show that if addictions are untreated, medical care becomes fragmented, inefficient and episodic. It is not just that addiction, by itself, risks health consequences and poor health outcomes. It is also that unrelated and co-existing health issues go unaddressed. For example, heavy drinking contributes to each of the top three causes of death: heart disease, cancer and stroke. Addiction also can lead to misdiagnoses, unexpected side effects from prescribed medications and poor medical outcomes. Finally, many persons with untreated addiction fail to fill a prescription or get laboratory tests, skip a follow-up doctor's appointment or do not follow the treatment plan.

ASAM and other advocacy groups also are working to ensure that the addiction field will share in the workforce development programs envisioned under the various bills, such as forgiveness of educational loans and increased residency training slots. "It could become a real issue if we get parity and have a big increase in patients with no providers to serve them," Carol points out.

Finally, addiction advocates are pressing lawmakers to ensure that treatment programs can tap into assistance to develop and enhance electronic health records to improve coordination and efficiency, while at the same time recognizing the special confidentiality issues inherent in addiction treatment, Carol says.

Currently, the addiction field "comes out better in the House bill, although both the House and Senate measures are acceptable. Neither of the bills addresses specific health care benefits. If a health reform law is enacted, benefit design will be handled by special committees established under the reform act.

ASAM has been and continues to be actively engaged in the health reform debate through the work of the Public Policy Committee, through our Legislative Days, and through the efforts of our staff and consultants like Carol McDaid. In all of these efforts, we do our best to understand and represent the efforts of ASAM's members and their patients.

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.

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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).

SAMHSA Administrator Pamela S. Hyde, J.D.

New SAMHSA Administrator Sworn In

Pamela S. Hyde, J.D., has been sworn in as the new Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), parent agency of the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS). As Administrator, Ms. Hyde leads SAMHSA's staff of approximately 550 public health professionals and manages a budget of approximately $3.5 billion.

Since 2003, Ms. Hyde served as Secretary of the New Mexico Human Services Department. Before that, she was Director of the Ohio Department of Mental Health, the Ohio Department of Human Services, and the Seattle Department of Housing and Human Services. She also has worked as CEO of Comcare, a private not-for-profit behavioral health organization.

In commenting on the selection, New Mexico Governor Elliot Richardson said Ms. Hyde "has been with my administration since day one and has been a tremendous asset for the people of New Mexico, providing greater access to quality resources they need to be successful in life. She not only improved the services available through the Human Services Department but took on the task of improving and streamlining the way behavioral health services are administered in our state, something no other state has tried, much less accomplished."

Secretary Kathleen Sebelius of the Department of Health and Human Services said, "Pamela Hyde has worked tirelessly on behalf of the people of New Mexico to expand access to health and human services programs and improve their quality…. Pamela's health policy expertise and management experience will be invaluable to our department."

Rear Admiral Eric Broderick has served as Acting Administrator of SAMHSA since the departure of former Administrator Terry Cline, Ph.D., in late 2009.

IG Report Critical of U.S. Antidrug Efforts in Pakistan, Afghanistan

In a newly recently report, the Inspector General for the U.S. Department of State sharply criticized antidrug efforts in Pakistan and Afghanistan, saying that the U.S. strategy, objectives and tactics all are insufficient. The report also says that clear roles are lacking for both military and civilian antidrug efforts, and that cooperation between the U.S. embassies in Kabul, Afghanistan and Islamabad, Pakistan has been poor because embassy officials in Pakistan don't see a link between drug trafficking and insurgents in Pakistan. Drug eradication efforts also are handicapped by the Afghan government's weak justice system, corruption, and lack of political will, the report adds.

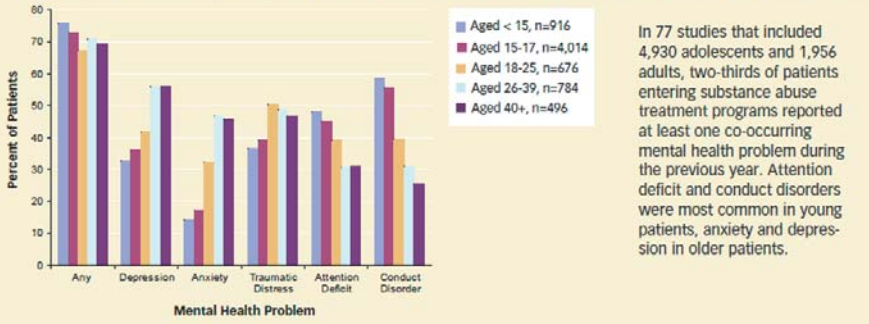
In mid-2009, the Obama administration announced what was described as a fundamental change in U.S. drug policy in the area. Richard C. Holbrooke, the Obama administration's special representative for Afghanistan and Pakistan, told reporters that, instead of trying to eradicate opium poppy fields, as the Bush administration had done, greater emphasis would be placed on assisting Afghan farmers to make a living through alternate crops and on seizing drugs leaving the country. Ambassador Holbrooke said the Bush-era eradication policy, which cost hundreds of millions of dollars, failed because it had put farmers out of work, alienating the Afghan people and driving them into the arms of the Taliban.

The U.S. wants to stop the Taliban from profiting from the heroin trade. Afghanistan supplies over 90 percent of the world's heroin, and the United Nations estimates that the Taliban earn as much as $300 million annually from the opium trade. Precisely because the Afghan economy is so dependent on the drug trade, the new policy is unlikely to significantly reduce the country's dependence on that trade, according to Vanda Felbab-Brown, a fellow at the Brookings Institution.

Source: JoinTogether.com, January 14, 2010 and June 28, 2009.

By the Numbers

Most People Entering Drug Treatment Have Additional Mental Health Problems



In 77 studies that included 4,930 adolescents and 1,956 adults, two-thirds of patients entering substance abuse treatment programs reported at least one co-occurring mental health problem during the previous year. Attention deficit and conduct disorders were most common in young patients, anxiety and depression in older patients.

SOURCE: Chan YF, Dennis ML & Funk RL. Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. *Journal of Substance Abuse Treatment* 34(1):14-24, 2008.

Addiction Medicine: An International Perspective

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

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

As we all know, addiction is a wide spread problem, the effects of which are not limited to the addicted individual, but also impact entire communities and our nation as a whole. However, in our focus on the effects of addiction on our patients and communities, we sometimes forget that addiction also is a universal problem, from which many communities across the globe — whether developed or developing — suffer.

ASAM took positive steps toward recognizing addiction as a worldwide problem when it helped create the International Society of Addiction Medicine (ISAM) in 1997. In addition, the Board of Directors has designated a seat on the Board for a representative elected by non-U.S. members of ASAM (and which is currently held by Raju Hajela, M.D., M.P.H., FASAM, of Canada).

I was reminded of the global nature of addiction as I participated in the 6th United Kingdom/European Symposium on Addictive Disorders (UK/ESAD) last May in London. The conference featured expert presenters from the U.S., the U.K., and many European nations, discussing everything from basic research to new clinical techniques to how national policies on prevention and treatment influence access to care. I was pleased to represent ASAM and to deliver presentations on "The Role of Doctors in the Care of Patients with Addiction" and "Physician Impairment in the U.S.A." At the invitation of Dr. Brian Iddon, M.P., I also addressed the British Parliament's All Party Drugs Misuse Group in the House of Lords, where I was joined by Christopher Kennedy Lawford, Professor Roger Weiss of Harvard University, and Professor David Rosenbloom of the Center for Addiction and Substance Abuse at Columbia University.

One of the highlights of the meeting for me was an opportunity to meet a British physician, Dr. Mark Atkinson, who asked for ASAM's help in developing a British Society of Addiction Medicine (BSAM). Dr. Atkinson's vision is that BSAM will become the lead medical organization for the advancement of addiction medicine and addiction treatment and care within the U.K. The founding members have agreed that BSAM's mission will be to:

1. Create a fellowship of physicians who are committed to the advancement of addiction medicine and to the care of those with addictions.
2. Establish addiction medicine as a recognized medical specialty within the U.K.
3. Support and contribute to the development of addiction treatment, care and provision in the U.K.
4. Inspire and support addiction-related research.
5. Collaborate with allied organizations in order to establish the U.K. as one of the world's leaders in addiction treatment.
6. Provide physicians with continuing professional development through approved addiction-related training courses and workshops.
7. Provide support and educational materials to medical student organizations and medical schools with an interest in addiction medicine.

In the immediate future, BSAM's objectives are to:

- ★ Achieve a membership of 50 medical doctors and 5 medical students by May 2010.
- ★ Become financially self-supporting by May 2010.
- ★ Launch a minimum of two approved online educational courses for physicians by September 2010.
- ★ Conduct a minimum of two approved live workshops on addiction diagnosis, treatment and care by September 2010.

One of BSAM's key strategies is to build collaborative relationships with ASAM, as well as with the International Society of Addiction Medicine (ISAM), the Addiction Recovery Foundation, and major British medical groups such as the Royal College of Psychiatrists, the Royal College of General Practitioners, and the Royal College of Physicians.

I have put Dr. Atkinson in touch with Eileen McGrath, J.D., ASAM's Executive Vice President and CEO, who is an expert administrator and someone who can help BSAM address many of its organizational issues. We will help Dr. Atkinson and his colleagues connect with others who can help BSAM take its initial steps and provide other types of assistance as requested. Not only is it a pleasure and privilege to assist our colleagues in the U.K., it also strengthens ASAM by helping us continue to be a proactive partner with similar organizations around the globe.

UK/ESAD SPEAKERS *(l-r): **Professor Larry Ashley of the University of Nevada; Professor Roger Weiss of Harvard University; Professor David Rosenbloom of CASA; Patrick Kennedy Lawford, ASAM President Louis E. Baxter, Sr., M.D.; Jaime Delgado of Behavioral Health of the Palm Beaches; Association of Intervention Specialists board member Jane Eigner Mintz; IC&RC President Jeff Wilbee; Addiction Recovery Foundation CEO Deirdre Boyd; HRDI CEO Andrea Barthwell, M.D.; Tammi VerHelst of IITAP; Patrick Carnes; interventionist John Southworth; and Freedom Consultancy director Johan Sorensen.***

THE PROBLEM OF CO-PAYS

Michael M. Miller, M.D., FASAM, FAPA
Dr. Miller is Immediate Past President of ASAM. However, the opinions expressed here are his own and do not necessarily reflect ASAM policy.

Recommendation: Co-pays for outpatient mental health and addiction care visits should be set at a reasonable dollar amount per visit, not a percentage amount per visit.

Rationale: Employers want a healthy and productive workforce where attendance is reliable and workplace errors are low. The number one contributor to diminished productivity and a disability among all health conditions is depression. And one of the most conspicuous contributors to absenteeism and workplace errors is addiction and other substance use disorders. It is therefore important that mental health and addiction problems in the workforce be treated adequately — that patients have access to effective, evidence-based treatment, and that they engage in treatment and stay in treatment until the desired results of treatment are attained. Therefore, financial barriers that keep patients away from treatment or keep them from staying in treatment are counterproductive and not in the best interest of employers. They certainly aren't in the best interest of patients and their families.

Background: Professional fees are generated by physicians and other health care providers when they provide diagnostic and therapeutic services for patients. These fees generate income used to cover all practice expenses, including staff salaries, and the balance comprises the compensation the health care provider receives her/himself.

Physicians generate their salaries in different ways. Fees for "procedures" are generally set relatively high, so that the number of dollars generated per minute or hour is much higher than a general office visit.

The economics of different medical specialties vary. The classic "procedure" is a surgical procedure – a surgeon does some sort of invasive activity that can be life-saving. It's very intensive. The fee for the service is high enough that it sometimes covers an entire episode of care, including the pre-operative evaluation of the patient and all post-op visits. Obstetrical contracts sometimes involve single fees that cover all office visits, so that the intensive procedure (labor and delivery) are essentially non-billed.

For non-surgeons who perform procedures (such as cardiac catheterizations, endoscopies, or even office-based minor surgeries), it's the procedures themselves that generate a significant portion of their incomes. The amount charged for a routine office visit does not need to be very high because there is an alternate source of income that can be used to cover practice expenses and contribute to the physician's final salary. A given encounter may have a small office visit charge entered concurrently with a higher charge for the "procedure" done that day.

For office-based primary care physicians or psychiatrists who do not perform procedures, the only way to generate income is through the office visit itself. Time itself is what is billed. The hourly rate for office visits for psychiatrists is much higher than the hourly rate for non-psychiatric physicians.

If a patient is charged a 20% or 50% co-pay for an office visit and the fee for that visit is $80 or $100, it may be affordable and the patient may conclude that the value is worth the cost. But if the charge for an office visit is $300 or $500, a 20% or 50% co-pay is a much more substantial amount of money, and the patient may conclude that it is too expensive to continue such visits, especially when chronic disease management (more than six visits per year) is required for a psychiatric or addictive disorder.

Thus, we see an unintended consequence of parity reforms at the Federal level. When discriminatory limits on inpatient days, outpatient visits, etc., were eliminated for psychiatric care by the Mental Health Parity and Addiction Equity Act of 2008, a number of insurers simply declared that "all claims will be medical claims" — that is, every office visit is treated the same as a general medical visit. As explained above, if a patient has a percentage co-pay for those visits, general medical visits are far more affordable than psychiatric visits. This is the way the arithmetic works out, although it probably was not a consequence planned by anyone.

Prior to the adoption of parity reforms, many patients with depression, anxiety or other conditions would seek care from their primary care provider, because their insurance coverage for behavioral health conditions was absent or woefully inadequate. It has been estimated that more than 20% of the visits to primary care physicians are for mental health or substance abuse complaints. Some of the strongest advocates for parity reforms were pediatricians, family physicians, internists and ER physicians, who wanted their patients to have access to effective and efficient care. Primary care providers treat the whole spectrum of their patients' concerns and conditions, and they want to have specialists available and accessible when there is a case that exceeds their level of expertise in a given specialty, such as psychiatry or addiction medicine. If patients gravitate to primary care for mental health or addiction care for economic reasons — because they cannot afford the co-pays for psychiatric and specialized addiction care — then primary care providers will be in the same position as if parity reform hadn't happened at all.

Co-pays and other methods of expense-sharing by patients is an important component of our health care system. But a "percentage of fee" structure for co-pays applied to mental health and addiction treatment outpatient visits is detrimental to patients accessing care or coming back for necessary revisits. Hence, my recommendation is that insurance plans structure their co-pays based on a flat dollar amount rather than a percentage of total fees for mental health and specialty addiction services.

AMA MEMBERS DEBATE HEALTH REFORM

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

The American Medical Association was under siege as physicians gathered for the House of Delegates meeting in Houston last November. While protesters gathered outside, distressed at the AMA's support for HR 3962, the Affordable Health Care for America Act, some physicians were submitting letters of resignation, likely an acceleration of what had begun earlier in the year when the AMA pledged support for an earlier version of health care reform legislation. The AMA's House of Delegates therefore began with a 90-minute closed session for discussion of health system reform. The AMA underscored that it had not endorsed HR 3962 but rather had supported it, a difference that may not be recognized outside the Beltway. "Support" indicates a belief that there are still significant issues that need correction, whereas "endorsement" means that we fully agree with a bill.

Only hours after the AMA's closed session, the US Congress passed The Affordable Health Care for America Act, before the AMA House of Delegates had a chance to vote on whether or not to support the bill. The next morning, Sunday, the AMA House agreed to discuss the bill — a process which would inevitably end in the entire House either supporting the AMA Board or asking that the Board rescind the organization's support for HR 3962. On Monday afternoon, the entire House came together to begin deliberations. These talks lasted most of the day. The AMA Board supported several new or amended points:

1. The AMA will work to pass health care reform consistent with AMA policy.
2. The AMA will support insurance in exchange only if it is not subsidized, does not require physician participation, and does not restrict access to non-par physicians.

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

3. The AMA will support the right of physicians to privately contract for medical care with patients.
4. The AMA will oppose creation of an independent Medicare Advisory council.
5. The AMA will actively oppose health system reform if it contains certain specific content such as reduced payments to physicians for failing to report quality data.
6. The AMA will continue to advocate for tort reform.

Opponents of HR 3962 asked if the Board of the AMA might be so insular that it has made multiple decisions that are out of touch with physicians. Is it the Board that is insular in the face of the need for change? Or is it the AMA's House that has become insular? Based upon the debate and resulting resolutions that passed, the impression I have is that the Board has accurately reflected the will of the HOD. Yes, communications could have been better, and yes, we may disagree on the tactical decision to support a particular bill, but the HOD made it clear that the Board's decision to supAMA because they disagree with the House of Delegates — or that it is, and that most physicians aren't members for other reasons (such as cost). Given that members of the House of Delegates are, in fact, elected to their positions by their own state or specialty societies, I would expect to see far more turnover of delegates if those organizations were dissatisfied with the AMA's direction. So the evidence suggests that members of the Federation are, in fact, supportive of the AMA's policy and direction, and that the House of Delegates is not insular.

Like our country, medicine is at a turning point. The days of solo practice and fee-for-service are, perhaps, numbered and our recently graduated physicians are very comfortable with that. Even the scope of practice issues are growing less acute, as I've seen our younger cohorts truly embrace a multidisciplinary practice style wherein they provide medication while other clinicians provide diagnostic and therapeutic treatments. Is this bad for medicine or bad for physicians? Yes, unless we change with the times. And that's what the AMA House of Delegates is doing. If anything, it may be lagging a bit because of the differences in demographics from the mean.

A quick story: back in the early 1900s, my grandfather started a linen supply company with his three brothers. The company grew strong and had many components nationwide. In the late 1960s, hotels began to take their linen laundering services in house; paper companies began to provide paper towels for public restrooms instead of the towels on a roll that we had provided; mechanics were told to clean their uniforms at home. The company suffered. It could have taken a clue from the turbulent times and used its wealth to branch out into paper supply, or into small laundering services, or

"Medicine is a company. The world has changed. And we're in a time of turbulence."

any number of other alternatives. Instead, it continued with the old model, trying to make that model more efficient until ultimately they could no longer compete. By the middle of the 1990s, not only was the family business gone, but most of its competitors were gone as well.

Medicine is a company. The world has changed. And we're in a time of turbulence. We can embrace that turbulence, seek out what physicians' roles are within the new age, or lose our potential entirely. That last outcome is not unrealistic in an age where many patients seem quite content to see a nurse as their primary care provider, and where bills in Congress contain enormous implications for a changing of the guard from physicians to other clinicians. Many of us, myself included, have been trying to maintain the ability of physicians to do what physicians have done for hundreds of years. But we're being told, now not just by outsiders but by our own peers, that it's time to move on. Our job is to reinvent ourselves, to discover our place in the new era and to thrive in that place. There will always be some fee-for-service physicians, just as there are a few small linen services still afloat. But we can't run our "company" with policies based on the past.

MARIJUANA

For many years, there has been a growing interest in the use of marijuana as a medicine. The AMA has long recommended that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of research indicating that marijuana has any significant medical value. Such research has not yet taken place, and the AMA Council on Science & Public Health has taken note that due to the Schedule I status of marijuana, it is unlikely that such research *could* take place. Given that 15 State legislatures have acted without such research by approving some form of marijuana use or prescription despite the absence of supporting research, and given the Federal government's relaxed stance with respect to enforcing laws with respect to marijuana *[see page 13 of this issue],* the House of Delegates acted responsibly in reopening the AMA's position for discussion. The AMA therefore urged that marijuana's status as a Schedule I substance be reviewed, "with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines." The AMA specifically noted that is was not endorsing State-based medical cannabis programs and that scientific evidence on therapeutic use of cannabis does not meet the current standard for a prescription drug product. The AMA also formed related policy affirming that free and unfettered exchange of information on this topic between patients and physicians should not be subject to criminal sanctions.

FUTURE AMA MEETINGS

For many years, the AMA House of Delegates has met twice a year. There is a group within the AMA that has been trying to reduce this frequency to once a year. Given the importance of the meeting just held, this was not the time for such a change. The motion failed and the entire matter was referred back for further study. The AMA's next meetings will be held in Chicago in June 2010 and in San Diego in November 2010.

Many thanks to Doctors Michael Miller, Don Kurth, Brian Hurley, and other ASAM members who were in the November House of Delegates meeting to represent other organizations, for all their efforts on behalf of ASAM.

Survey Measures Physician Support for Health Reform

Nearly two-thirds of physicians nationwide support efforts to expand health care coverage, according to a survey by the Robert Wood Johnson Foundation that was summarized in the September 14, 2009, issue of the *New England Journal of Medicine*. The survey shows that 62.9 percent of physicians nationwide favor proposals to expand health care coverage that include both public and private insurance options — where persons under the age of 65 would have the choice of enrolling in a new public health insurance plan (such as Medicare) or in a private plan. Just 27.3 percent of physicians support a program that does not include a public option and instead provides subsidies for low-income persons to purchase private insurance. Only 9.6 percent support a system where a Medicare-like public program is created in lieu of any private insurance. A majority of physicians (58 percent) also support expanding Medicare eligibility to those between the ages of 55 and 64.

In every region of the country, a majority of physicians supported a combination of public and private options, as did physicians who identified themselves as primary care providers, surgeons, or other medical subspecialists. Among those who identified themselves as members of the American Medical Association, 62.2 percent favored both the public and private options.

The survey was conducted between June 25 and September 3, 2009, by Salomeh Keyhani, M.D., M.P.H., and Alex Federman, M.D., M.P.H., of the Mount Sinai School of Medicine in New York City. While the survey was conducted in several "waves" over a tumultuous summer for the health reform debate, no statistically significant differences were identified in physician responses throughout the summer. The full report of survey results can be accessed at HTTP://WWW.RWJF.ORG/HEALTHREFORM/QUALITY/PRODUCT.JSP?ID=48408.

Nearly two-thirds of physicians nationwide support efforts to expand health care coverage.

N&A Council Opens Petition Process for Election of At-Large Board Members

Michael M. Miller, M.D., DFAPA, FASAM, Chair of ASAM's Nominations & Awards Council, recently released the following guidelines for the upcoming election of At-Large members of the Society's Board of Directors.

Dr. Michael M. Miller

REQUIREMENTS FOR CANDIDACY

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

PETITION PROCESS

Petitioners must provide the required information to the Nominating & Awards Council no less than 45 days before the 2010 Med-Sci Conference. A list of petitioning candidates will be provided to all registering ASAM members near the registration desk so that ASAM members can decide whether or not to sign any candidate's petition. To satisfy the requirements for placement on the ballot and to participate in the ASAM approved campaign process, a petitioning candidate will be required to obtain 100 signatures of ASAM members in good standing by 12:00 noon on the day of the ASAM Meet the Candidates Forum during the Med-Sci Conference.

OTHER ELECTION POLICIES

- Before their names are submitted to the Board for approval, candidates must complete and sign a conflict-of-interest form entitled "ASAM Disclosure of Interests and Affiliations."
- ASAM campaign guidelines prohibit written or electronic communication campaigning, restricted or unrestricted, either by the candidates or on their behalf.
- Once balloting is completed, all votes tabulated, and all candidates notified by telephone and letter, the vote results will be made available to the membership in **ASAM News** and any other forum ASAM deems appropriate. Candidates will be notified of this procedure before they stand for office.

2009-2011 N&A COUNCIL

The following individuals are members of the ASAM Nominations & Awards Council.

Michael M. Miller, M.D., FASAM, FAPA *(Council Chair)*
Louis E. Baxter, Sr., M.D., FASAM *(ASAM President)*
Donald J. Kurth, M.D., M.B.A., FASAM *(Ex officio)*
Eileen McGrath, J.D. *(Ex officio)*

(Elected by the Board of Directors)
Margaret A.E. Jarvis, M.D., FASAM
Richard G. Soper, M.D., J.D., M.S., FASAM

(Elected by the Chapter Presidents)
Terry L. Alley, M.D., FASAM
Berton J. Toews, M.D., FASAM

(Elected by Council/Committee Chairs)
Paul H. Earley, M.D., FASAM
Petros Levounis, M.D., M.A.

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The prestigious FASAM designation is granted only every second year to select ASAM physician members in recognition of their significant contributions to the Society and the field of addiction medicine. Eligible members are urged to apply for Fellow status no later than February 15, 2010. This is your opportunity to apply to join the distinguished ranks of some of your colleagues by receiving recognition for your considerable professional efforts.

The American Society of Addiction Medicine and the ASAM Board of Directors recognizes these elite professionals for special recognition as Distinguished Fellows due to their significant contributions to the the field of Addiction Medicine and their work as outstanding, prominent, and distinguished professionals in the Medical Community. These professionals have been "uniquely" singled out for special distinction out of an estimated 1.5 Million physicians.

ASAM Fellows are chosen on the basis of an outstanding, sustained demonstration of competence in the field of Addiction Medicine, exceptional professionalism, consummate integrity, demonstrated service, significant contributions, and noted leadership. Fellows are strong advocates of the field of Addiction Medicine and promote sustained service, contributions and leadership in the field.

Fellows employ the FASAM designation after their names as a Mark of Distinction and to provide a description of their unique position. The designation represents the awardee as a Distinguished Fellow of the American Society of Addiction Medicine." So they write in their signature block: "Fellow member name", FASAM.

To qualify to become a Fellow of ASAM, candidates must meet rigorous criteria such as being a member for at least five consecutive years, giving significant service to the Society, and making considerable contributions in certain areas.

The following documents are available on the ASAM website (WWW.ASAM.ORG):

- ★ 2010 Fellow application
- ★ Criteria for election as a Fellow
- ★ Current list of ASAM Fellows
- ★ Schedule of events
- ★ Frequently asked questions

Members of the Fellow Committee (all of whom are current ASAM Fellow members) will review all submissions in March 2010, and candidates will be notified of the outcome by March 15. 2010. ASAM will present Fellow certificates during the Awards Luncheon during the 2010 Med-Sci Conference in San Francisco.

Addressing Substance Use Disorders in the Patient-Centered Medical Home

Norman Wetterau, M.D., FAAFP, FASAM
ASAM Liaison to the American Academy of Family Practice

The "patient-centered medical home" is a new buzzword. A full description of this can be found at WWW.TRANSFORMMED.ORG or at WWW.PCPCC.NET. Briefly, the "medical home" is a method of delivering primary care that emphasizes prevention, early intervention and the treatment of chronic disease through ongoing rather than episodic care. ASAM has a strong policy statement supporting the patient-centered medical home.

On our website, go to Advocacy on the top bar, scroll down on advocacy to policy. Once there type in medical home on the search line and the policy will come up.

A key part is recommendation 2: Addiction is often a chronic disease and should be cared for as any other chronic disease. Prevention of substance use disorders should also be part of prevention services offered in the medical home.

Norman Wetterau, M.D., FAAFP, FASAM

ASAM Recommendation on the Medical Home

ASAM recommends that in such a context, screening, brief interventions and referrals to specialty care in Addiction Medicine can take place for substance use problems and addiction. The primary care provider (acting alone or with the assistance of consulting physicians and other professionals with specialty training in addiction medicine) should apply evidence-based approaches to assist the patient.

ASAM has a liaison, Dr. Norman Wetterau, to the Primary Care Patient-centered Collaborative (PCPCC). He participates in the behavioral health group and has worked to make sure addiction is addressed. The group's goal is to make sure behavioral health, which includes mental health, and substance abuse is integrated into the patient-centered home. The group has input into NCQA, other medical groups, transfer med and businesses through the PCPCC. The group has the ear of the business community and it is not unusually to receive an e-mail from Paul Grundy of IBM after one of these calls. This group formed a subgroup to make recommendations to NCQA, which Dr. Wetterau agreed to lead.

The hope is that NCQA will change its recommendations for certifying patient-centered home to include some behavioral health. An example of a suggested change would be for the requirement that three chronic diseases are selected, that alcoholism, or depression might be considered.

Under the pharmacy section, we have suggested that alcohol usage and illegal drug usage might be important information to be in the record.

In the introduction, I was able to place part of the ASAM policy statement only we added mental health. It reads as follows: "At the core of the clinical approach of the patient-centered medical home is team based care that provides care management and supports individuals in their self-management goals." Care management is central to the shift in orientation embodied in the medical home, away from a focus on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions.

Substance use and mental health disorders are often chronic diseases and should be cared for as any other chronic disease. In addition many chronic medical diseases have underlying behavioral health issues that need to be addressed. Screening for tobacco, unhealthy alcohol use and depression should be done as recommended by the U.S. Preventive Services Task Force. Prevention, early diagnosis and intervention for substance use and mental health disorders should be part of the services offered in the medical home.

Evidence-Based Practices Needed

Evidence based methods should be employed. This might not seem like much but we were able to move part of our policy statement into a PCPCC document that will be seen by other groups and by NCQA. We also need to circulate our statement, which says much more. Right now health care reform is uncertain, but if it occurs, it is critical that addiction medicine is part of both primary care and specialty care.

ASAM is interested in any patient-centered home that is trying to incorporate addressing substance use disorders in a medical home model.

"Prevention, early diagnosis and intervention for substance use and mental health disorders should be part of the services offered in the medical home."

Cocaine Vaccine Is Safe, But Has Limited Efficacy

No pharmacotherapy exists for cocaine dependence. Preclinical and open-label studies suggest that vaccination to produce anticocaine antibodies attenuates cocaine's reinforcing effects. This randomized, double- blind, placebo-controlled clinical trial evaluated the safety and efficacy of a cocaine vaccine among 115 volunteers recruited from a US urban methadone maintenance program. Over the 12-week intervention period, 109 of 115 subjects received 5 injections of vaccine or placebo. Follow-up was at 24 weeks.

The most common adverse effects were injection site induration and tenderness. There were no treatment-related serious adverse events, study withdrawals, or deaths. The frequency of cocaine-free urine samples during weeks 1–4 and weeks 5–24 did not differ between treatment conditions in intent-to-treat analyses.

The 38% of vaccinated subjects who attained a high serum IgG (antibody) level (≥43 _g/mL) had more cocainefree urine samples (45%) than those with a low IgG level or those who received placebo (35%). The proportion of subjects who had a 50% reduction in cocaine use was greater in subjects with a high IgG level (53%) than in those with a low IgG level (23%) during weeks 8–20, but there was no difference in complete abstinence.

Comment: Peter D. Friedmann, M.D., M.P.H., of the Boston Medical Center, who reviewed the study for *Alcohol, Drugs and Health: Current Evidence*, concluded: "The vaccine in this study appears to have reduced but not eliminated cocaine use for two months in the minority of cocaine-dependent persons who had a high antibody response. Before this approach can be considered for routine clinical use, better vaccines that generate a sustained blocking antibody level in a larger percentage of individuals and with a less intensive vaccination schedule are needed."

Reference: Martell BA, Orson FM, Poling J, et al. Cocaine vaccine for the treatment of cocaine dependence in methadone-maintained patients: A randomized, double-blind, placebo-controlled efficacy trial. *Arch Gen Psychiatry.* 2009;66(10): 1116–1123.

In OBOT, Abstinence Rates Differ by Retention and Insurance Status

As the use of buprenorphine for office-based opioid treatment (OBOT) has grown, an increasing number of reports describe practices and outcomes in real-world settings. This report describes a highly structured office-based program that included a 1–2 day inpatient induction, 5 weeks of 3-hour counseling sessions 4 times per week, then weekly counseling sessions for an additional 12 weeks. Participants attended subsequent monthly follow-up visits and were required to attend thrice weekly 12-step meetings. Full adherence was required to remain in the program. Among the 110 of 176 (63%) consecutively admitted patients available for follow-up at a minimum of 18 months, data show that:

- 85 patients (77%) reported continuous buprenorphine treatment.
- Patients who remained in treatment were more likely to report abstinence (p=0.01) and to be employed (p=0.03) than non-retained patients.
- Patients with insurance who remained in treatment were more likely to report abstinence than those without insurance (97% versus 86%, respectively) (p=0.04).

Comment: In reviewing the study for *Alcohol, Drugs and Health: Current Evidence*, Hillary Kunins, M.D., M.P.H., M.S., said: "The high retention rate in this structured office-based buprenorphine treatment program may reflect the selection of a highly motivated patient population. One might conservatively estimate that patients not available for follow-up had dropped out of treatment, resulting in a retention rate of 48% (similar to previous reports). The association between insurance status and abstinence is unsurprising given that treatment costs surely prevent full realization of efficacy. It further suggests that coverage for ongoing treatment of substance use disorders might improve long-term outcomes."

Reference: Parran TV, Adelman CA, Merkin B, et al. Long-term outcomes of office-based buprenorphine/ naloxone maintenance therapy. *Drug Alcohol Depend.* 2009;106(1):56–60.

Does Methadone Deplete Bone Density?

Patients receiving or considering methadone maintenance treatment (MMT) for opioid addiction often express concern that methadone causes bone disease and dental decay. Although this has long been considered a misconception, low bone density has been noted in some MMT patients. This cross-sectional study sought to determine the prevalence and risk factors associated with vitamin-D deficiency in patients receiving MMT. Deficiency was defined as a 25 hydroxyvitamin D level less than 20 ng/mL, while insufficiency was defined as a level between 20-30 ng/mL.

Of the 93 patients enrolled in the study, 36% had evidence of vitamin-D deficiency and an additional 16% had evidence of insufficiency. Vitamin-D deficiency was associated with age over 40 (odds ratio [OR], 3.47) and black or Hispanic race/ethnicity (OR, 3.34). Longer enrollment in MMT was not associated with vitamin-D deficiency.

Comment: In reviewing the study for *Alcohol, Drugs and Health: Current Evidence*, Jeanette M. Tetrault, M.D., said: "Although causation cannot be inferred and a model adjusting for all independent variables could not be constructed due to limited outcome cases, this small cross-sectional study did demonstrate a high prevalence of vitamin D deficiency among patients receiving MMT. These findings are important since vitamin D deficiency can lead to musculoskeletal pain, osteoporosis, and periodontal disease, all of which are common among MMT patients. Further investigation is needed to better understand the association between MMT, other risk factors (e.g., smoking), and vitamin D deficiency."

Reference: Kim TW, Alford DP, Holick MF, et al. Low vitamin D status of patients in methadone maintenance treatment. *J Addiction Med.* 2009;3(3):134–138.

AA and Spirituality in Addiction Recovery

Marc Galanter, M.D.

Dr. Galanter, who is Director of the Division of Alcoholism and Drug Abuse at New York University and a Past President of ASAM, was presented the R. Brinkley Smithers Distinguished Scientist Award at ASAM's 2009 Med-Sci Conference. Following are excerpts from his award lecture.

Alcoholics Anonymous (AA) defines itself as a fellowship that promotes recovery through spirituality and mutual support. With over two million members worldwide, it is an invaluable resource to the medical profession. In the AA context, we can understand spirituality as those deeply felt beliefs that give a person meaning in life; they may be religious in nature, but they can also be based on a commitment to higher ideals or the welfare of others.

"In the AA context, we can understand spirituality as those deeply felt beliefs that give a person meaning in life…but they can also be based on a commitment to higher ideals or the welfare of others."

Although spirituality is an issue of great importance to many of our patients, it has been paid relatively little attention in the medical literature. This is because our contemporary approach to medical illness is derived from the positivist orientation of the physical sciences, which is based on readily observed phenomena, not on subjective experiences. We typically categorize and treat "illnesses" in terms of manifest symptoms, rather than by asking patients what is most important in their lives. But there is now an emerging recognition for the role of this latter approach to spirituality in the clinical setting. In fact, attention to it is now even required by the Joint Commission on Accreditation of Healthcare Organizations as part of the assessment of addicted patients.

Spirituality does not stand apart from people's biology, and its underpinnings in our somatic selves are suggested by some recent studies. One suggests an association between serotonergic activity and an inclination toward spirituality. Subjects who completed a personality inventory were examined with positron emission tomography to determine the density of 5-HT1A receptors in various brain sites. Among seven temperament and character inventory dimensions, the only one significantly associated with the measured binding potential of these receptors was a subscale of spiritual acceptance[1] In another study,[2] genes that encode for both AP2_ and the serotonin transporter were localized. Both were found to have significant interactions with measures of the character traits of self-transcendence and spiritual acceptance.

Marc Galanter, M.D.

For AA members, spirituality can play a role in promoting remission in addiction. For example, alcoholics treated at one of the study sites in the federal Project MATCH study were evaluated three years after their initial treatment. Their scores on measures of spirituality within AA at that point were predictive of a positive outcome at ten years.[3]

In another study, alcoholics who entered treatment in a number of community-based programs were evaluated. Among patients who then attended AA, those who reported having a spiritual awakening were three times more likely to be abstinent three years later than those who did not have such an awakening.[4]

A number of large field studies have shown that patients who participate in AA typically benefit from their involvement. A large sample of people entering outpatient alcoholism treatment for the first time was evaluated at intervals up through 16 years. Longer participation in AA was found to make a positive contribution to both alcohol and social function outcomes independent of the quantity of treatment these patients received.[5] Attendance at AA meetings also appears to be instrumental in achieving a positive effect independent of a patient's prior motivation for recovery. In one large-scale study,[6] AA attendance within the first year after admission was found to predict lower alcohol-related problems at the two-year follow-up. This effect was independent of previously measured motivation for change, suggesting that AA itself plays a causative role in reducing drinking.

"…it is wise to discuss the nature of Twelve Step programs with all your addicted patients, and to encourage them to attend some local meetings."

Another reason AA membership can be of value to our patients is that professionally conducted, long-term follow-up for addictive disorders is typically not available, and is also limited by insurers. Learning about Twelve-Step Facilitation (TSF) is one approach for helping patients to become engaged in the initial three of AA's Twelve Steps. TSF is a way for addiction physicians to improve their ability to refer patients to the fellowship. In any case, it is wise to discuss the nature of Twelve Step programs with all your addicted patients, and to encourage them to attend some local meetings.

References: [1] Borg J et al., *Am J Psychiat*, 2003. [2] Nilsson KW et al., *Neurosci Letters*, 2007. [3] Moos RH, Moos BS, *J Clin Psychol*, 2006. [4] McKellar J et al., *J Consult Clin Psychol*, 2003. [5] Tonigan JS, *ACER*, 2003. [6] Kaskutas LA et al., *Alco Treat Quart*, 2003.

Dr. McLellan Outlines Administration's Addiction Policies, Priorities

A. Thomas McLellan, Ph.D.
Deputy Director, White House Office of National Drug Control Policy

In a special address to ASAM's State of the Art Course in late October 2009, Dr. McLellan outlined the Obama administration's policies and priorities related to prevention and treatment. Excerpts from his remarks follow.

A. Thomas McLellan, Ph.D.

You've all heard of the "Drug Czar," but you might not know what the Office of National Drug Control Policy does. It does three things: First, it drafts the strategy that the President will commit to for keeping drugs from our borders; reducing their availability internally; preventing and treating addiction; and helping with recovery. That's very important.

The teeth in these efforts comes from the second thing we do: ONDCP is the only agency other than the Office of Management and Budget to certify other agencies' budgets. There are 35 such agencies, so that's an important part of our role.

Third, once the budget's drafted and the strategy's announced, we work with those 35 agencies to see to it that the strategy is carried out in the manner intended….

Why do we need such a thing as a national drug control strategy? What are the problems that a strategy should try to address? There are several explanations. Look at Figure 1, which is an illustration of substance use problems in the United States, taken from a 1980 report of the Institute of Medicine.

You can see, at the bottom of the pyramid, that most adults do not use substances at all or, if they do, they use very little. If you move up the pyramid a bit, you see… what Dr. Richard Saitz has called "harmful use." Harmful to what? Harmful to relationships. Harmful to co-occurring medical problems. Harmful to performance at work. But such use does not mean alcoholism or drug addiction. How many persons fall into this category? We don't know, but the estimates are many tens of millions.

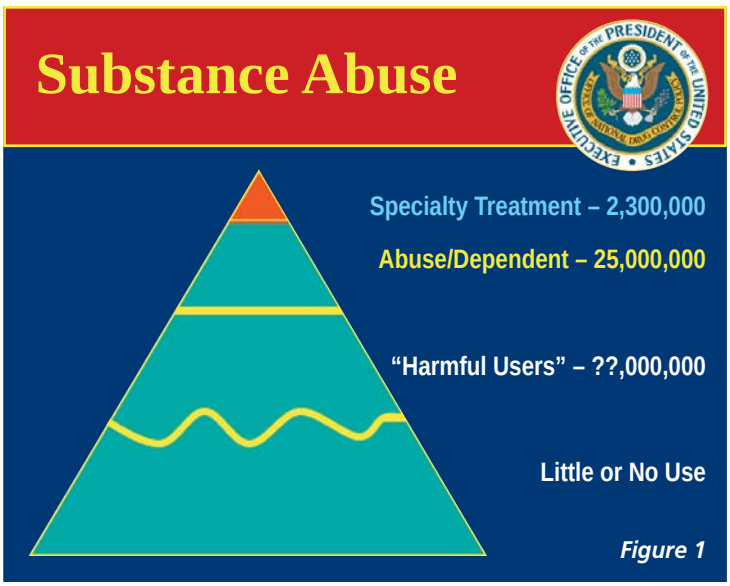


Figure 1

If you continue to move up the pyramid, you see a bright yellow line and that's where you meet diagnostic criteria for abuse or dependence. We know there are in the neighborhood of 23 to 25 million people in this category — about the same as the number of diabetics.

The orange pinnacle represents the people actually in treatment. This is about one-tenth of those who qualify and a much smaller proportion of those who might receive real benefit from some kind of appropriate care. Many of you are experts in this area because you, like me, have seen thousands of people who fit in the orange pinnacle of the triangle. But we're ***not*** experts in harmful use….

LINKAGE WITH PRIMARY CARE NEEDED

As I've said many times, this is a field that's always had specialty care, but has rarely has had any meaningful involvement of primary care. Yet most chronic illnesses are picked up first in the primary care office…. At ONDCP, we think primary care doctors could have a meaningful relationship with substance use disorders. We think primary care physicians can screen, intervene, and monitor patients….

When that's not enough, they can refer the patient for specialty care, which should do many of the same things specialists do in any other area of medicine: stabilize, motivate, medicate, train the patient in self-management techniques, help the family understand self-management techniques. And then refer the patient to recovery support services.

Now this is a brand new area. Recovery's not new, but the emphasis on recovery support services in the community is new. We want to make a lot of it. So the reason I'm telling you this is to set the stage for a strategy I'm going to talk about now.

Figure 2 shows the priority areas in the President's drug control strategy, which will be released in February 2010. Those 35 agencies I mentioned earlier have come to closure on these priorities and are working on a budget….

We are requesting two billion new dollars for substance abuse services, based on the fact that we think we can make a really significant difference. (Keep in mind that I'm talking about the 2011 budget. The new administration's budget actually starts October 2010.)

Figure 2

A NATIONAL PREVENTION SYSTEM

At ONDCP, we think it's time to do something powerful in the field of prevention by establishing a national prevention system to engage and entice primary care. It's time to get mainstream health care to include substance abuse prevention. They're not going to be doing us a favor; we're going to be doing them a favor, by including realization and awareness and understanding of what to do about substance use problems. We will improve medical care while reducing health care expenses. These are not my opinions. These are things that have been shown over and over in studies.

At the same time, we want to improve access to high-quality specialized care for those who meet the criteria for addiction. We want to double the number of people in treatment, but treat them in a qualitatively different way. And we want a special effort for drug-involved offenders. And finally, for once, performance measures. I think the time has come when we can actually do it.

ENGAGE PRIMARY CARE

What about primary care? One of the problems with our past efforts to engage primary care is in the way it's been sold. We've been wagging our fingers at primary care doctors and saying, "See here, you know we are a *bona fide* illness too. We're a chronic illness, and you should be screening for and treating substance abuse." It doesn't work, because primary care doctors are harried enough already.

We think there are far better ways to sell this. Number 1, increase the money that's available for screening, brief intervention, and referral to treatment. SBIRT doesn't have to be done by a physician — it can be done by a nurse or an allied health professional. Moreover, it's not just the dollar amount, it's the billing, which will be a lot more streamlined so it won't be so intimidating to do.

There's another, more clinical reason to do this in primary care. You're not just screening to find a case of addiction. You're screening to find individuals whose unhealthy substance use may be affecting other things they're being treated for.

CLOSE THE TREATMENT GAP

Now for treatment. We have to expand care. It's not good enough to have only one-tenth of the people affected by this public health problem being treated. So we're calling for and putting a lot of new money into treatment. We're putting new money into Federal health care systems from CMS and the Indian Health Service. Why? Because they have doctors. They have electronic health systems. They've got formularies. They've got populations that are desperately in need. There are about 8,000 Federally qualified health centers. Through them, we can reach an additional 20 million people. But the staff are going to need training.

They're going to need ASAM to help train their existing physicians, and they're going to need new physicians, nurses, and counselors. It's a big job, but we think it's far smarter to bring addiction to the mainstream health care system than to perpetuate what we have today, which is a fundamentally segregated system.

SPECIAL CARE FOR OFFENDERS

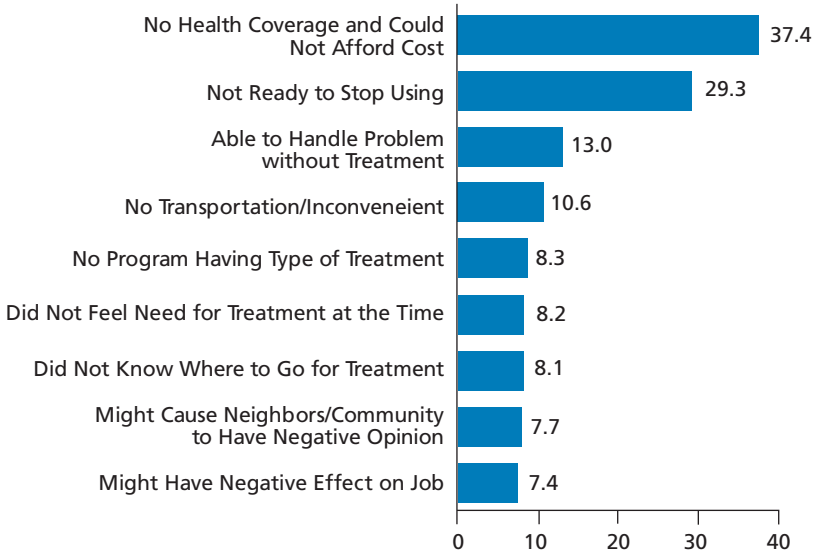
The last thing I will talk about is a special program for corrections. This comes directly from Vice President Biden's efforts: the Second Chance Act. There are seven million offenders out there. Five million in the community, and — conservatively — half of them have substance abuse problems. We think there's a lot of money to be saved. But you can't save it all: you're going to have to develop sensible partnerships between the treatment and correctional systems, to keep communities safe and to keep people in recovery.

So again, this is the 2011 plan and budget, which will start in October 2010. This is the Demand Reduction portfolio. It comes from 35 agencies and a lot of hard work by the staff at ONDCP. I'm excited about it: I think it's got a real shot at making a big difference in a problem that has not received the attention it deserves.

Lack of Health Coverage, Lack of Readiness to Stop Use Are Main Reasons for Not Receiving Treatment

An estimated 17.4 million persons who needed alcohol treatment in the past year and 6.4 million who needed treatment for drug use did not receive it, according to new Federal data. The 2008 National Survey on Drug Use and Health, conducted by the Substance Abuse and Mental Services Administration, found that the most commonly reported reasons for not receiving treatment among those who were classified as in need of treatment, and who agreed with that diagnosis, were (1) not having health coverage and consequently not being able to afford the cost of care,* and (2) not being ready to stop using alcohol or drugs. Other reasons given were not knowing where to go for treatment, a belief that receiving treatment might have a negative effect on employment or social relationships, or that they could "handle the problem" without treatment (see figure below).

Reasons for Not Receiving Substance Use Treatment Among Persons Aged 12 or Older Who Needed and Made an Effort to Get Treatment But Did Not Receive Treatment and Felt They Needed Treatment: 2005-2008 Combined.



Survey respondents were classified as *needing treatment* if in the past year they met the diagnostic criteria for abuse or dependence on the substance or received treatment for the substance at a specialty facility. A *specialty facility* was defined as an inpatient or outpatient rehabilitation facility, an inpatient hospital, or a mental health center. Responses to the categories are not mutually exclusive because respondents were able to choose multiple reasons.

**Another health coverage-related reason cited was "had health coverage but did not cover treatment or did not cover cost" (4.9% alcohol; 6.7% illicit drug).*

Reference: Adapted by CESAR from Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2008 National Household Survey on Drug Use and Health: National Findings, 2009*. Additional information is available online at HTTP://WWW.OAS.SAMHSA.GOV/NSDUHLATEST.HTM.

Higher Levels of Substance Abuse Among Older Adults Will Increase Demand for Treatment in Next Decade

According to a new report from the Substance Abuse and Mental Health Services Administration (SAMHSA), the need for substance abuse treatment among Americans older than age 50 is likely to double by 2020. A report issued by SAMHSA's Office of Applied Studies says the aging of the "baby boomer" generation is resulting in a dramatic increase in illicit drug use — and consequently treatment demand — among adults ages 50 and older.

The report, *Illicit Drug Use Among Older Adults*, examines the prevalence of any illicit drug use, marijuana use, or non-medical use of prescription drugs. It is based on data collected during 2006 to 2008 from a nationally representative sample of 19, 921 adults ages 50 or older who participated in SAMHSA's National Survey on Drug Use and Health

Based on these data, SAMHSA epidemiologists project that an estimated 4.3 million persons ages 50 or older (4.7 percent of the population) used an illicit drug in the past year. Experts also estimate that 8.5 percent of men aged 50 to 54 used marijuana in the past year, as opposed to only 3.9 percent of women in the same age group.

The SAMHSA report also says that marijuana use is more common than non-medical use of prescription drugs among males 50 and older (4.2 vs. 2.3 percent), while the rates of marijuana use and nonmedical use of prescription drugs were similar among females (1.7 versus 1.9 percent).

The new data have "profound implications for the health and well-being of older adults who continue to abuse substances," said SAMHSA Administrator Pamela S. Hyde, J.D. "These findings highlight the need for prevention programs for all ages as well as to establish improved screening and appropriate referral to treatment as part of routine health care services." Administrator Hyde pointed out that substance abuse at any age is associated with numerous health and social problems, but age-related physiological and social changes make older adults more vulnerable to the harmful effects of alcohol and drug use.

The full report can be accessed online at HTTP://WWW.OAS.SAMHSA.GOV/2K9/168/168OLDERADULTS.CFM. Print copies may also be obtained free of charge at HTTP://NCADISTORE.SAMHSA.GOV/CATALOG/PRODUCTDETAILS.ASPX?PRODUCTID=18246.

Methadone in the Medical Record: Implications for Patient Safety

Most patients who receive methadone maintenance treatment also require care for comorbid medical conditions, which typically occurs in separate health care venues with strict confidentiality rules about disclosure of medical information.

Since clinically important interactions can occur between methadone and some other medications, all treating physicians should know when a patient is receiving methadone. Researchers in this study identified all patients (N=84) in an opioid treatment program (OTP) who had given consent for the release of their medical information to an affiliated but separate medical center. The most recent primary care note or hospital discharge summary of each patient was reviewed for mention of opioid use, abuse, or dependence, participation in the OTP, and potential interactions between methadone and other drugs. The results showed that:

- Medical records lacked documentation of opioid dependence in 30% of patients.
- Medical records lacked documentation of methadone maintenance treatment in 11% of patients.
- Sixty-nine percent of patients were prescribed at least 1 medication with the potential to interact with methadone, while 19% were on 3 or more such medications.

Comment: Marc N. Gourevitch, M.D., M.P.H., of New York University, who reviewed the study for *Alcohol, Drugs and Health: Current Evidence*, concluded that the transfer of medical information between the OTP and the medical center in this study likely was a "best-case scenario due to the close relationship between the two treatment venues and having signed releases in place. Prescription of medications with the potential to interact with methadone is common; however, many medications can be safely prescribed to MMT patients as long as the clinician and patient are aware of and monitoring the potential for interaction. Clinicians can optimize exchange of clinical data between treatment sites by routinely obtaining signed consent from patients for communication between providers, by co-locating MMT with other medical care, and by promoting integrated delivery systems that allow provider access to a single eletronic health record."

Reference: Walley AY, Farrar D, Cheng DM, et al. Are opioid dependence and methadone maintenance treatment (MMT) documented in the medical record? A patient safety issue. *J Gen Intern Med.* 2009;24(9):1007–1011.

Inverse Association between Alcohol Consumption and Mortality May Differ by Ethnicity

Moderate alcohol consumption is associated with a reduced risk of total mortality among Caucasian women, but whether it has the same protective effect for African-American women or all women with hypertension is unclear. This prospective study assessed the relationship between alcohol intake and mortality among 10,576 black and 105,610 white postmenopausal women participating in the Women's Health Initiative. Women with a history of cancer or cardiovascular disease at baseline were excluded. Mean follow-up was 8 years.

A total of 5608 women died over the follow-up period. After adjusting for potential confounders, moderate drinking (1 to <7 drinks per week) was associated with a lower risk of mortality among Caucasian women (hazard ratio [HR], 0.81) and all hypertensive women (HR, 0.76) compared with lifetime abstainers, but it had no significant protective effect for African-American women (HR, 0.94).

Overall, in comparison with lifetime abstainers, current drinking of any amount from <1 drink per month to <14 drinks per week was associated with a lower risk of mortality among Caucasian women whether or not they had hypertension and among hypertensive African-American women (HR, 0.74), but it had no protective effect for nonhypertensive African-American women (HR, 1.31).

Comment: In reviewing the study for *Alcohol, Drugs and Health: Current Evidence*, R. Curtis Ellison, M.D., said: "There have been conflicting data as to whether the inverse association between moderate drinking, cardiovascular disease, and mortality seen among Caucasians also occurs among African Americans. As stated by the authors, the results among African-American women in this study may have been affected by the low prevalence of moderate drinking and the low mortality rate among lifetime abstainers without hypertension. Thus, the question of whether African Americans respond differently to alcohol than Caucasians in terms of mortality, and whether such differences, if they exist, relate to drinking pattern or biologic factors, remains unclear."

Reference: Freiberg MS, Chang YF, Kraemer KL, et al. Alcohol consumption, hypertension, and total mortality among women. *Am J Hypertens.* 2009;22(11):1212–1218.

Single-Question Screen Detects Unhealthy Alcohol Use in Primary Care Patients

A 2005 Guideline from the National Institute on Alcohol Abuse and Alcoholism recommended a single-question screen for problem drinking: "How many times in the past year have you had X or more drinks in a day?", where X was 4 drinks for women and 5 drinks for men.

In a recently published cross-sectional study, researchers validated this single-question screen among 286 patients recruited from an urban primary care setting. The sensitivity and specificity of the question was compared with a calendar-based assessment designed to assess risky consumption levels and a structured questionnaire designed to establish DSM-IV criteria for an alcohol use disorder (the AUDIT consumption test). The research team found that:

- The single-question screen was 84% sensitive and 78% specific for risky consumption and 88% sensitive and 67% specific for a current alcohol use disorder.
- The single-question screen was 82% sensitive and 79% specific for any unhealthy use (risky consumption or an alcohol use disorder).
- The single-question screen performed comparably to the 3-item AUDIT-C.*

Test characteristics did not vary by gender, ethnicity, or education.

Comment: Peter D. Friedmann, M.D., M.P.H., of the Boston Medical Center, who reviewed the study for *Alcohol, Drugs and Health: Current Evidence*, concluded: The brevity and performance of this single-question screen recommends its use to detect both risky drinking and alcohol use disorders in the busy primary care setting. The phrasing of the item should facilitate more discussion of heavy episodic (binge) drinking, a major source of adverse consequences among nondependent drinkers. The vast majority of people who drink heavily at times are not dependent, and any success in decreasing their drinking will greatly reduce societal and personal harms from alcohol use.

Reference: Smith PC, Schmidt SM, Allensworth-Davies D, et al. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009;24(7):783–788.

HHS Secretary Sebelius Addresses Parity for Addiction and Mental Health Care

At a December 16, 2009, event in Towson, Maryland, Secretary of Health and Human Services Kathleen Sebelius spoke about the importance of parity for addiction and mental health services, and how such parity might be achieved under health reform. Excerpts from her remarks follow.

HHS Secretary Kathleen Sebelius

Mental illness and substance abuse are far more common than most Americans realize. About one in five Americans will have a mental illness this year. Almost half of Americans will have a mental illness in their lifetime. And we know that many of these people do not get the care they need. More than ten million adults said they didn't get the mental health care they needed last year. About twenty million said they didn't get the substance abuse care they needed.

If ten or twenty million Americans were walking around with open wounds, we'd call it a national crisis. But because mental illnesses and addictions can be harder to see, we don't feel the same urgency. And yet, the costs of mental illness are right there in front of us. Thirty-two thousand Americans commit suicide each year. People with mental illness make up half of the 700,000 homeless people in America. People with substance abuse disorders account make up four out of five prisoners. The National Academies estimate that mental illness in Americans under 25 alone costs our country almost $250 billion a year.

Given the high price we pay for these gaps in care, the Mental Health and Addiction Equity Act, which Congress passed last year and which will soon go into effect, is a huge step forward. Congress should be commended for passing the bill, especially the late Senator Paul Wellstone and Senator Domenici who fought for it for years. And I also want to commend all of you in the advocacy community for helping to educate members of Congress about this important issue.

> ***"Parity establishes the principle that as a society, we have just as much of an obligation and interest in treating diseases of the brain as we do diseases that affect the rest of the body."***

Thanks to parity, millions of Americans with mental illness and substance abuse disorders will get the care they need. It's going to help people afford their medicines. It's going to make them less likely to put off important care. And it's also an important symbolic step. For years, we thought about mental illnesses and addictions in terms of its costs for the rest of us who weren't sick. Then we slowly began to acknowledge, "okay, maybe we can help some of these people."

And it's only been recently that we've contemplated the possibility of full recovery.

Parity establishes the principle that as a society, we have just as much of an obligation and interest in treating diseases of the brain as we do diseases that affect the rest of the body. That said, we need to understand what we mean when we say parity. What we're really talking about is "parity in reimbursement by private health insurance plans that cover mental health and substance abuse services." That's significant, but it's just a starting point. A broader definition of parity would encompass investments in prevention, investments in health care delivery reform, investments in support services like housing that can affect behavioral health outcomes, and investments in treatment and service system research. And it's this fuller version of parity that we should be striving for.

One idea we've talked a lot about is integrated care. The idea here is that providers deliver higher quality care when they work as a team. So say you have diabetes. Instead of being told, "You need to exercise more and eat better. Come back and see me in six months," you have a team of nurses

> ***"Thanks to parity, millions of Americans with mental illness and substance abuse disorders will get the care they need."***

"We need you to be advocates not just for more resources for mental health and substance abuse prevention and treatment, but for smarter use of those resources."

and dieticians working with you to figure out a diet and exercise plan that you can stick to. And the same approach can work for mental illnesses and addictions. Mental health and addiction professionals can serve as what are called "recovery navigators," helping to connect patients with health screening, as well as counseling, medication management, housing, and job training.

We know that these integrated care models can be especially effective when they combine behavioral and physical health conditions. That's because mental illnesses and substance use disorders usually go hand in hand with other physical conditions.... And we also know that when physical and mental health problems come together, they usually make each other worse. For example, the cost of treating a patient a medical problem and comorbid psychiatric condition is twice as high as the cost for a patient with the medical condition alone. . . .

And we also need to make integration work the other way. We know that barely half of public mental health centers have the capacity to provide medical treatment for physical health problems, either onsite or through referral. We need to do better, and SAMHSA is currently administering a grant program designed to figure out how we can incorporate primary care services into these community behavioral health centers.

Another idea that we need to borrow from our work to improve our physical health care system is investing in prevention. We know from the latest research that half of all mental illnesses begin by age 14. Three fourths begin by age 24. We also have decades of research showing that the most cost-effective mental health interventions are the ones that prevent or delay the onset of mental illnesses. Part of why these early interventions are so effective is that they can also prevent associated problems like drug use. We know for example that kids between the ages of 12 and 17 who were depressed in the past year were twice as likely to take their first drink or use drugs for the first time as those who did not experience depression.

So there's a lot to gain by preventing mental illness. And while we still have more to learn about which of these interventions work best, we're aggressively looking for answers. For example, the National Institute of Mental Health is currently conducting a major early intervention trial for people who have just experienced their first episodes of schizophrenia.

What makes this research unique is that we've already assembled a working group from three of our agencies, including SAMHSA, that is thinking about how we could pay for this intervention if the study is successful. Given the benefits of prevention, we want to make sure we're moving as fast as possible to implement the best ideas we have.

A third idea we need to incorporate into our mental health and substance abuse response are partnerships that go outside the public health community. Just as we understand that our physical health is affected by food we eat and the air we breathe and the physical environment we live in, we need to realize that prescription drugs and counseling are not the only factors that affect our mental well-being. For example, we know that two of the most effective tools we have to help people recover from mental illnesses or addictions are a home and a job. That's why my department is working with the Department of Housing and Urban Development on a demonstration project that will combine housing vouchers with behavioral health and other support services to see if this combination can help reduce homelessness for people with severe mental illness or substance abuse disorders. We've already seen one study in Chicago where providing housing and case management reduced hospital stays and emergency room visits by 25 percent, and we want to try to build on that success.

We've also formed partnerships to help us reach some of the Americans with mental illnesses who may not be getting the services they need. So we're also working with the Department of Education and the Department of Agriculture to promote behavioral health in schools. We're working with the Veterans Administration to reach veterans. We're working with the Department of Labor and other agencies to reach out to families in the cities that have been hardest hit by the economic downturn. And if we're going to treat mental illness and substance abuse effectively, we're going to need more of these partnerships, public and private.

Of course, the change that you're probably most curious about is health insurance reform. And I'm sorry to say, I didn't come here today to announce a secret deal. As you're all aware, the House has passed a bill and the Senate is still trying to work out the details on its own bill. We in the Obama administration are continuing to support them any way we can. But while we can't know exactly what the final reform bill will look like, we do know that any reform bill that meets the President's basic criteria will have huge benefits for Americans with mental illnesses and substance use disorders. Any reform bill will expand access to insurance, which will especially benefit people with mental illnesses who we know are twice as likely to be uninsured. It will prevent insurance companies from calling your substance addiction a preexisting condition and denying you coverage. Through pilot programs and new incentives, reform will encourage the kind of integrated care models and prevention strategies I talked about earlier.

At the same time, we know that even the strongest reform bill will not provide all the services that Americans with the most serious and disabling mental and substance use disorders need. That's why it's so important that we continue to work to prevent these conditions from occurring and deliver the services that help Americans with these disorders fully recover and become contributing members of society. To do that, we'll need your help. As much progress as we've made, there is still a long way to go. We need you to be advocates not just for more resources for mental health and substance abuse prevention and treatment, but for smarter use of those resources. We have a better understanding than ever before about the kind of programs that are most effective, and we need to apply that knowledge to get the best results.

Nora D. Volkow, M.D.

Substance Abuse Among Troops, Veterans, and Their Families

Nora D. Volkow, M.D.
Director, National Institute on Drug Abuse

Military experts are concerned that the wars in Iraq and Afghanistan may be precipitating a rise in problems related to substance use and abuse among the military personnel who have been deployed to those fronts. NIDA has joined forces with the Department of Defense, Department of Veterans Affairs, and other Federal agencies in a campaign to assess and find solutions to this threat to the health and well-being of our service men and women, veterans, and their families.

Demographic factors and the military's unique organizational structures, culture, and experiences contribute to service members' overall high prevalence of smoking and binge drinking and low prevalence of illicit substance abuse, when compared with civilian rates. The patterns of tobacco use illustrate the impact that war can have on substance use: Tobacco use is about 50 percent higher among the Nation's active duty military personnel and veterans than in the civilian population. Yet studies reported at a recent NIDA-cosponsored meeting indicate that smoking rates are an additional 50 percent higher among personnel who have served in war zones.

> ***"Combat exposure appears to be a primary mediator of the impact of war deployment on substance abuse rates."***

Combat exposure appears to be a primary mediator of the impact of war deployment on substance abuse rates. In one study, one in four veterans of Iraq and Afghanistan reported symptoms of a mental or cognitive disorder; one in six reported symptoms of post-traumatic stress disorder (PTSD). These disorders are strongly associated with substance abuse and dependence, as are other problems experienced by returning military personnel, including sleep disturbances, traumatic brain injury, and violence in relationships.

NIDA research has established effective principles for preventing and treating substance abuse and co-occurring problems and has proven the efficacy of a variety of interventions. This knowledge may provide a basis for reducing substance abuse and its consequences among the military. Modifications may be required, however. Ways will have to be found, for example, to counter some service members' reluctance to seek treatment, which may reflect a cultural emphasis on showing strength rather than needs, or perhaps worries about potential disciplinary consequences. We will need to learn how factors associated with deployment affect service members' risks for substance abuse and their recovery pathways. The high rates of co-occurring PTSD and substance abuse among those who have directly experienced combat have put a premium on research to develop stronger responses to these difficult problems.

NIDA and its coalition partners have issued a call for research on the epidemiology, causes, prevention, and treatment of substance use and abuse and co-occurring problems among service members, veterans, and their families (RFA-DA-10-001 and RFA-DA-10-002). In this and other efforts, NIDA is working with military and mental health specialists to help those who have served the Nation. *Reprinted with permission from NIDA Notes, Volume 22, Number 5 (November 2009).*

NHTSA Administrator Confirmed

The Senate has confirmed David Strickland as the new Administrator of the National Highway Traffic Safety Administration. NHTSA is the lead Federal agency overseeing highway safety, including standards for drinking and drugged driving.

Mr. Strickland has been Senior Counsel to the Senate Subcommittee on Consumer Protection, Product Safety and Insurance of the Committee on Commerce, Science and Transportation, which has jurisdiction over NHTSA, and thus is knowledgeable about the agency's mission and priorities.

NIAAA Launches New "Webzine"

The National Institute on Alcohol Abuse and Alcoholism has launched *NIAAA Spectrum*, the agency's first-ever web-only magazine, or "webzine." Each issue includes feature articles, news updates from the field, articles and photo essays, and an interview with an NIAAA staff member or alcohol researcher. *NIAAA Spectrum* will be published three times a year. The inaugural issue can be accessed at HTTP://WWW.SPECTRUM.NIAAA.NIH.GOV/MEDIA/PDF/NIAAA_SPECTRUM_SEPT_09.

Alcohol, Other Drugs, and Health: Current Evidence

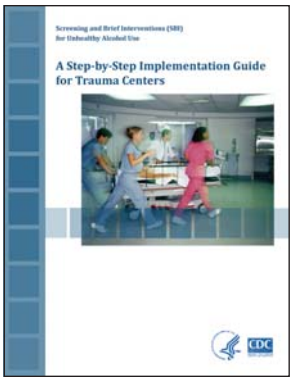
Alcohol, Other Drugs, and Health: Current Evidence is a free online newsletter that summarizes the latest clinically relevant research on alcohol, illicit drugs, and health. Through its summaries and other features, the newsletter aims to highlight alcohol and other drug issues and provide valuable information that can be applied in clinical teaching, practice, and research.

Published every two months, the newsletter features:

- Succinct and timely summaries of important alcohol and other drug research published in peer-reviewed journals, written by physicians with clinical, research, and educational expertise in alcohol- and drug-related issues.
- PowerPoint slide presentations that can be downloaded and used as teaching tools.
- "Update on Alcohol, Other Drugs, and Health," a grand-rounds-like presentation of the research summaries in the newsletter.
- Journal Club, which critically appraises a study highlighted in the newsletter using the User's Guides to the Medical Literature.
- Free continuing education credits for physicians, nurses, counselors and others (one AMA PRA Category 1™ credit per issue).

A project of the Boston Medical Center, the newsletter is supported by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It is produced in cooperation with the Boston University Schools of Medicine and Public Health.

To learn more, contact the Boston University School of Medicine/Boston Medical Center, Clinical Addiction Research and Education Program (CARE), 801 Massachusetts Ave., 2nd Floor, Boston, MA 02118, email aodhce@bu.edu, or visit WWW.AOD HEALTH.ORG.



CDC Publishes Guide to Use of Screening and Brief Intervention in Trauma Centers

The Centers for Disease Control and Prevention (CDC) has published a guide for implementing alcohol screening and brief intervention (SBI) in trauma centers. Screening and Brief Intervention (SBI) for Unhealthy Alcohol Use: A Step-By-Step Implementation Guide for Trauma Centers provides step-by-step suggestions to help Level I and II trauma centers plan, implement, and continually improve programs that conform to the new requirements of the Committee on Trauma of the American College of Surgeons. The guide covers the following steps and resources:

- Developing an SBI plan
- Choosing the SBI team, including those providing the intervention
- Gaining long-term "buy-in"
- Implementing and refining the SBI plan
- Worksheets to plan and track results
- Online resources
- Research articles on SBI.

The 46-page guide can be downloaded at no cost from HTTP://WWW.CDC.GOV/INJURYRESPONSE/ALCOHOL-SCREENING/RESOURCES.HTML. CDC plans to publish a similar guide on use of SBI in primary care settings.

SAMHSA Offers Grants to Expand Treatment Capacity for Drug Courts

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year 2010 grants to expand substance abuse treatment capacity in adult drug courts. The purpose of the program is to expand and/or enhance substance abuse treatment services in "problem solving" courts that use the treatment drug court model to provide defendants/offenders with alcohol and drug treatment, recovery support services, screening, assessment, case management, and program coordination.

SAMHSA anticipates that approximately $2.5 million per year will be available to fund up to 8 grants. Awardees are eligible for up to $325,000 per year for up to three years. The program is expected to provide a total of $7.5 million over three years. (Actual amounts may vary, depending on the availability of funds and the performance of grantees.) The grants will be administered by SAMHSA's Center for Substance Abuse Treatment.

Eligible applicants are existing adult treatment drug courts that have relationships and agreements with existing public and private community-based treatment programs, as well as units of tribal, State and local governments that submit applications on behalf of an individual drug court (see the RFA for complete eligibility information).

Applications for grant number TI-10-011 are available by calling SAMHSA's Health Information Network at 1-877-SAMHSA7 or by downloading the application from HTTP://WWW.SAMHSA.GOV/GRANTS/2010/TI-10-011.ASPX. Applicants are encouraged to apply online using HTTP://WWW.GRANTS.GOV/.

The due date for applications is March 16, 2010. Applications must be received by the due date and time to be considered for review. Applicants are encouraged to review Section IV-3 of the application announcement for submission requirements. Applicants with questions about program issues should contact Holly Rogers at 240-276-2916 or HOLLY.ROGERS@SAMHSA.HHS.GOV. Questions about grants management should be addressed to William Reyes at 240-276-1406 or WILLIAM.REYES@SAMHSA.HHS.GOV.

CHAPTERS COUNCIL PURSUES MULTIPLE GOALS

Richard G. Soper, M.D., J.D., M.S., FASAM
Chair, ASAM Chapters Council

We are making major progress in developing and supporting ASAM's chapters. Leaders of the State societies and chapters are urged to continue to assist members and use the resources of ASAM's national office, as well as the Regional Directors, to support all the efforts each chapter and potential chapter is making.

Expand Vets' Access to Buprenorphine, Other Addiction Treatment, Report Says

The U.S. military's Tricare program is coming under fire for not providing reimbursement for buprenorphine and methadone maintenance treatment — two leading pharmacological interventions for opioid addiction.

The *Navy Times* reported November 5th that a new report from the Drug Policy Alliance called on the federal government to expand veterans' access to addiction treatment, including medication-assisted therapy.

Tricare currently prohibits payments for "drug maintenance programs when one addictive drug is substituted for another on a maintenance basis [such as methadone substituted for heroin]" — a policy deemed "outrageous" by Robert Newman, M.D., of the Rothschild Chemical Dependency Institute.

The report notes that addiction problems are strongly associated with incarceration of veterans and that about 19 percent of returning Iraq and Afghan war vets have been treated by the Veterans' Administration for addiction.

Medication-Assisted Treatment Booklets for Patients, Families, and Friends

In October, the Center for Substance Abuse Treatment (CSAT) announced the availability of three consumer booklets on medication-assisted treatment (MAT) for current or potential patients, their families, and friends. The booklets are designed to provide basic information about MAT for opioid addiction including medication options for treatment — methadone, naltrexone, and buprenorphine. The booklets also explain how medication options fit into the overall recovery process.

One booklet is directed at families and friends of patients entering MAT. The other two booklets present facts about naltrexone and buprenorphine and are directed at patients entering MAT.

A PDF file of the Medication-Assisted Treatment booklet is available at:
HTTP://WWW.KAP.SAMHSA.GOV/PRODUCTS/BROCHURES/PDFS/MED_ASSISTED_TX_FACTS.PDF

A PDF file of the Facts About Naltrexone booklet is available at:
HTTP://WWW.KAP.SAMHSA.GOV/PRODUCTS/BROCHURES/PDFS/NALTREXONE_FACTS.PDF

A PDF file of the Facts About Buprenorphine booklet is available at:
HTTP://WWW.KAP.SAMHSA.GOV/PRODUCTS/BROCHURES/PDFS/BUPRENORPHINE_FACTS.PDF

Source: Substance Abuse and Mental Health Services Administration — October 22, 2009.

SAMHSA Awards More Than $38.2 Million to Help Expand Adult Drug Treatment Courts

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently announced the award of 44 new grants for $38.2 million over the next three years to expand the treatment capability of adult drug courts. The grants will be used to expand and/or enhance substance abuse treatment services in "problem solving" courts, which use the treatment drug court model in order to provide alcohol and drug treatment, recovery support services supporting substance abuse treatment, screening, assessment, case management, and program coordination to adult defendants/offenders.

> ***"Drug treatment courts made a tremendous difference in helping steer people on the path of recovery and giving them the support needed to help break free from substance abuse,"***

"Drug treatment courts made a tremendous difference in helping steer people on the path of recovery and giving them the support needed to help break free from substance abuse," said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. "These new grants will expand the successes of the more than 2,200 treatment drug courts operating in communities across the nation."

ASAM's recently formed Criminal Justice and Addiction Action Group will be involved in this activity.

New Treatment Improvement Protocol Available

Clinical supervision has become the cornerstone of quality improvement in the substance abuse treatment field. In addition to providing a bridge between the classroom and the clinic, clinical supervision improves client care, develops the professionalism of clinical personnel, and imparts and maintains ethical standards in the field. Organized into three parts, TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor presents basic information about clinical supervision:

- **PART 1** (for clinical supervisors): presents basic information about clinical supervision in the substance abuse treatment field and provides a "how to" of clinical supervision.
- **PART 2** (for program administrators): helps administrators understand the benefits and rationale behind providing clinical supervision for their program's substance abuse counselors.
- **PART 3** consists of three sections: an analysis of the available literature, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. Part 3 is available only online through KAP.

TIP 52 can be downloaded at:
HTTP://KAPLIST.JBSINTERNATIONAL.COM/LISTS/LT.PHP?ID=CU0CBASIVFFLUGOESLVWCAA%3D

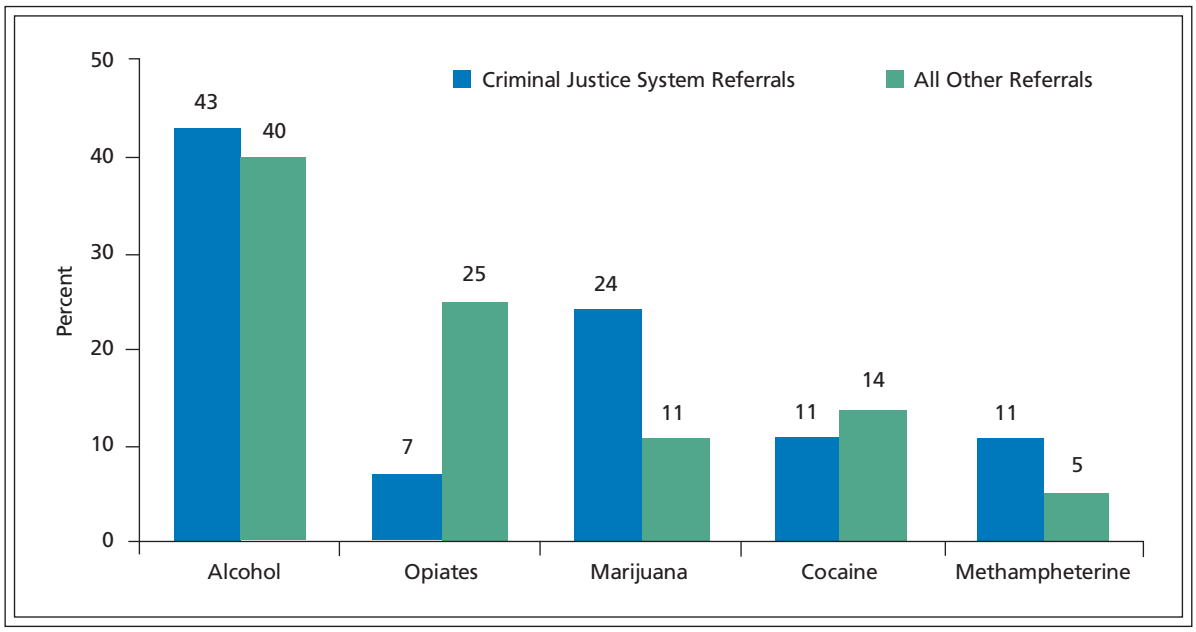
The TIP 52 Literature Review can be downloaded at:
HTTP://KAPLIST.JBSINTERNATIONAL.COM/LISTS/LT.PHP?ID=CU0CBASIVFDLUGOESLVWCAA%3D

Treatment Referrals Most Likely to Come from Criminal Justice System

The criminal justice system accounts for more than one in three referrals to addiction treatment programs nationally, and such referrals are more likely to result in completed treatment stays, according to the latest Treatment Episode Data Set (TEDS) report from the Substance Abuse and Mental Health Services Administration (SAMHSA).

A total of 1.8 million Americans were admitted to treatment programs in 2007, according to the TEDS report, and of these 671,000 (37 percent) were referred by the criminal justice system. Researchers found that 22 percent of criminal justice referred patients dropped out of treatment, compared to 27 percent of overall treatment patients.

It should be noted that, according to a August 2009 TEDS special report, the majority of referrals from the criminal justice system are for alcohol treatment. Only 7% of referrals to treatment for opioid addiction came from the criminal justice system (see the chart below).



Source: The TEDS Report: Substance Abuse Treatment Admissions Referred by the Criminal Justice System — August 13, 2009

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**.

Dear Colleague:

We are pleased to report that the Endowment Fund has received a number of excellent applications for the 2010 Ruth Fox Scholarship Program. Since 2002, when the Scholarship program was established, we have sponsored 30 physicians-in-training to attend ASAM's Annual Medical-Scientific Conference and Ruth Fox Course for Physicians, and we look forward to hosting another group of physicians-in-training in San Francisco at ASAM's 2010 Medical-Scientific Conference.

Please make a point of greeting these outstanding young physicians at the Ruth Fox Donor Reception, which will be held on Friday evening, April 16th. As in past years, the Fund is grateful to long-time benefactor Joseph S. Dorsey, M.D., FASAM, and Mrs. Dorsey, for their gracious gift of funds to underwrite the event. Please make a point of acknowledging their generosity when you greet them at the Reception.

Invitations to the reception are extended only to Ruth Fox Fund donors, so if you have not already contributed or pledged to the Endowment Fund, please do so now. Also let us know if you have included the Endowment in your estate plans so that we can acknowledge your generosity. All contributions to the Endowment Fund are tax-deductible to the full extend provided by law.

For information about making a pledge, contribution, bequest, memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman by phone at 1-800/257-6776 or 1-718/275-7766, or email Claire at ASAMCLAIRE@AOL.COM. She welcomes your calls. Your support will be greatly appreciated.

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

Claire Osman
Director of Development

Dr. Miller Named to New Post

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

ASAM Immediate Past President Michael M. Miller, M.D., FASAM, FAPA, will become Medical Director of the Herrington Recovery Center at Rogers Memorial Hospital, Oconomowoc, Wisconsin, in April. The Herrington Recovery Center is named after its founder, the late Roland Herrington, M.D., who is credited with establishing the practice of addiction medicine in Wisconsin. Dr. Herrington trained hundreds of physicians, including Dr. Miller. The Herrington Recovery Center specializes in the treatment of professionals in need of alcohol and other drug rehabilitation.

Dr. Miller has been Medical Director of Meriter Hospital's NewStart Alcohol/Drug Treatment Program. Located in Madison, Wisconsin, Meriter has been a leader in providing addiction treatment services for almost 50 years.

During his 20-year tenure at Meriter, Dr. Miller has established and chaired the Department of Addiction Medicine and the Medical Staff Wellness Committee. He also established NewStart's Addiction Medicine Consultation and Evaluation Service (AMCES) and helped make NewStart one of the area's leading providers of office-based treatment of opioid addiction. In addition to Dr. Miller, the Meriter Addiction Medicine staff includes Ian Powell, M.D. and Aaron Sheridan, P.A., as well as certified nurses and addiction counselors.

Dr. Brown Named to CPDD Board

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

Dr. Lawrence S. Brown, Jr., Executive Senior Vice President of the Addiction Research and Treatment Corporation/ Urban Resource institute was elected to The Board of Directors for the College of Problems on Drug Dependence (CPDD) for a four-year term, beginning in June 2009.

Formerly the Committee on Problems of Drug Dependence, CPDD has been in existence since 1929 and is the longest standing group in the United States addressing problems of drug dependence and abuse. It also functions as a collaborating center of the World Health Organization.

Dr. Brown recently was named "2009 Addiction Physician of the Year" by the New York State Office of Alcoholism and Substance Abuse Services. The honor is bestowed on physicians who have earned wide recognition from their peers and whose work reflects the highest level of professional conduct and dedication to serving individuals and families suffering from alcoholism and/or substance abuse.

ASAM Conference Calendar

ASAM EVENTS

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

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

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

October 14-16, 2010
ASAM Review Course
in Addiction Medicine
Westin O'Hare Hotel,
Rosemont (Chicago), Illinois
[21 Category 1 CME credits]

OTHER EVENTS OF NOTE

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

February 21-24, 2010
Southeast Conference on
Addictive Disorders (SECAD)
Co-sponsored by NAADAC and NAATP
Gaylord Opryland Hotel,
Nashville, Tennessee
[For more information or to register, email INFO@VENDOMEGRP.COM]

March 4-5, 2010
12th Annual Fundamentals of
Addiction Medicine Conference
Tulalip Resort & Spa,
Marysville, Washington
Sponsored by Providence Regional Medical Center, Everett, Washington
[For more information or to register, visit WWW.PROVIDENCE.ORG and click on "For Physicians"]

April 22-23, 2010
Blending Addiction Science and Practice: Evidence-Based Treatment and Prevention in Diverse Populations and Settings Albuquerque, New Mexico
Sponsored by the National Institute on Drug Abuse
[For more information or to register, visit HTTP://WWW.SEISERVICES.COM/BLENDINGALBUQUERQUE]

July 26-28, 2010
4th National Conference on Women, Addiction and Recovery: Thriving in Changing Times
Chicago, Illinois
Sponsored by the Substance Abuse and Mental Health Services Administration
[For more information or to register, visit
HTTP://WWW.SAMHSAWOMENSCONFERENCE.ORG
or email
SAMHSAWOMENSCONFERENCE@AHPNET.COM]

October 23-27, 2010
Building Partnerships: Advancing Treatment & Recovery —
American Association for the Treatment of Opioid Dependence (AATOD) National Conference
Hilton Hotel, Chicago, Illinois
[For more information or to register, visit WWW.AATOD.ORG]

Except where otherwise indicated, additional information is available on the ASAM website (WWW.ASAM.ORG) or from the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email EMAIL@ASAM.ORG.

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.

Register Now for ASAM's 2010 Review Course in Addiction Medicine!

Register now for ASAM's 2010 Review Course in Addiction Medicine, which meets Thursday, October 14th through Saturday, October 16th, at the Westin Hotel in Rosemont, Illinois, adjacent to Chicago's O'Hare Airport.

Co-chaired by Karen Drexler, M.D., and Paul Earley, M.D., FASAM, the course is designed to meet the needs of multiple audiences, including:

- Physicians who are preparing to take the ABAM Certification/Recertification Examination;
- Addiction specialists who seek an update on recent developments in addiction practice; and
- Primary care physicians, nurses, counselors and others who seek a concise review of the knowledge needed to successfully identify and manage patients whose medical problems are caused or complicated by alcohol, tobacco or other drug use.

Course registrants will receive a detailed Syllabus as a printed handbook and on CD-Rom.
The course is expected to be approved for up to 21 Category 1 CME credits.

For additional information or to register for the Review Course, visit the ASAM website at **WWW.ASAM.ORG** or contact ASAM's Department of Conferences & Meetings at **301/656-3920**.