



ASAMNews

Newsletter of The American Society of Addiction Medicine

To improve the care and treatment of people with the disease of addiction and advance the practice of Addiction Medicine.

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ASAM State of the Art Course to Meet in Washington, DC

ASAM's 2011 Course on the State of the Art in Addiction Medicine will meet October 27th to 29th at the Washington Hilton Hotel in Washington, DC. The course focuses on cutting-edge research and its potential to enrich the practice of addiction medicine. This year's course will be dedicated to the memory of three great contributors to addiction medicine: Drs. John Chappel, Alan Marlatt, and Robert Schuster (see the memorials on page 15).

ASAM's State of the Art Courses consistently receive very strong evaluations for their effectiveness in translating research findings into evidence-based practice. The courses are topical: at the 2011 course, a major theme is the impact of genetic research on our understanding of the nature of addiction, as well as the development of personalized treatments. They also are practical: at the October course, researchers and clinicians will examine the current surge in abuse of prescription opioids, new treatments for comorbid medical and psychiatric disorders, and the emergence of new evidence-based therapies. See pages 4-5 for an overview of the State of the Art program.

Attendance is limited, so be sure to register early! For more information or to register, visit the ASAM Website at WWW.ASAM.ORG, phone the ASAM Meetings staff at 301-656-3920 ext. 113, or register on site (on-site registration opens at 5:00 p.m. on Wednesday, October 26th.)

New ASAM Program Mentors Primary Care Physicians

ASAM is partnering with the National Institute on Drug Abuse (NIDA) to launch a free, nationwide service to help primary care physicians identify and advise their patients who have or are at risk for substance use disorders. The Physician Clinical Support System for Primary Care (PCSS-P) offers peer-to-peer mentorship and resources on incorporating screening and follow-up into regular patient care. The program is overseen by two leading addiction experts, Louis E. Baxter, Sr., M.D., FASAM, and David A. Fiellin, M.D., as well as a Clinical Advisory Committee composed

of experts drawn from family medicine, internal medicine, and emergency medicine.

"Increasingly, primary care physicians are faced with the complications of substance use disorders in terms of their patients' medical outcomes and may be limited in training and tools to evaluate and treat these problems," said Dr. Fiellin, who is Professor of Medicine at the Yale University School of Medicine. "The increased prevalence of addiction issues makes it necessary for primary care physicians to address these cases directly."

continued on page 6



Penny S. Mills,
M.B.A.

My Goals for ASAM

Penny S. Mills, M.B.A.

During the annual Med-Sci conference, I had an opportunity to deliver a brief report on what I've learned about ASAM and my goals for the Society. My report focused on four primary goals: increasing ASAM's value to members, supporting members in their practices, educating primary care physicians about addiction, and strengthening communications with members.

INCREASING ASAM'S VALUE TO MEMBERS

First, we really want to focus on strengthening and increasing member value, and we are offering several new benefits to do that. We have also tried to make pricing more favorable for members in terms of registering for programs and products.

Two programs have been launched this year, and a third starts later this spring. The Career Center started in February to connect members with potential employers on an online job center. In March, ASAM Weekly was launched to keep members up-to-date on all the news concerning the Society and its members. In early summer, the Live Learning Center will be launched.

SUPPORTING MEMBERS IN THEIR PRACTICES

An example of supporting members is seen in the annual Legislative Days, when ASAM officials and members visit with members of Congress to discuss issues such as the Paul Wellstone and Pete Domenici Mental Health Parity and the Addiction Equity Act.

Through the Society's annual Legislative Days, members have an opportunity to engage directly with their members of Congress. ASAM's Government Relations staff help members arrange meetings with their Senators and Representatives to discuss addiction issues and share concerns and expertise as they relate to Federal alcohol, drug and addiction treatment policies. The staff also provide advocacy training sessions, including overviews of current issues and talking points for use with Federal officials. ASAM also helps members with legislative and regulatory issues in their States, such as by assisting in efforts to defeat "medical marijuana" legislation.

EDUCATION OF PRIMARY CARE PHYSICIANS

ASAM's role in educating primary care physicians about addiction received a boost with the launch of the Physician Clinical Support System for Primary Care (PCSS-P), the latest addition to ASAM's mentor network (see the report on page 1).

Med-Sci saw the launch of a new ASAM reference work for primary care physicians: *Principles of Addiction Medicine: The Essentials*. The editors of *Essentials* served as "translators" by selecting and condensing information from *Principles of Addiction Medicine* so as to make it accessible to primary care physicians and other caregivers who wish to identify, manage and appropriately refer patients suffering from addictive disorders.

In addition, ASAM will launch an online skills training program on Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the next few months.

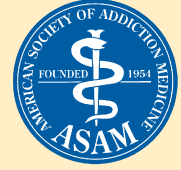
STRENGTHENING COMMUNICATIONS WITH MEMBERS

Strengthening our communications with members to keep them up to date on what is happening within ASAM and the field of addiction medicine is important. Publications are key, including ASAM News, ASAM Weekly and the Med-Sci Daily News, distributed during the annual meeting. In addition, the ASAM website will be updated in the near future to offer richer content and improve navigation.

I have had an opportunity to meet many ASAM members at educational programs and Chapter meetings, and I look forward to continuing to do that. Your questions and suggestions are always welcome; simply email me at PMILLS@ASAM.ORG.

Renew Now to Take Advantage of Special Membership Rate

ASAM's "Half-Price Half-Year" membership began June 1st and applies to Regular and Early Career Physician Memberships. Half-year memberships are valid through December 31, 2011. For more information, contact the ASAM Membership Department at 301-656-3920 or at EMAIL@ASAM.ORG.



American Society of Addiction Medicine

4601 North Park Ave.
Suite 101 Upper Arcade
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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ASAM News

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Agencies Announce Prescription Drug Abuse Action Plan



ONDCP Director Gil Kerlikowske announces the Obama Administration's plan to combat prescription drug abuse.

Officials of major Federal agencies have jointly announced a new action plan to address what they characterized as an “epidemic” of prescription drug abuse. In an April 19th press conference, ONDCP Director Gil Kerlikowske, Assistant Secretary for Health Howard Koh, M.D., FDA Commissioner Margaret A. Hamburg, M.D., and DEA Administrator Michele M. Leonhart released the Administration’s comprehensive action plan on prescription drug abuse and announced new Federal requirements aimed at educating the medical community about proper prescribing practices.

Titled “Epidemic: Responding to America’s Prescription Drug Abuse Crisis,” the plan focuses on four major areas:

- **Education.** Officials said that a crucial first step in tackling the problem of prescription drug abuse is to educate parents, youth, and patients about the dangers of abusing prescription drugs, while requiring prescribers to receive education on their appropriate and safe use, and patients to be educated in the proper storage and safe disposal of prescription drugs.
- **Monitoring.** The plan calls for adoption of prescription drug monitoring programs (PDMPs) in every state, and enhancing existing PDMPs to make sure they can share data across State lines and are used by physicians and other health care providers.
- **Proper Medication Disposal.** The plan proposes convenient and environmentally responsible prescription drug disposal programs to help decrease the supply of unused prescription drugs in the home.
- **Enforcement.** A fourth step involves providing law enforcement agencies with the tools necessary to eliminate improper prescribing practices and to stop “doctor-shoppers” and eliminate drug-seeking behavior.

In support of the action plan, the Food and Drug Administration (FDA) announced its long-awaited Risk Evaluation and Mitigation Strategy (REMS) for selected opioids. The new program will require manufacturers of long-acting and extended-release opioid analgesics to provide educational programs to prescribers of those medications, as well as materials prescribers can use when counseling patients about the risks and benefits of opioid use.

ASAM Joins ABAM, AMERSA in Endorsing Action Plan

Acknowledging the alarming statistics from the Centers of Disease Control and Prevention regarding the rise in prescription drug overdoses throughout the country, as well as the clinical experiences of their own members, a coalition of physician and other healthcare addiction treatment providers supports the need for a federal response to this growing problem.

ASAM recently joined with the American Board of Addiction Medicine Foundation (ABAMF) and the Association for Medical Education and Research in Substance Abuse (AMERSA) in issuing a joint press release endorsing the Obama Administration’s prescription drug abuse action plan.

“Any physician or health care provider licensed to prescribe, dispense or administer these prescription drugs should be educated on how to do so in a safe and clinically appropriate way,” said ASAM President Donald Kurth, M.D., M.B.A., M.P.A., FASAM. “Prescription opioids are powerful medications that need to be used very carefully,” added AMERSA President Patrick G. O’Connor, M.D., M.P.H. “Prescribing physicians need to have a state-of-the-art understanding of their indications, risks and benefits and be exceedingly thoughtful about how they are prescribed. Patients must be to be actively engaged and informed in the decision-making process about the use of these medications and closely monitored to assure safe and effective patient care.”

Kevin Kunz, M.D., President of ABAM, added that “It is doubly important that addiction medicine residents be trained so that they can educate other physicians about prevention and proper prescribing, and so that they can be the addiction medicine specialists in their community to treat patients with prescription opioid dependence or addiction.”

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“Today we are making an unprecedented commitment to combat the growing problem of prescription drug abuse. The Government, as well as parents, patients, health care providers, and manufacturers all play a role in preventing abuse. This plan will save lives, and it will substantially lessen the burden this epidemic takes on our families, communities, and workforce.”

~ Vice President Joseph Biden (April 19, 2011)

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ASAM's 2011 Course on the State of the Art in Addiction Medicine

Thursday, October 27 – Saturday, October 29, 2011 • Washington Hilton Hotel, Washington DC

Who Should Attend? ASAM's 2011 Course on the State of the Art in Addiction Medicine is designed specifically for the physician or other health care professional who seeks an advanced level of knowledge about recent breakthroughs in understanding the nature of addiction, as well as evidence-based strategies for preventing, diagnosing and treating addiction and co-occurring medical and psychiatric disorders.

Co-Sponsors. The State of the Art Course is co-sponsored by the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, SAMHSA's Center for Substance Abuse Prevention, and SAMHSA's Center for Substance Abuse Treatment.

Educational Objectives. The goal of ASAM's 2011 Course on the State of the Art Course in Addiction Medicine is to present the most up-to-date information on the science of addiction and the practice of addiction medicine.

Program sessions will focus on the latest research into the causes, prevention and treatment of addictive disorders, and will translate the research findings into clinically useful knowledge. At the conclusion of the course, participants should be able to:

- Discuss recent research into the causes and progression of alcohol and drug use disorders and how such knowledge translates into new approaches to prevention and treatment.
- Identify emerging drug problems and patterns of use involving alcohol-caffeine drinks, prescription drugs, marijuana and related cannabinoids, herbal preparations, and khat.
- Describe emerging vaccines and other therapies for alcohol, opioid, methamphetamine, cocaine and tobacco addiction, as well as the most beneficial combinations of pharmacologic and non-pharmacologic approaches.
- Assess the safety and efficacy of various treatment interventions for individual patients, and understand how to integrate treatment for addiction with therapies for co-occurring medical and psychiatric disorders.

Session 1. Genetics—Shaping Our Understanding of Addiction and Its Treatment (Thursday, October 27th, 8:45 a.m. to 12:15 p.m.)

KEYNOTE ADDRESS: NIH and the Human Genome. Francis Collins, M.D., Ph.D., Director, National Institutes of Health, Bethesda, Maryland (invited)

Genetic Contribution to Relapse Risk. David A. Flockhart, M.D., Ph.D., Harry and Edith Gladstein Chair in Cancer Genomics, and Professor of Medicine, Medical Genetics and Pharmacology, and Director of the Division of Clinical Pharmacology, Indiana University School of Medicine, Indianapolis, Indiana

Gene x Disease Interaction on Orbitofrontal Gray Matter in Cocaine Addiction. Rita Z. Goldstein, Ph.D., Scientist, Brookhaven National Laboratory, Medical Research Center, Neuropsychology Group, Upton, New York

Preliminary Evidence for Genetic Determinants of Response to Alcohol Pharmacotherapies. Kent Hutchison, Ph.D., Department of Psychiatry and Neuroscience, University of Colorado Boulder

Pharmacogenetic Approaches to Alcohol Dependence. Bankole A. Johnson, M.D., Ph.D., D.Sc., Chair, Department of Psychiatric Medicine, UVA Health Sciences Center, University of Virginia, Charlottesville, Virginia

Session 2. Use and Abuse of Prescription Opioids—Current Evidence (Thursday, October 27th, 1:15 to 5:00 p.m.)

KEYNOTE ADDRESS: The Administration's Prescription Drug Abuse Action Plan. Gil R. Kerlikowske, Director, Office of National Drug Control Policy, Executive Office of the President, The White House, Washington, DC

Efficacy of Long-Term Opioids to Treat Chronic Pain: A Review of the Evidence. Gilbert Fanciullo, M.D., Director of the Pain Management Center, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire (invited)

Injury, Pain, and Prescription Opioid Use Among Former NFL Players. Linda B. Cottler, Ph.D., M.P.H., Chair and Dean's Professor of Epidemiology, University of Florida College of Public Health and Health Professions, Department of Epidemiology, Gainesville, Florida

Abuse-Deterrent and Tamper-Resistant Opioid Formulations: What Is Their Role in Preventing Prescription Drug Abuse? Lynn R. Webster, M.D., FACPM, FASAM, Medical Director, Lifetree Pain Clinic, Salt Lake City, Utah

FDA's REMS and Other Educational Approaches to Reducing Misuse and Abuse of Prescription Opioids. Roger Chou, M.D., Scientific Director, Oregon Evidence-Based Practice Center, Portland, Oregon (invited)

Session 3. Clinical Challenges in Addiction Medicine—Marijuana and the Cannabinoids (Thursday, October 27th, 7:00 to 9:15 p.m.)

The Role of Endocannabinoids: Results of Animal Studies. Eliot Gardner, Ph.D., Neuropsychopharmacology Section, Intramural Research Program, National Institute on Drug Abuse, Baltimore, Maryland

Medicolegal Issues Involved in Prescribing/Recommending Marijuana Therapy. Timmen Cermak, M.D., Private Practice of Psychiatry and Addiction Psychiatry, Mill Valley, California, and President, California Society of Addiction Medicine

Does Use of Cannabis Increase the Risk or Speed the Onset of Psychosis? Alan Green, M.D., Chair, Department of Psychiatry, Dartmouth Medical School, Hanover, New Hampshire

Marijuana and Driving Risk. Robert L. DuPont, M.D., founding Director, National Institute on Drug Abuse, and President, Institute for Behavior & Health, Bethesda, Maryland

Session 4. New Therapeutic Strategies for Co-Occurring Disorders (Friday, October 28th, 8:45 a.m. to 12:15 p.m.)

KEYNOTE ADDRESS: Frances M. Harding, Director, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

Prevalence of Addiction-Related Disorders After Mild Traumatic Brain Injury. Shannon C. Miller, M.D., FAPA, FASAM, Associate Professor of Clinical Psychiatry and Director, Addiction Psychiatry and Addiction Medicine Fellowships, University of Cincinnati College of Medicine, Cincinnati, Ohio, and Timothy Webb, Ph.D., Senior Research Statistician, Air Force Research Laboratory, Cincinnati, Ohio

Epidemiologic Links Between Drug Use and HIV Epidemics: An International Perspective. Chris Beyrer, M.D., M.P.H., Professor and Director, Johns Hopkins Fogarty AIDS International Training and Research Program, Johns Hopkins University, Baltimore, Maryland

Neuropsychiatric Complications of Hepatitis and HIV Infections in Addiction Patients and How to Manage the Health Consequences.

Glenn J. Treisman, M.D., Ph.D., Professor of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, The Johns Hopkins Hospital. Baltimore, Maryland

Cardiac Risk with Methadone and Other Opioids: Who Should be Screened, When and How? Raymond L. Woosley, M.D., Ph.D., Director, Critical Path Institute and the Arizona Center for Education and Research in Therapeutics (AzCERT), Tucson, Arizona

Session 5. Emerging Drugs of Abuse—A Global Perspective (Friday, October 28th, 1:15 to 5:00 p.m.)

KEYNOTE ADDRESS: Breakthroughs in Alcohol Research. Kenneth R. Warren, Ph.D., Acting Director, National Institute on Alcohol Abuse and Alcoholism

Emerging Drugs and Patterns of Abuse: What Do the Data Show? Lloyd D. Johnston, Ph.D., Distinguished Research Scientist and Research Professor, Survey Research Center Institute for Social Research, University of Michigan, Ann Arbor, Michigan

Alcohol-Caffeine Combinations, Other New Patterns of Alcohol Use, and the Prevention of Under-Age Drinking. Ralph W. Hingson, Sc.D., M.P.H., Director, Division of Epidemiology and Prevention Research, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland

Cannabis Analogs, "Bath Salts," "Spice," Salvia, Herbs, Vaporizers, and Other Hallucinogens. Matthew Johnson, M.D., Johns Hopkins University School of Medicine, Baltimore, Maryland (invited)

Khat and Other International Imports: Special Problems in Special Populations. Jag H. Khalsa, Ph.D., Chief, Medical Consequences Branch, Division of Pharmacotherapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse, Bethesda, Maryland

Session 6. Integrating Addiction-Related Competencies Into Physician Training and Practice (Friday, October 28th, 7:00 to 9:15 p.m.)

Educating All Physicians About Addiction: The Impact of Health Care Reform.

J. Harry Isaacson, M.D., Associate Professor of Medicine and Director of Clinical Education, Department of General Internal Medicine, The Cleveland Clinic Lerner College of Medicine, Cleveland, Ohio, and founding member, Coalition on Physician Education in Substance Use Disorders (COPE)

Encouraging Adoption of Evidence-Based Practices: Lessons from SBIRT. Daniel P. Alford, M.D., M.P.H., Associate Professor of Medicine, Boston University School of Medicine, and Medical Director, MASBIRT Program. Boston Medical Center, Boston, Massachusetts

Emerging Tools and Techniques for Continuing Medical Education: Assessing Their Impact on Learning and Practice Change. Bradley Tanner, M.D., President, Clinical Tools, Inc., and Clinical Associate Professor of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, North Carolina

ASAM and FRI Collaborate on a Practice-Based Research Network: Initial Steps. Frank J. Vocci, Ph.D., President, Friends Research Institute, Baltimore, Maryland, and former Director, Division of Pharmacologic Therapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse

Session 7. Addiction Treatment—New Approaches to Old Problems (Saturday, October 29th, 8:45 a.m. to 1:00 p.m.)

KEYNOTE ADDRESS. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, Maryland

Development of a Human Monoclonal Antibody to Treat Cocaine Addiction. Andrew B. Norman, Ph.D., Professor of Psychiatry and Director of the Division of Neuroscience, University of Cincinnati Academic Health Center, Genome Research Institute, Cincinnati, Ohio

Treatment of Nicotine and Tobacco Dependence: Therapeutic Options and Pipeline Developments. Richard Hurt, M.D., FASAM, Director, Nicotine Dependence Center, The Mayo Clinic, Rochester, Minnesota

Probuphine and Other Agents to Treat Prescription Drug Abuse. Walter Ling, M.D., Professor of Psychiatry and Director of Integrated Substance Abuse Programs, UCLA, and Department of Psychiatry & Biobehavioral Sciences, David Geffen School of Medicine, UCLA, Los Angeles, California

Depot Naltrexone to Treat Opiate Addiction. Charles P. O'Brien, M.D., Ph.D., Kenneth

Appel Professor and Vice Chair of Psychiatry, The Charles O'Brien Center for Addiction Treatment, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania

Naltrexone XR to Treat Amphetamine Addiction. George E. Woody, M.D., Professor of Psychiatry, Treatment Research Institute, Philadelphia, Pennsylvania

Planning Committee

Course Chair

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Members

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Bonnie B. Wilford, M.S., Coalition on Physician Education in Substance Use Disorders (COPE)

Registration & Hotel Reservations

For more information or to register, visit the ASAM website at WWW.ASAM.ORG, or phone the ASAM Meetings Department at 301-656-3920.

Washington Hilton Hotel, 1919 Connecticut Avenue, NW, Washington, DC 20009; Tel: 1-202-483-3000; Fax: 1-202-232-0438; Web address: [HTTP://WWW1.HILTON.COM/EN_US/HI/HOTEL/DCAWHHH-WASHINGTON-HILTON-DISTRICT-OF-COLUMBIA/INDEX.DO](http://WWW1.HILTON.COM/EN_US/HI/HOTEL/DCAWHHH-WASHINGTON-HILTON-DISTRICT-OF-COLUMBIA/INDEX.DO).

A limited number of rooms are being held at the special conference rate of \$245 single or double. To receive this rate, reservations must be made by Monday, October 3, 2011. Reservations are available on a first-come first-served basis, so please reserve early!

Phone the Washington Hilton Hotel at 1-800-445-8667 or 202-483-3000. All reservations must be accompanied by a deposit equal to one night's room and tax, or be guaranteed with a major credit card. To receive the conference rate, tell the reservation agent that you will be attending the "ASAM State of the Art Course."

ABAM Accredits 10 New ADM Residencies

Kevin Kunz, M.D., M.P.H., FASAM, President of the American Board of Addiction Medicine (ABAM) Foundation, has announced that 10 residency programs have been accredited to train residents in addiction medicine, beginning July 1, 2011.

The one- to two-year residency programs, which feature a 12-month core educational component, will include rotations through inpatient and outpatient settings, with electives to round out residents' training. "Someone coming in with a pediatric background may want to do an elective on care of adults, while an internist might want three months in psychiatry," explained ABAM Board member Richard Blondell, M.D., who will lead the addiction medicine residency program at the State University of New York at Buffalo. He added that inpatient rotations may include a hospital-based rehabilitation program or medically managed residential program, while outpatient rotations may involve addiction medicine consult services or opioid treatment programs.

The newly accredited programs are as follows (except where noted, programs are accepting applications for 2011-2012 and 2012-2013):

- ★ **Addiction Institute of New York Fellowship in Addiction Medicine.** Sponsored by St. Luke's and Roosevelt Hospitals, New York City; Petros Levounis, M.D., M.A., Program Director
- ★ **Boston University Medical Center Addiction Medicine Residency.** Sponsored by Boston University Medical Center; Daniel P. Alford, M.D., M.P.H., FACP, FASAM, Program Director
- ★ **Cincinnati Addiction Medicine Fellowship.** Sponsored by University Hospital, University of Cincinnati College of Medicine; Shannon C. Miller, M.D., FASAM, FAPA, Program Director
- ★ **Geisinger Addiction Medicine Residency at Marworth.** Sponsored

by Geisinger Health System; David J. Withers, M.D., Program Director

- ★ **Minnesota Addiction Medicine Residency Program.** Sponsored by the University of Minnesota Medical School; Sheila M. Specker, M.D., Program Director
- ★ **University at Buffalo Addiction Medicine Fellowship** (accepting applications for 2012-2013 only). Sponsored by the University at Buffalo School of Medicine; Richard D. Blondell, M.D., Program Director
- ★ **University of Florida Addiction Medicine Program.** Sponsored by the University of Florida College of Medicine; Scott M. Teitelbaum, M.D., FAAP, FASAM, Program Director
- ★ **University of Hawaii Addiction Medicine Training Program.** Sponsored by the University of Hawaii John A. Burns School of Medicine; William F. Haning III, M.D., FASAM, DFAPA, Program Director
- ★ **University of Maryland- Sheppard Pratt Institute** (accepting applications for 2012-2013 only). Sponsored by the University of Maryland Medical System; Devang H. Gandhi, MBBS, M.D., FASAM, Program Director
- ★ **University of Wisconsin Program.** Sponsored by the University of Wisconsin School of Medicine and Public Health; Randall T. Brown, M.D., Ph.D., Program Director

"Physicians who graduate from these residencies will be a vital component of the multidisciplinary teams that treat addictive disorders," Dr. Kunz said, adding that he expects the ABAM Foundation to accredit an additional 10 residencies in 2012.

For more information on any of these training programs, including application instructions and due dates, go to WWW.ABAM.NET.

New ASAM Mentor Program *continued from page 1*

To help them do so, the PCSS-P features a warm line service ("warm" because the response is within 24 hours rather than an immediate response typical of a hotline), available at no cost. Practitioners who register with PCSS-P receive information on how to contact a mentor by phone or email. Mentors are available to provide general guidance as well as to answer specific questions about clinical situations involving patients' use of alcohol, tobacco and other drugs.

The initiative stresses the vital role of the physician-patient relationship in identifying unhealthy behaviors before they evolve into life-threatening conditions. "Primary care providers can be the first line of defense against substance abuse and addiction, but they need the right tools and resources," said NIDA Director Nora D. Volkow, M.D., in announcing the new program.

NIDA also has launched a quick screening tool to help practitioners identify patients in need of such services. The NIDA Quick Screen is an online interactive single-question screening instrument that asks: "In the past year, how many times have you used the following: more than 4 drinks of alcohol a day (for women) or 5 drinks a day (for men); tobacco products; prescription drugs for nonmedical reasons; or illegal drugs?" If a patient indicates past year use of illegal drugs or of prescription



David Fiellin, M.D.

drugs for nonmedical purposes, the clinician has the option of conducting NIDA's full screening tool for the drug in question. Dr. Volkow said, "Our NIDAMED screening tool is a user-friendly, interactive means to help providers quickly screen their patients for drug abuse. PCSS-P goes a step further, providing peer-to-peer mentorship in the use of these resources."

According to Dr. Baxter, who is ASAM's Immediate Past President, the PCSS-P builds on the success of SAMHSA's clinical support systems on buprenorphine and methadone. Dr. Baxter and Dr. Fiellin also point out that it is a natural role for ASAM to be involved in such a venture. "Because we are a leading organization in the field of addiction medicine with many physicians trained in primary care specialties," Dr. Fiellin said, "we are particularly sensitive to and aware of the knowledge, skills and attitudes that are needed to address substance use and addiction in primary

care settings."

Primary care clinicians can enroll in the PCSS-P by phoning 877-630-8812, sending an email to PCSSproject@asam.org, or visiting the website www.pcssmentor.org. The full menu of NIDAMED resources, including the Quick Screen, can be accessed online at [HTTP://WWW.DRUGABUSE.GOV/NIDAMED/](http://WWW.DRUGABUSE.GOV/NIDAMED/).

Nominations Sought for ASAM Officer, Director Positions

Louis E. Baxter, Sr., M.D., FASAM, Chair, Nominations & Awards Council

I am pleased to report that ASAM's Nominations & Awards Council has announced the eligibility requirements for the Society's 2012 election of Officers and Regional Directors.

OFFICERS

Nominees for the offices of ASAM President-Elect, Secretary and Treasurer must be current members of the Board of Directors, or have served on the Board as voting or *ex-officio members* without vote within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a nominee from the general membership, having qualifications for the position and having been active on the Finance Committee within the past four years. The term of office for these positions is 2013-2015.

REGIONAL DIRECTORS

Nominations for Regional Directors shall be made by a Regional Nominating Committee of Chapter Presidents and State Chairs of the Region, or by at least 25 active members of the Society residing in a Region. Each Region shall nominate at least two candidates. Regional Directors who have not already served two consecutive four-year terms are eligible for nomination as candidates. All candidates for Regional Director, including incumbents, are subject to nomination by the respective Regional Nominating Committee.

The deadline to submit nominations is **October 15, 2011**. Those who submit nominations should first verify that the candidate meets the criteria cited above and is willing to run, if nominated. All nominations will be submitted to the Board of Directors for approval, at their January Board meeting in the year of the election.

As specified in the Bylaws, the candidate in each Region who receives the most votes will be elected Regional Director, and the candidate who receives the next highest number of votes, will be elected Alternate Regional Director. Term of office for these positions is 2013-2017.

Nominations should be sent to the Regional contact person. The Regional contact person is responsible for sending the names of at least two nominees to the Nominations & Awards Council, ASAM, 4601 N. Park Avenue, Upper Arcade #101, Chevy Chase, MD 20815.

The following incumbent Regional Directors and Alternate Regional Directors are eligible to run for re-election, except for the Region I Director, Dr. Marc Galanter, the Region IV Director, Dr. John Femino, and the Region IX Director, Dr. Raju Hajela, each of

whom will have served the maximum of two consecutive four-year terms.

Region I

Edwin A. Salsitz, M.D., FASAM (Alternate Director)

Region II

David R. Pating, M.D. (Regional Director)
Peter Banys, M.D., M.Sc. (Alternate Director)

Region III

Kenneth I. Freedman, M.D., M.B.A., FACP (Alternate Director)

Region IV

John J. Verdon, Jr., M.D., FASAM (Regional Director)
Mark Philip Schwartz, M.D., FASAM (Alternate Director)

Region V

J. Ramsay Farah, M.D., MPH, FAAP, FACMP, FASAM (Regional Director)
P. Bradley Hall, M.D. (Alternate Director)

Region VI

Dora Dixie, M.D. (Regional Director)
Carl Christensen, M.D., Ph.D. FACOG, FASAM (Alternate Director)

Region VII

John P. Epling, Jr., M.D., FASAM (Regional Director)
Howard C. Wetsman, M.D., FASAM (Alternate Director)

Region VIII

William F. Haning, III, M.D., FASAM (Regional Director)
Berton J. Toews, M.D., FASAM (Alternate Director)

Region IX

David C. Marsh, M.D., CCSAM (Alternate Director)

Region X

Richard G. Soper, M.D., J.D., M.S., FASAM (Regional Director)
Bernd A. Wollschlaeger, M.D., FAAP, FASAM (Alternate Director)

REGIONAL NOMINATING COMMITTEE CHAIRPERSONS

If you meet the qualifications and are interested in running for Regional Director, or wish to nominate someone else, contact the Nominating Committee Chairperson for your Region, listed below:

Region I (New York)

Gregory C. Bunt, M.D.
(GBUNT@DAYTOP.COM)

Region II (California)

Kerry Parker (CSAM@COMPUSERVE.COM)

Region III (CT, MA, ME, NH, RI, VT)

Stephen J. Ryzewicz, M.D.
(STEPHEN.RYZEWICZ@BHS.ORG)

Region IV (NJ, OH, PA)

Steven C. Matson, M.D.
(STEVEN.MATSON@NATIONWIDE
CHILDRENS.ORG)

Region V (DE, DC, GA, MD, NC, SC, VA, WV)

Ray Gaskin, M.D., FASAM
(GASKINJRR@AOL.COM)

Region VI (IA, IL, IN, MI, MN, WI)

Sheila Specker, M.D.
(SPECK001@UMN.EDU)

Region VII (AR, OK, KS, LA, MO, NE, TX)

Terry A. Rustin, M.D., FASAM
(TERRY.RUSTIN@GMAIL.COM)

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

Michael Shiesser, M.D.
(MIKES@PAINMO.COM)

Region IX (Canada & International)

Raju Hajela, M.D., M.P.H., FASAM
(RAJUHAJELA@HOTMAIL.COM;
RAJU.HAJELA@GMAIL.COM)

Region X (AL, FL, KY, MS, PR, TN, VI)

Ellen A. Ovson, M.D. (EOVSON@YAHOO.COM)

PETITION PROCESS

Petitioners must submit to the Nominations & Awards Council the same information required of all candidates 90 days before the 2012 Med-Sci Conference. A list of petitioning candidates will be provided to all registering ASAM members near the registration desk at Med-Sci so that ASAM members can decide whether or not to sign a given candidate's petition.

To satisfy the requirements to be placed on the ballot and to participate in the ASAM approved campaigning process, a petitioning candidate is required to obtain 100 signatures of active ASAM members.

If you have questions please go to ELECTIONS@ASAM.ORG.

New Benefit for ASAM Members

As a current ASAM member, when you order anything from Hazelden's newest catalog you'll enjoy a **20% discount**.

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Addiction Agencies See Cuts in Current Year Funds

A newly released spending plan shows how the U.S. Department of Health and Human Services is responding to the appropriations bill approved by Congress in April for the current fiscal year, which ends September 30, 2011. Because seven months of the fiscal year had passed by the time Congress approved the budget, spending reductions must be accommodated in the remaining five months. Changes that affect addiction research, education, and services are outlined below.

Substance Abuse and Mental Health Services Administration

Current year spending for SAMHSA is funded at \$3.37 billion, which is a \$51.5 million reduction from FY2010. The reductions are reflected in the following changes in budget for SAMHSA's component agencies:

Center for Substance Abuse Treatment. Under the spending plan, CSAT's budget for the current fiscal year is \$2.22 billion, or \$28.2 million less than in FY2010. The loss of funding is reflected in the following changes to specific CSAT programs:

- **SAPT Block Grant** (supports publicly funded treatment programs): Funded at \$1.78 billion, or \$15.9 million less than in FY2010
- **Criminal Justice Activities:** Funded at \$65 million (a \$2.2 million reduction from FY2010)
- **NASPER** (supports evaluations of Prescription Monitoring Programs): Eliminated (\$2 million)
- **SBIRT** (supports expansion of Screening, Brief Intervention and Referral to Treatment): Funded at \$26.2 million (an \$869,000 reduction from FY2010)
- **TCE- General:** Funded at \$28 million (a \$989,000 reduction from FY2010)
- **Recovery Community Supports:** Funded at \$5.2 million (a \$433,000 reduction from FY2010)
- **Access to Recovery:** Funded at \$98.9 million (a \$426,000 reduction from FY2010)
- **Treatment Systems for the Homeless:** Funded at \$41.6 million (an \$880,000 reduction from FY2010)
- **Addiction Technology Transfer Centers:** Funded at \$9 million (a \$69,000 reduction from FY2010)
- **Congressional Projects (earmarks):** Eliminated (\$4.6 million)

Center for Substance Abuse Prevention. CSAP's budget for the current fiscal year is set at \$195.5 million, or \$6.5 million less than in FY2010. Within CSAP, the following programs have had funds reduced or eliminated:

- **SPF:** Funded at \$110 million (\$1.7 million less than in FY2010)
- **Mandatory Drug Testing:** Funded at \$4.9 million, or \$296,000 less than in FY2010)
- **Center for the Application of Prevention Technologies:** Funded at \$8.0 million (a \$293,000 reduction from FY2010)
- **Congressional Projects (earmarks):** Eliminated (\$3.9 million)

Center for Mental Health Services. CMHS is funded at \$988.8 million, or \$16.2 million less than in FY2010.

National Institutes of Health

Funds for key components of NIH also were cut, as follows:

National Institute on Drug Abuse. NIDA is funded at \$1.05 billion, a \$16.2 million reduction from FY 2010.

National Institute on Alcohol Abuse and Alcoholism: NIAAA is funded at \$458.2 million, or \$3.3 million less than in FY2010.

Members of Congress are predicting even steeper cuts in the next fiscal year (FY2012), which begins October 1, 2011.

FDA: E-Cigarettes to be Regulated as Tobacco Products

The Food and Drug Administration (FDA) has announced that it will regulate smokeless electronic cigarettes as tobacco products, similar to traditional cigarettes. The announcement is considered a victory for e-cigarette makers and distributors. Last year the FDA lost a court case after it tried to treat e-cigarettes as drug-delivery devices, which must satisfy stricter requirements than tobacco products, including clinical trials to prove they are safe and effective.

Available in the U.S. since 2006, e-cigarettes are designed to deliver nicotine in the form of a vapor that is inhaled by the user. The devices usually have a rechargeable, battery-operated heating element, a replaceable cartridge containing nicotine or other chemicals, and a device called an "atomizer" that converts the contents of the cartridge into a vapor when heated. In appearance, many e-cigarettes resemble regular cigarettes.

In court filings, the FDA said its tests found that the liquid in some e-cigarettes contain toxins in addition to nicotine, as well as cancer-causing substances found in tobacco. Public health experts say the level of the cancer-causing agents is similar to those found in nicotine replacement therapy, which contains nicotine extracted from tobacco.

CDC: Ignition Interlocks Reduce DUI Episodes

The Centers for Disease Control and Prevention (CDC) recently reviewed 15 scientific studies of ignition interlocks. When an interlock is installed in a car or truck, it prevents that vehicle from being driven by anyone with a blood alcohol concentration (BAC) above a specified level, usually set at 0.02 to 0.04 grams per deciliter (g/dL). (The minimum illegal BAC level is 0.08 g/dL in every State.)

Interlocks can be installed in DUI offenders' vehicles to help prevent future episodes of impaired driving, which accounts for 11,000 deaths and nearly \$110 billion in health care and other costs each year. Use of interlocks often is mandated by a court or offered as an alternative to a suspended license, with most devices installed for 6 to 24 months.

Unfortunately, only a small proportion of DUI offenders participate in interlock programs. As of December 2010, only 13 States required interlocks for all convicted offenders, including those with first convictions. However, more than half of all States require some offenders — such as those with multiple convictions or extremely high BAC levels at the time of arrest — to install ignition interlocks.

The CDC review found that during the time interlocks were installed, re-arrest rates for alcohol-impaired driving were about 67% lower among drivers with interlocks than in a comparison group of drivers who did not use the devices. Based on this evidence of effectiveness, the CDC recommends ignition interlocks for everyone convicted of a DUI offense, even those with first convictions.

More information about causes and prevention of impaired driving is available at WWW.CDC.GOV/MOTORVEHICLESAFETY. Additional information on the review of ignition interlocks, including full-text articles released in the March 2011 issue of the *American Journal of Preventive Medicine*, can be found at [HTTP://WWW.THECOMMUNITYGUIDE.ORG/MVOI/AID/IGNITIONINTERLOCKS.HTML](http://WWW.THECOMMUNITYGUIDE.ORG/MVOI/AID/IGNITIONINTERLOCKS.HTML).

Combination Therapy Most Effective in Helping Smokers Quit

In a randomized clinical trial of five smoking-cessation treatments, a combination of the nicotine patch and nicotine lozenge produced the greatest benefit, as compared to placebo, in helping patients quit smoking and remain abstinent for at least six months.

While current public health guidelines recognize that several medications increase smokers' success in stopping tobacco use, a lack of comparative data makes it difficult for physicians and patients to choose one treatment over another.

FIVE TREATMENTS TESTED

Researchers at the University of Wisconsin's Transdisciplinary Tobacco Use Research Center tested five treatments side-by-side to determine how each performed relative to other treatments and to placebos. Study subjects were 1,504 adults who had smoked more than nine cigarettes a day, on average, for at least the preceding six months. All wanted to quit and had already tried to do so an average of five to six times. The smokers were moderately dependent on nicotine, based on the Fagerström Test, which is commonly used to measure degree of nicotine dependence.

Each participant was randomly assigned to one of five smoking-cessation treatments — the nicotine lozenge, the nicotine patch, bupropion, the nicotine patch plus the nicotine lozenge, or bupropion plus the nicotine lozenge — or to a placebo treatment designed to mimic one of the five regimens. Neither the participants nor the study staff knew who was receiving the active treatments. Varenicline (Chantix), a more recently introduced smoking cessation aid, was not included in the study.

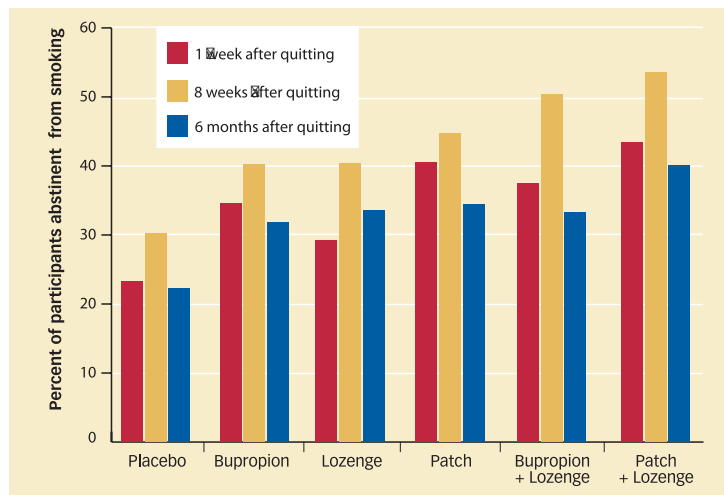
The patients began using bupropion and the corresponding placebo one week before their chosen quit date, and the other therapies and their respective placebos on the quit date. All the treatment regimens continued for eight weeks after the quit date except the nicotine lozenge and lozenge placebo, which continued for 12 weeks. All participants received two smoking-cessation counseling sessions before the quit date, one session on the quit date, and three additional sessions. Abstinence from smoking was confirmed by breath carbon monoxide levels measured during visits to the clinic.

MANY THERAPIES REDUCE SMOKING

Most of the patients in every group avoided smoking for at least one day during the week following their quit dates, but those receiving the active medications did so at higher rates than those receiving placebos. Patients assigned to three of the active regimens — the patch plus lozenge, bupropion plus lozenge, and the patch alone — were most likely to be abstinent on day 7 and at the end of the eight-week treatment period. (Abstinence rates for all the treatments peaked at the eight-week assessment.) However, at six-month follow-up, only the group using the patch plus lozenge had a significantly higher rate of abstinence than those receiving placebo: 40% versus 22%.

The patch plus lozenge combination also stood out as being one of two regimens — with bupropion plus lozenge — that signifi-

MANY THERAPIES REDUCE SMOKING



cantly increased the number of days from the quit date to relapse, which was defined as smoking on 7 consecutive days. All of the active medication regimens except the lozenge alone lengthened the interval between lapses (defined as taking a first puff on a cigarette after a period of abstinence) and relapses. (Investigators say the latter finding suggests that continuing medication after a lapse may reduce the chance of a relapse.)

EFFECTIVENESS ACROSS THE BOARD

The study results indicate that the combination of nicotine patch plus lozenge affords smokers the best chance of quitting. There are several possible explanations, according to the researchers. One is that this combination therapy provides two different ways to address withdrawal: a steady dose of nicotine from the patch, plus the as-needed lozenge to help with transient strong cravings or challenges induced by an environmental cue. "Alternatively, the effect may be due primarily to the higher nicotine dose from the two mechanisms of administration," Dr. Piper explained.

Dr. Piper also noted that, although the patch plus lozenge showed the best results relative to placebo, the quit rates for all the groups — including those receiving a placebo — were unusually high for a smoking-cessation trial. She suggested that this might be attributed to the counseling sessions, which may have been particularly effective, or to the high level of motivation on the part of participants, who had agreed to be part of a three-year clinical study of the physical and psychological consequences of smoking cessation.

SOURCE: Piper ME et al. (2009). A randomized placebo-controlled clinical trial of 5 smoking cessation pharmacotherapies. *Archives of General Psychiatry* 66(11): 1254–1262 (summarized in Reynolds S, NIDA Notes, 2011; 23:7-8).

Treatment with a nicotine patch and lozenge outperformed four other smoking-cessation therapies in a large clinical trial.

METHAMPHETAMINE: An Old Problem, New Again?

EDITOR'S NOTE: While the nation has been focused on the epidemic of prescription drug abuse, problems with other drugs are receiving less attention. ASAM News asked epidemiologists Jane C. Maxwell, Ph.D. and Mary-Lynn Brecht, Ph.D., for their assessment of one such drug: methamphetamine. Dr. Maxwell is Senior Research Scientist at the University of Texas at Austin and Dr. Brecht is a Research Statistician with the UCLA Integrated Substance Abuse Programs.

Jane Carlisle Maxwell, Ph.D. and Mary-Lynn Brecht, Ph.D.

The cyclical nature of methamphetamine use is well-documented in the literature.¹ Reductions in use often are accompanied by a lessening of attention to the problem, despite the fact that, over the past few decades, such reductions typically have been short-lived and followed by sometimes dramatic increases.

Recent data suggest that we are in a similar cycle now, with the decline in demand seen from 2005-2008 apparently reversing in 2009-2010, and notable increases seen in States that have had significant problems with methamphetamine in the past.

Of equal significance, but receiving less attention, is a recent change in the nature and dangerousness of methamphetamine use because of a reformulation of the drug itself.

CYCLES OF SUPPLY, DEMAND

Until the late 1980s and early 1990s, most methamphetamine for illicit use was supplied by "super labs" located in the southern California desert. However, in the mid-1990s, a smokable and highly pure form of d-methamphetamine hydrochloride, known as "ice," "crystal," or "tina," began to be shipped from the Far East to Hawaii² and from there to the West Coast of the U.S. This was followed by a gradual expansion of the supply route toward the East Coast.³

To meet the growing demand, a cadre of small-time local producers used over-the-counter cold medications containing ephedrine or pseudoephedrine to manufacture methamphetamine, using either the Birch reduction technique (the so-called "Nazi" method), which employed ephedrine or pseudoephedrine in combination with lithium and anhydrous ammonia, or the so-called "cold" method, which combined ephedrine or pseudoephedrine with red phosphorus and iodine crystals.⁴

Between 1989 and 1997, availability of ephedrine and pseudoephedrine in forms used by large-scale producers was partially disrupted by Federal regulations targeting bulk products, but precursors smuggled in from Mexico filled the void. However, 1995 and 2001 regulations targeting over-the-counter products had little or no impact.⁵ Further disruptions did occur in the mid-2000s as States began to limit access to over-the-counter pseudoephedrine products, followed by enactment of Federal restrictions (PL 109-177) in 2006.

The effects of the 2005-2006 limitations in the U.S., coupled with a 2008 ban on all ephedrine and pseudoephedrine in Mexico, were reflected in a sharp decline in treatment admissions in Texas and Mexico,⁶ in the number of methamphetamine samples seized and examined in forensic laboratories that report to the U.S. Drug Enforcement Administration (DEA), and in the number of clandestine laboratories manufacturing methamphetamine.^{7,8}

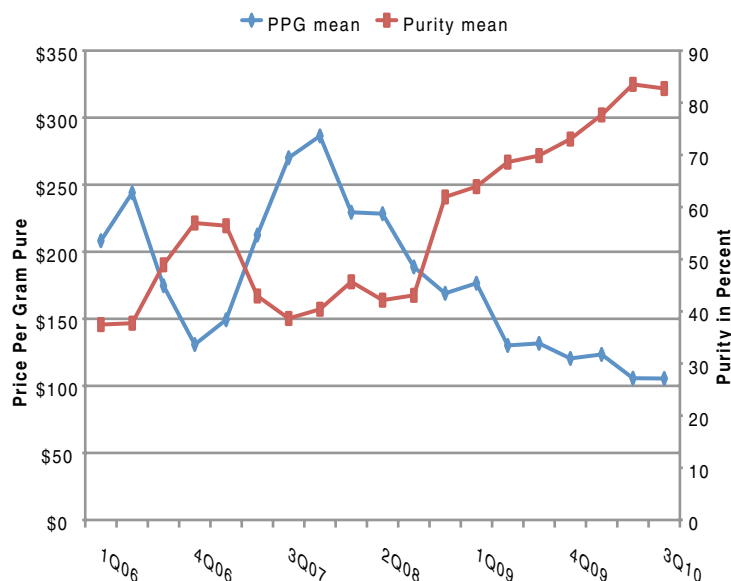
The cycle changed again in 2008. Local "cooks" continued to obtain quantities of precursor chemicals sufficient to make small amounts of methamphetamine. At about the same time, Mexican producers shifted to the phenyl-2-propanone (P2P) process, which uses chemicals other than pseudoephedrine.⁹ The changeover was

rapid: by the fourth quarter of 2010, some 69% of the domestic and Mexican samples examined by the DEA had been produced using the P2P process, while the older phosphorus method was identified in only 9% of the samples (the other 22% was produced using different combinations of ingredients or unknown precursors).¹⁰

Methamphetamine has two isomers: d- and l-. The d- form is associated with more potent physiologic and behavioral effects and higher abuse liability.¹¹ In one study, experienced users injected with d-, dl-, or l-methamphetamine gave l-methamphetamine significantly lower ratings for its ability to produce "intoxication" and "drug liking." In contrast, d-methamphetamine was reported to produce more intense stimulant effects and higher abuse liability.¹²

The DEA's examination of data submitted by law enforcement agencies found that, from July 2007 through September 2010, the purity of methamphetamine samples increased 114%, from 39% to 83%. At the same time, the price of a gram of methamphetamine dropped by 61%, from \$270 to \$105¹³ (see Figure 1).

Figure 1. Price and Purity of All Methamphetamine Purchases (DEA Data, 2006-2010)



DEA, Intelligence Division, Indications and Warning Section

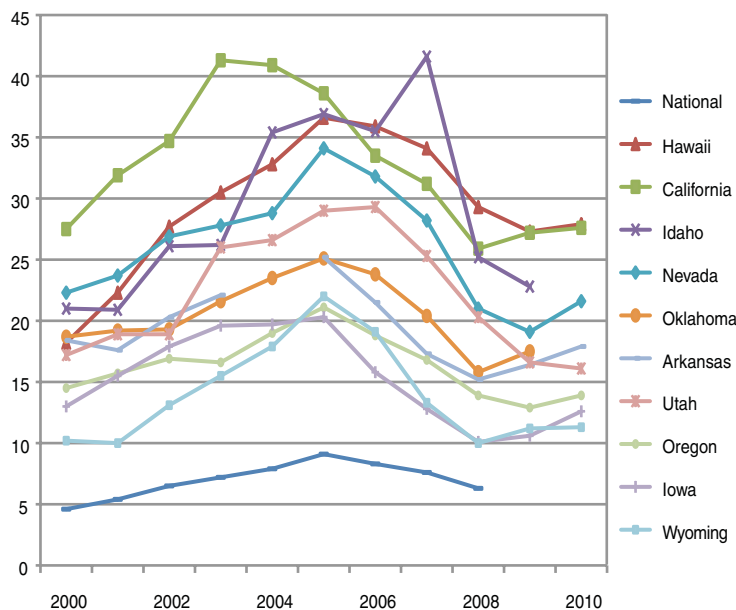
CHANGING INDICATORS OF DEMAND

Emergency department visits associated with methamphetamine declined from a rate of 45.3 per 100,000 in 2004 to 20.9 per 100,000 in 2009.¹⁴ National data on treatment admissions show a similar decline, from 172,270 (9.1% of all admissions) in 2005, to 127,000

(6.3% of all admissions) in 2008.¹⁵ However, the data also show considerable variation from one geographic region to the next. For example, 11 States reported that fewer than 1% of their 2010 TEDS admissions were for primary methamphetamine use, while two States reported that more than 27% of their admissions were methamphetamine-related.

In the 10 States with the highest percentages of methamphetamine treatment admissions, methamphetamine accounted for more than 20% of all admissions in the 2000-2010 period. Those 10 States accounted for more than 60% of all methamphetamine admissions in 2009-2010. In each State, some reduction in methamphetamine admissions followed the peak in 2005, but all showed a leveling-off of the reductions or an actual increase from 2008 to 2010. In several States, levels of methamphetamine admissions to treatment were as high as those seen in the early 2000s. For example, methamphetamine admissions in Oregon accounted for 14.5% of the State's admissions in 2000, rising to 21.1% in 2005, then declining to 12.9% in 2009 and rising again to 13.9 in 2010¹⁵ (see Figure 2).

Figure 2. Methamphetamine-Related Admissions to Addiction Treatment, 2000-2010, National and Selected States



Other indicators also suggest that demand for methamphetamine is increasing. For instance, an upward trend in methamphetamine use has been captured by the National Survey on Drug Use and Health (NSDUH), an annual survey of 68,700 individuals. NSDUH data show increases between 2008 and 2009 in both the number of new users and the prevalence of past month use¹⁶; results were significant at the $p=.05$ level.

CONCLUSIONS

Supply and demand data show that methamphetamine indicators are again increasing in certain parts of the U.S., following several years of decline in the mid-2000s. This change parallels a continuing refinement of methods so as to produce a purer and more potent product. Of particular concern are reports from the DEA that Mexican manufacturers are looking to other areas of the world for the required chemicals, and that Asian manufacturers (who use

ephedrine and pseudoephedrine to produce large quantities of very pure methamphetamine) may become important suppliers of methamphetamine in the U.S.

Changes also are apparent in the preferred routes of administration, as methamphetamine users shift away from powdered product that must be injected or inhaled and toward a crystalline product that can be smoked. In addition, the increasing purity and potency of may result in the shortening of the time between initial use of methamphetamine and addiction to the drug.

Finally, experience suggests that the U.S. may be approaching a point at which methamphetamine will become established as a major chronic drug problem like cocaine and heroin. This points to the need for continuing attention to control and interdiction strategies, as well as efforts to prevent initiation of methamphetamine use and development of improved treatment approaches and increased treatment capacity, particularly in States such as California where the need is already apparent.

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ASAM Leaders Address Annual Business Meeting

ASAM's annual business meeting on Friday, April 15th, brought together past, present and future leaders of the Society.

In a very special observance, Stanley E. Gitlow, M.D., FASAM, FACP, was honored on the 50th anniversary of his inauguration as ASAM President as he watched his son, Stuart Gitlow, M.D., M.P.H., assume the office of President-Elect. The younger Dr. Gitlow reflected on the changes in medical practice over that time — from more personal care to guideline-oriented medicine, “where people will be treated as if on a production line.” He added: “As to what our future holds as physicians, as addiction specialists, and as an organization, the challenge is clear — we must protect the individuality of our patients, retain our own individuality as physicians, and ensure that our organization always leads the way rather than following unacceptable choices made by others.”

Outgoing President Louis E. Baxter, Sr., M.D., FASAM, reflected on his term in office and was rewarded with a plaque recognizing his service to ASAM (see page 5 for a summary of his report at the meeting).

Immediate Past President Michael M. Miller, M.D., FASAM, offered his own going-away comments, which drew a standing ovation from attendees.

The chartering of the new Northern New England Chapter of ASAM was formally announced.

Ruth Fox Scholarships to Be Awarded

The application period for 2012 Ruth Fox Scholarships has opened. The scholarships cover travel expenses and registration fees for ASAM's 43rd Annual Medical-Scientific Conference, to be held April 19-22, 2012, in Atlanta, Georgia, as well as a three-year membership in ASAM.

As in years past, ASAM provides the scholarships as a way to help physicians-in-training learn about addiction. The scholarships are funded by interest income from the Ruth Fox Memorial Endowment Fund, with additional support from the National Institute on Drug Abuse.

Applications must be received no later than November 30, 2011. See the application form in this issue of ASAM News.

ONDCP Leader Thanks ASAM for Support

During a policy plenary session on “Health Reform and Parity Implications for Addiction Medicine,” David K. Mineta, M.S.W., Deputy Director for Demand Reduction in the White House Office of National Drug Control Policy (ONDCP) thanked ASAM for its support of the Nation's drug control strategy. “The relationship and partnership between ONDCP and ASAM is of critical importance to the field and the millions of people we are able to serve,” Mr. Mineta said. “Our office relies on continued coordinated effort with ASAM to ensure that doctors and other health care providers receive ongoing communication in addiction medicine.”

The Administration's 2011 National Drug Control Strategy gives high priority to educating physicians about addiction, promoting the appropriate role of physicians in the care of patients with addictive disorders, establishing addiction medicine as a recognized medical specialty, and supporting addiction research and prevention.

Mr. Mineta specifically commended the American Board of Addiction Medicine (ABAM) achievement in accrediting 10 new residency training programs in addiction medicine, noting that “a shortage of health care professionals knowledgeable about addiction does not allow the health care field to efficiently identify addicts early enough to provide them with much-needed services that could stem the tide of addiction.” He called the current lack

of knowledge about addiction “tragic” for patients, “because undetected substance abuse complicates other illness and exponentially increases health care costs, affecting local economies.”

Closing with an invitation to ASAM to continue the close collaboration with ONDCP, Mr. Mineta said that “if we can meet the challenges that confront us now, we will be able to look back on this period...as game-changing.”



ONDCP Deputy Director David K. Mineta, M.S.W., addresses a policy plenary session during the Med-Sci Conference.

ASAM Members Visit the Capitol on Legislative Day

More than 35 ASAM members spent a day in Washington visiting their members of Congress to discuss addiction-related issues. As in years past, ASAM's Legislative Advocacy Committee organized the day to allow members of the Society to speak directly to Congress members and their staffs about issues of importance to the specialty. The effort has the strong support of incoming ASAM President Don Kurth, M.D., who once held public office as the mayor of Rancho Cucamonga, California.

Ken Roy, M.D., FASAM, chair of ASAM's Legislative Advocacy Committee, explained that the purpose of Legislative Day is “to help legislators understand that addiction is truly a medical illness and what the data has so far demonstrated about the effectiveness and cost-effectiveness of treatment.”

The day began with a training session, featuring an address by Rep. Paul Tonko (D-NY) and advice on how to approach legislators. ASAM members spent the rest of the day on Capitol Hill meeting with their Senators and Representatives. Dr. Roy reports that a major topic of discussion was health care reform, explaining that “The fight's not over with the passage of legislation, because there is subsequent rule-making and then actual practice.” He added that ASAM members have “a strong interest in advocating that whatever evolves [will] continue to include the treatment of addiction at parity...with other health conditions.”

Awards Honor Contributions to Addiction Medicine

ASAM recognized outstanding contributions to the Society and to addiction medicine during the annual Awards Luncheon, a highlight of which was the presentation of the John P. McGovern Award on Addiction and Society to addiction researcher and educator A. Thomas McLellan, Ph.D., former Deputy Director of the White House Office of National Drug Control Policy and founder of the Treatment Research Institute at the University of Pennsylvania. Established in 1997 to honor an individual who has made highly meritorious contributions to public policy, treatment, research, or prevention and who has increased our understanding of the relationship of addiction and society, the award is sponsored by an endowment from the John P. McGovern Foundation.

Also during the luncheon, ASAM Annual Awards were given to Kevin Kunz, M.D., M.P.H., FASAM, "for outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine," and to Marc Galanter, M.D., FASAM, "for expanding the frontiers of the field of addiction

.....
ASAM recognized outstanding contributions to the Society and to addiction medicine during the annual Awards Luncheon...

medicine and broadening our understanding of the addictive process through research and innovation."

The Young Investigator Award went to Randall Brown, M.D., Ph.D., "for the best abstract submitted by an author who is within five years of receipt of a doctoral degree." The Medical-Scientific Committee Program Committee Award went to Hannu Alho, M.D., Ph.D., "for the submitted abstract receiving the highest rating for its scientific merit." The ASAM Media Award recognized writer and producer Dirk Wales for his DVD series, "Wearing Masks."

Awards also went to outgoing Board Members R. Jeffrey Goldsmith, M.D.; Margaret

A.E. Jarvis, M.D., FASAM; Michael M. Miller, M.D., FASAM, FAPA; Marvin D. Seppala, M.D.; C. Chapman Sledge, M.D., FASAM; Scott Smolar, D.O.; and Penelope P. Ziegler, M.D., FASAM; Medical-Scientific Conference Chair Gavin Bart, M.D.; Ruth Fox Course for Physicians Course Co-Directors Margaret A. E. Jarvis, M.D., FASAM, and John C. Tanner, D.O., FASAM; and Pain and Addiction Common Threads Course Co-Directors Herbert Malinoff, M.D., FACP, FASAM, and Edwin A. Salsitz, M.D., FASAM. Louis E. Baxter, Sr., M.D., FASAM, received the ASAM President's Award.

A special Employee Achievement Award was given to Claire Osman in recognition of her 40 years of service to ASAM. Ms. Osman was recognized for her notable achievements in promoting education and training in addiction medicine; for being instrumental in establishing ASAM as a viable, thriving Society; for tirelessly soliciting support for the Society's programs, including the Ruth Fox Memorial Endowment Fund; and for other significant contributions that demonstrate her "wisdom, generosity, and respect for persons suffering from addiction."

New Diplomates Recognized at Awards Luncheon



The new class of ABAM Diplomates gathered at the ASAM Awards Luncheon to be recognized for their achievement in passing the Certification/Recertification Examination. A complete list of those recognized appears in the Supplement to the emailed ASAM News.

RUTH FOX MEMORIAL ENDOWMENT FUND



Dr. Ruth Fox

Dear Colleague:

Six Ruth Fox Scholarship winners were recognized during the annual Donor Reception at ASAM's Med-Sci Conference. Additional funding for the scholarships was provided by the National Institute on Drug Abuse and the Christopher D. Smithers Foundation. Recipients of 2011 Ruth Fox Scholarships are: Timothy J. Cordes, M.D. Ph.D. (Madison, Wisconsin); Katherine Grieco, D.O. (New Haven, Connecticut); Vanessa Lentz, M.D., (Cambridge, Massachusetts).

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

The reception, which was sponsored by Dr. & Mrs. Joseph E. Dorsey, M.D., FASAM, and Dr. Tommie E. Lauer, also honored contributors to the Ruth Fox Endowment Fund. Max Schneider, M.D., FASAM, received an award for his years of service as chair of the Ruth Fox Endowment Fund and of the Ruth Fox Scholarship Program. Medallions also were presented to longtime supporters of the Ruth Fox Endowment Fund. The following donors were also recognized:

Receiving the Bronze Medallion:

Dr. Theodore Hunter
Dr. Richard and Mrs. Cheryl McKinley
Dr. Rohinton Merchant
Dr. Norman Wetterau

Receiving the Silver Medallion:

Dr. Sarz Maxwell
Dr. J. Ramsay Farah
Dr. Michael Liepman
Dr. Michel Sucher

Receiving the Gold Medallion: Dr. Terry and Mrs. Laura Rustin

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

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

Claire Osman
Director of Development

8th Annual INEBRIA Conference

September 21-23, 2011
Liberty Hotel, Boston

The INEBRIA Conference communicates new findings from research on screening and brief intervention (SBI, also known as early identification and brief intervention, EIBI), fosters professional collaboration, and facilitates the development and dissemination of SBI research, with a particular focus on implementation and sustainability.

September 21:

Implementing and Sustaining Alcohol and Other Drug Screening and Brief Intervention (AOD-SBI) Meeting: Lessons from Large Scale Efforts

September 22-23:

New Frontiers:
Translating Science to Enhance Health

To register for the conference, go to:
www.inebriaboston.org

or
<http://www.bumc.bu.edu/care/inebria/>

For more information, contact:
info@inebriaboston.org

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DR. JOHN N. CHAPPEL

John N. Chappel, M.D., passed away at his home in Reno, Nevada, on March 9th. He was 79 and had courageously battled prostate cancer and Parkinson's disease.

Born in Grande Prairie, Alberta, Canada, Dr. Chappel received his medical degree from the University of Alberta. He went on to earn a Masters in Public Health from Harvard University. He completed his residency in psychiatry at the University of Chicago, and was a member of their medical school faculty from 1968-1974.

He later was named a Distinguished Professor at the University of Nevada, Reno, where he taught in the medical school from 1974 to 2009.

Dr. Chappel was a pioneer of addiction medicine, an early champion of treatment for impaired physicians, and medical director of an opioid treatment program. His knowledge of the scientific basis of Alcoholics Anonymous and other mutual help programs made him a popular speaker at courses offered by ASAM and other organizations, and he contributed chapters on the topic to ASAM's textbook, Principles of Addiction Medicine. He was devoted to helping others, including his students, his patients, his community, and his family.

With his wife, Valerie Macdonald Chappel, he traveled the world, beginning with a stint in Malaysia with Care Medico from 1962-1964. Dr. and Mrs. Chappel took multiple trips to Valerie's native Scotland and many trips to scuba dive in the South Pacific and the Caribbean. In addition to his wife, Dr. Chappel is survived by three daughters and six grandchildren.



DR. G. ALAN MARLATT

G. Alan Marlatt, Ph.D., professor of psychology at University of Washington, died of melanoma on March 14th at age 69. An internationally respected researcher, Dr. Marlatt wrote or edited more than 20 books and hundreds of journal articles, and received major awards for his contributions to the fields of alcoholism and substance abuse.

As a researcher and director of the University of Washington's Addictive Behaviors Research Center, Dr. Marlatt was one of the first researchers to examine the scientific basis of relapse in addiction treatment and to develop and systematically test ways to help prevent an addict's slip from becoming a full-blown relapse. He also developed techniques to reduce the harm associated with college binge-drinking. His most recent studies explored the use of mindfulness meditation in recovery from addiction and depression.

His friends, family and colleagues remembered him with great admiration. "Alan was a trail-blazing, game-changing researcher, clinician and academic. He was always out on the edge, challenging conventional wisdom in search of what is true about substance misuse and what is most helpful to people struggling with these issues.... He was the person who invented relapse prevention," said Andrew Tatarsky, Ph.D., a New York City psychologist specializing in addiction.

Dennis Donovan, Ph.D., director of the Alcohol and Drug Abuse Institute at the University of Washington and one of the many researchers Dr. Marlatt mentored over his career, added that "he was a visionary and a luminary. He generated ideas that were ahead of their time in so many different ways."



DR. CHARLES R. SCHUSTER

Former Director of the National Institute on Drug Abuse and noted researcher Charles R. (Bob) Schuster, Ph.D., died of a stroke on February 21st in Houston, Texas.

Dr. Schuster received his doctorate in psychology from the University of Maryland in 1962 under the mentorship of Professor Joseph V. Brady. After six years in the Department of Pharmacology at the University of Michigan, he joined the Departments of Psychiatry, Pharmacology, and Behavioral Sciences and founded the University of Chicago's Drug Abuse Research Center.

In 1986, Dr. Schuster was appointed Director of the National Institute on Drug Abuse, a position he held until 1992. On leaving government, he joined Wayne State University as Professor in the Department of Psychiatry and Behavioral Neurosciences, and later was named director of that university's Addiction Research Institute. Over the course of his career, he won numerous awards and authored more than 250 journal articles, as well as numerous book chapters and several books.

In a letter posted on the NIDA web page, Director Nora Volkow, M.D., said: "Bob's prodigious career includes seminal contributions that will continue to illuminate the path of future generations of behavioral pharmacologists and neuroscientists. His achievements would be too many to list. But he was a true visionary.... He left us not only a plethora of discoveries and achievements from which to draw inspiration, but also the memory of a gentle and generous man who was able to make a difference in the lives of millions through the work that he so much loved."

In recognition of their many contributions to the science and practice of addiction medicine, ASAM's Board has directed that the Society's 2011 Course on the State of the Art in Addiction Medicine shall be dedicated to the memory of Dr. Chappel, Dr. Marlatt, and Dr. Schuster.



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ASAM CONFERENCE CALENDAR

ASAM EVENTS

October 27-29, 2011
 ASAM Course on the State of the Art in Addiction Medicine
 Washington Hilton Hotel
 Washington, DC

December 2-4, 2011
 Comprehensive MRO Course:
 Toxicology Testing and the Physician's Role in the Prevention and Treatment of Substance Abuse
 (Approved for 20 AMA PRA Category 1 credits)
 Capitol Hilton Hotel
 Washington, DC

April 19-22, 2012
 43rd Annual Medical-Scientific Conference
 Atlanta, Georgia

September 20-22, 2012
 ASAM Review Course in Addiction Medicine
 Nashville, Tennessee

ASAM CHAPTER EVENTS

August 26-27, 2011
 Georgia Society of Addiction Medicine
 2011 Summer Conference
 Atlanta, Georgia
 For information or to register, contact Robin McCowan at 678-447-1595

September 8-11, 2011
 Cape Cod Symposium on Addictive Disorders
 (in partnership with the ASAM New England Chapters)
 Hyannis, Massachusetts
 For information or to register, go to [HTTP://CCSAD/COM](http://CCSAD/COM)



September 15-16, 2011
 Texas Society of Addiction Medicine Annual Business Meeting and 4th Annual Addiction Symposium: "Walking the Tightrope of Pain Management"
 Austin, Texas
 To register, phone 512-669-1188

October 12-15, 2011
 California Society of Addiction Medicine
 Addiction Medicine State of the Art
 2011 Hyatt Regency Hotel
 Long Beach, California
 To register, go to [HTTP://WWW.CSAM-ASAM.ORG](http://WWW.CSAM-ASAM.ORG)

OTHER EVENTS OF NOTE

September 6-10, 2011
 International Society of Addiction Medicine Annual Conference, Oslo, Norway
 For more information visit [HTTP://WWW.ISAMWEB.ORG](http://WWW.ISAMWEB.ORG)

November 3-5, 2011
 Association for Medical Education and Research in Substance Abuse (AMERSA) 35th Annual National Conference
 Sheraton Crystal City Hotel, Arlington, Virginia
 For more information or to register, go to [HTTP://WWW.AMERSA.ORG/CONF.ASP](http://WWW.AMERSA.ORG/CONF.ASP)

December 8-11, 2011
 American Academy of Addiction Psychiatry 22nd Annual Meeting and Symposium
 Scottsdale Resort & Conference Center
 Scottsdale, Arizona
 For more information or to register, go to WWW.AAAP.ORG

Find even more coverage in the Supplement to your email edition of this
ASAM NEWS:

- ✓ **Medical Marijuana:** Dr. Kurth describes a hard-won success in Montana.
- ✓ **Treatment:** New research on the link between methadone and cardiac arrhythmias.
- ✓ **News to Use:** SAMHSA's treatment advisory on patients with traumatic brain injury; a parity action toolkit; and a new smart phone app with prescribing information
- ✓ **Funding Opportunities:** NIH support for drug discovery
- ✓ **Around the States:** Policy developments in your State.
- ✓ **Member News:** A complete list of those who have been Certified or Recertified in Addiction Medicine by ABAM.



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 Upper Arcade, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email EMAIL@ASAM.ORG.

MoreASAMNews

Supplement to the Newsletter of The American Society of Addiction Medicine

Online Supplement to Volume 26, Number 2, 2011

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- ★ *Around the States: Recent legislative and policy developments*
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Medical Marijuana

Legislation Defeated in Montana, Survives Elsewhere

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

In May, legislators in Delaware joined those in 15 other States and the District of Columbia in voting to legalize "medical marijuana." I have been directly involved in the fall-out from a marijuana ballot initiative that passed in Montana in 2004 and want to keep all of you fully informed. But before I get to that, let me give you a little background. My great grandparents moved to Fort Benton, Montana, shortly after the Big Sky Country achieved statehood in 1889. Although I now live in California, I have many friends and relatives living throughout Montana. Some of those friends are at the Rimrock Foundation, a highly respected non-profit addiction treatment program in Billings. When they invited me to give a talk on "medical marijuana," I just could not turn them down. So on a blustery, snowy day this past February, I spoke in Billings for Rimrock's Recovery Day. After the talk, I flew back to sunny southern California and thought nothing further of my chilly northern visit.

But a few weeks later, I received a call from Mike Milburn, Speaker of the Montana House of Representatives. He asked if I could fly to the State capital, Helena, the following day to present my talk to a joint meeting of the Montana Senate and House of Representatives. So early the next morning, I headed back to the Big Sky Country to do what I could to help clear the air on this issue.

After the Montana medical marijuana ballot initiative was approved in 2004, use of marijuana spread slowly at first, with only a thousand people applying for cards that allowed them to purchase marijuana at dispensaries during the first six years. However, in late 2009, the U.S. Department of Justice issued the "Ogden memo," which essentially said that Federal agencies would not focus their resources on medical marijuana users who were in compliance with State law. This change in Federal policy led to an almost overnight boom in the medical marijuana industry in Montana, as growers hired marijuana-sympathetic physicians and sent medical caravans across the State to sign up new cardholders.

The result was that, in just over a year, the number of cardholders mushroomed from 1,000 to 30,000. Today, it is growing at a rate of more than 1,000 per month. Some local experts have estimated that the number will reach 68,000, in a state with fewer than one million residents. Similarly, the number of "caregivers" (marijuana distributors) has increased from a few hundred to more than 5,000.

Only a few growers and distributors seem to be producing marijuana on a large scale, but they appear to be producing the drug in quantities far in excess of what could possibly be used by the number of Montana citizens who currently hold medical marijuana cards. Not surprisingly, surrounding States have begun to complain about the export of Montana marijuana to their cities and towns. Think about it: while it is risky and difficult to transport truckload quantities of marijuana across the Mexican border into the U.S., driving a load of marijuana from Montana to Idaho, Wyoming or South Dakota, and from there to Los Angeles, New York or Boston, you just have to load a pickup truck or a semi, tie a tarp over the top, and off you go.

Until recently, Montana had seen a decades-long decline in marijuana use in the public schools. That trend has reversed since medical marijuana consumption took off, and marijuana now exceeds even alcohol as the drug of choice among high school students. Medical marijuana card holders' purchases are limited to one ounce of marijuana at a time. But reports indicate that as each ounce is purchased, the cardholder simply walks outside, sells it to his friends for a profit, and walks back into the "caregiver" to purchase another ounce. This can happen six, eight, or ten times every day, generating huge profits for all involved.

One might ask how this problem erupted in healthy, middle-America Montana. The answer is that, with a population of less than a million, a little bit of political money goes a long way. The campaign to approve medical marijuana by voter initiative in 2004 cost only

\$550,000. Public records show that, of that amount, only \$38 came from within the State, with all the rest given by out-of-state funders. The media blitz that ensued was unexpected, and focused on compassionate end-of-life care for elderly patients suffering from terminal cancer or similar illnesses. The mostly rural Montanans were simply unprepared to oppose the initiative.

Nor did anyone expect the chaos that followed. Medical marijuana “caregivers” are making millions of dollars a year and many Montanans are desperately afraid that the marijuana producers will soon dominate the political scene. In a State the size of Montana, a million dollar campaign war chest can make anybody a very viable candidate for governor.

Once I arrived in Helena, the Speaker briefed me on the political lay of the land and my work began. I met privately with dozens of legislators either individually or in small groups or committees to discuss the science of marijuana. A few of them were highly informed, others less so, and a fair number were terribly misinformed with regard to the facts about marijuana.

I was invited to speak in the historic Montana Supreme Court chambers to a combined group of House and Senate legislators. I attribute my warm reception, at least in part, to my stories of my great-grandparents’ pioneer days in Montana shortly after Statehood was achieved. But the fact is that the legislators were thirsty for factual information and asked many perceptive questions.

I also had the pleasure of meeting a group of deeply concerned parents from Billings, Montana, who had formed a group called Safe Neighborhoods — Safe Kids to help educate the legislators. Their dedication to this issue was truly moving.

Resources for Combating Marijuana Initiatives

The California Society of Addiction Medicine’s President, Tim Cermak, M.D., has compiled a compendium of fully referenced marijuana facts, which is available on the CSAM website at WWW.CSAM-ASAM.ORG.

Also, in a number of communities, local coalitions have been working for adoption of policies that would ban marijuana dispensaries at the local level. For information on how those efforts work, visit [HTTP://WWW.CADCA.ORG/POLICYADVOCACY/PRIORITIES/MARIJUANA](http://WWW.CADCA.ORG/POLICYADVOCACY/PRIORITIES/MARIJUANA).



ASAM’s Policy on Medical Marijuana

[Excerpts from ASAM’s 2010 policy statement follow]

... In order to think clearly about “medical marijuana,” one must distinguish first between (1) the therapeutic potentials of specific chemicals found in marijuana that are delivered in controlled doses by nontoxic delivery systems, and (2) smoked marijuana.

Second, one must consider the drug approval process in the context of public health, not just for medical marijuana but also for all medicines and especially for controlled substances. Controlled substances are drugs that have recognized abuse potential. Marijuana is high on that list because it is widely abused and a major cause of drug dependence in the United States and around the world. When physicians recommend use of scheduled substances, they must exercise great care. The current pattern of “medical marijuana” use in the United States is far from that standard.

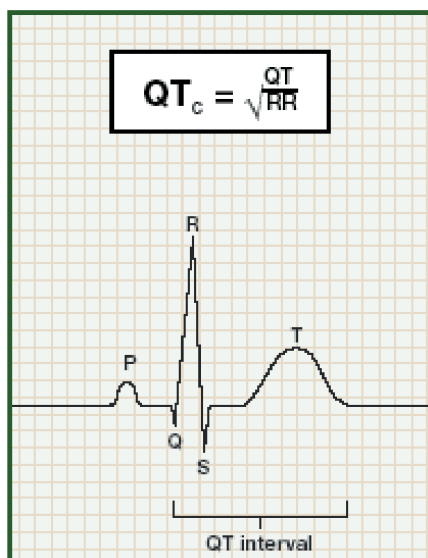
If any components of marijuana are ever shown to be beneficial to treat any illness, then those components can and should be delivered by nontoxic routes of administration in controlled doses, just as all other medicines are in the U.S.

In order for physicians to fulfill their professional obligations to patients, and in order for patients to be offered the high standard of medical care that we have come to expect in the United States, cannabis-based products must meet the same exacting standards that we apply to other prescription medicines. Members of the American Society of Addiction Medicine (ASAM) are physicians first and experts in addiction medicine with knowledge specific to the risks associated with the use of substances with high abuse potential. ASAM must stand strongly behind the standard that any clinical use of a controlled substance must meet high standards to protect the patient and the public; the approval of “medical marijuana” does not meet this standard.

RECOMMENDATIONS

1. ASAM asserts that cannabis, cannabis-based products, and cannabis delivery devices should be subject to the same standards that are applicable to other prescription medications and medical devices and that these products should not be distributed or otherwise provided to patients unless and until such products or devices have received marketing approval from the Food and Drug Administration.
2. ASAM rejects smoking as a means of drug delivery, since it is not safe.
3. ASAM recognizes the supremacy of Federal regulatory standards for drug approval and distribution. ASAM recognizes that States can enact limitations that are more restrictive but rejects the concept that States could enact more permissive regulatory standards. ASAM discourages State interference in the Federal medication approval process.

4. ASAM rejects a process whereby State and local ballot initiatives approve medicines, because these initiatives are being decided by individuals not qualified to make such decisions (based upon a careful science-based review of safety and efficacy, standardization and formulation for dosing, or provide a means for a regulated, closed system of distribution for marijuana, which is a CNS drug with abuse potential).
5. ASAM recommends its members and other physician organizations and their members reject responsibility for providing access to cannabis and cannabis-based products until such time that these materials receive marketing approval from the Food and Drug Administration.
6. ASAM asserts that physician organizations operating in States where physicians are placed in the gate-keeping role have an obligation to help licensing authorities assure that physicians who choose to discuss the medical use of cannabis and cannabis-based products with patients:
 - Adhere to the established professional tenets of proper patient care, including
 - History and good faith examination of the patient;
 - Development of a treatment plan with objectives;
 - Provision of informed consent, including discussion of side effects;
 - Periodic review of the treatment's efficacy;
 - Consultation, as necessary; and
 - Proper record keeping that supports the decision to recommend the use of cannabis
 - Have a bona fide physician-patient relationship with the patient, i.e., should have a pre-existing and ongoing relationship with the patient as a treating physician;
 - Ensure that the issuance of "recommendations" is not a disproportionately large (or even exclusive) aspect of their practice;
 - Not issue a recommendation unless the physician has adequate information regarding the composition and dose of the cannabis product;
 - Have adequate training in identifying substance abuse and addiction. *(Adopted by the ASAM Board of Directors, April 2010)*



Prolonged QT interval on electrocardiogram

Treatment

ECG May Not Be Sufficient to Detect Cardiac Problems in Patients Taking Methadone

Controversy surrounds the question of whether methadone prolongs QT interval, sometimes leading to the potentially life-threatening problem of Torsades de Pointes, as well of the corollary question of which patients should undergo electrocardiographic (ECG) screening and when.

A study presented at the American Pain Society's 30th Annual Scientific Meeting found a dose-dependent effect on QT interval in patients taking more than 120 mg of methadone per day.

To assess the issue, researchers from New York's Beth Israel Medical Center performed a single ECG and 24-hour Holter monitoring study of patients older than age 50 (age increases risk for QTc) who had received methadone for the treatment of chronic pain. Study subjects also were monitored for electrolytes (K, Ca, Mg) drawn during the first visit and repeated 8 weeks later during the second visit.

Subjects were grouped on the basis of methadone dose: 0 mg, 10–40 mg, 41–120 mg, and more than 120 mg per day. All data were analyzed by an experienced cardiologist.

Of 39 subjects who completed an initial visit, a single ECG detected QT prolongation in 15 patients (males >430ms; females >450ms; 5/15>500ms). Of those 15 patients, 12 had at least one Holter reading that showed QTcP in 11 (5/11>500ms). Of the five patients with QTc >500ms by EKG, three had correlative Holter readings that detected two QTc. Of the 36 patients that had at least one Holter reading, 21 showed QTcP that was detected by EKG in 11 patients. A time point analysis showed EKG/Holter QTcP detection: 12a.m.=10/12; 6a.m.=9/17; 12p.m.=7/15; and 6p.m.=9/13. At baseline, patients in the >120mg group showed significantly higher QTcP than the lower three dose groups (479.3 ± 82.5 vs. 439.8 ± 32.4, P=0.01). A single EKG detected fewer patients with QTcP than Holter (15 vs. 20) but the same number of patients with QTc >500ms.

Investigators concluded that there is a dose dependent effect on QTcP with patients taking more than 120mg/day of methadone compared with lower doses. Twenty-four hour Holter monitoring detected twice as many patients with prolonged QTc than did ECG at 12 noon, suggesting that one ECG may not be sufficient to identify patients at risk.

News to Use

Two New Tools to Help Patients with TBI

Traumatic brain injury (TBI) is a frequent but under-recognized condition that frequently occurs in combination with substance use disorder (SUD). TBI can cause a wide range of cognitive and behavioral consequences that interfere with an individual's ability to progress in addiction treatment. Moreover, epidemiologic surveys have established that acute intoxication or SUD dramatically increase the risk of, and impair recovery from, TBI.

Two new resources can help physicians and other health care professionals address the problem. The Department of Defense has released a new mobile application for health care professionals, the Mild Traumatic Brain Injury Pocket Guide. The app, which was developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and developed at the National Center for Telehealth & Technology (T2), provides a quick reference that includes clinical practice guidelines for assessing and treating persons with mild traumatic brain injury. Although developed for military personnel, the guidance is useful for all patients. The mobile app is free and available for download at <https://market.android.com/details?id=org.t2health.mtbi>.



Specifically for addiction treatment professionals, the Substance Abuse and Mental Health Services Administration (SAMHSA) has released a Substance Abuse Treatment Advisory titled "Treating Clients with Traumatic Brain Injury" (Vol. 9, Issue 2, 2010). The advisory covers the incidence and prevalence of TBI, its relationship to substance use disorders, TBI diagnosis and treatment, and the implications of TBI for addiction treatment.

To order a free copy of the advisory, phone SAMHSA at **1-877-SAMHSA-7**.

The Parity Toolkit for Addiction and Mental Health Consumers, Providers and Advocates: Simplifying the Appeals Process: Strategies for Winning Disputes with Your Health Plan is a new resource from the Parity Implementation Coalition. Learn all about the law — including how to file complaints and appeal denied claims if you need to. For more information about the Parity Implementation Coalition, go to WWW.MENTALHEALTHPARITYWATCH.ORG.

The Parity Action Toolkit

The toolkit was released just as researchers at Harvard University and the RAND Corporation demonstrated that providing parity in benefits for addiction treatment reduces patients' out-of-pocket costs but has almost no impact on insurers' overall costs.

In the first study to look specifically at the impact of parity on utilization of addiction treatment services, the Harvard and RAND researchers examined the spending and services used between 1999 and 2002 by continuously enrolled participants in six Federal Employees Health Benefit (FEHB) plans, and compared them with the spending and services used by participants in matched health plans that did not require parity in coverage. They found no significant difference in the rate at which participants in parity plans utilized addiction treatment. Out-of-pocket spending by the parity group dropped appreciably (the mean difference in per capita spending between the plans requiring parity and those that did not was \$101.09), but total plan spending per participant was not significantly different between the parity and non-parity plans.

Concluded Vanessa Azzone, Ph.D., who led the study: "Policymakers should be assured that the parity law does what it's supposed to do: lower out-of-pocket expenses for covered individuals, not increase the overall costs." The study, "Effect of Insurance Parity on Substance Abuse Treatment," was published in the February 2011 issue of the journal *Psychiatric Services*.

MedScape App Features Prescribing Information

MedScape® — the world's largest provider of online medical information — has announced a new app for Blackberry and other "smart phones" to help physicians quickly access clinically important information on drugs they are considering prescribing.

For example, the app (which can be downloaded at no charge) features a Drug Reference that allows users to search prescribing and safety information for more than 8,000 brand-name, generic and over-the-counter drugs, as well as herbals and supplements. For each drug, the app provides information on adult and pediatric dosing, adverse effects, contraindications, cautions and warnings, pregnancy and lactation guidelines, and more.

Another feature, the Drug Interaction Checker, allows users to research any drug or combination of drugs, herbals and supplements for a range of adverse events, from mild interactions to serious contraindications. The program covers more than 8,000 drugs and other agents, and provides detailed information on each potential interaction.

MedScape says that the app can be accessed anywhere, because no Internet connection is required (after full installation of the app on a phone or tablet device). For more information, go to WWW.MEDSCAPE.COM.



Funding Opportunities

NIH Program Supports Drug Discovery

The National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) invite applications to advance the discovery, preclinical development, and proof of concept testing of new, rationally based candidate medications to treat mental disorders or drug or alcohol addiction, and to develop novel ligands as tools to further characterize existing or to validate new drug targets.

The purpose of the National Cooperative Drug Discovery/Development Group (NCDDG) Program is to create multidisciplinary research groups or partnerships for the discovery of pharmacological agents to treat and to study mental illness, drug or alcohol addiction. Eligible applicants include public and private universities, other not-for-profit organizations, for-profit organizations and small businesses. Partnerships between academia and industry are strongly encouraged.

Objectives of the program are to accelerate innovative drug discovery; to develop pharmacologic tools for basic and clinical research on mental disorders, or drug or alcohol addiction; to develop and validate models for evaluating novel therapeutics for mental disorders; and to support early-phase human clinical testing to rapidly assess the safety and efficacy of promising drug candidates and new indications for IND-ready drugs for the treatment of mental disorders or alcohol addiction.

The full announcement is available at <http://grants.nih.gov/grants/guide/pa-files/PAR-11-206.html> (funding opportunity number PAR-11-206). The closing date for applications is February 22, 2013.

Around the States

California: Bill Would Ban Alcohol Sales at Self-Service Checkouts

A bill under consideration by the California Senate would ban retailers from selling alcohol through self-service checkouts. The bill already has been approved by the state Assembly.

The bill aims to make it more difficult for minors or already-intoxicated customers to purchase alcohol. Supporters say it would also reduce theft. Similar bills have been considered twice before by the California Legislature; in fact, a similar bill was approved by the Legislature in 2009 but vetoed by Governor Arnold Schwarzenegger.

The bill is supported by United Food and Commercial Workers Union, Mothers Against Drunk Driving, several police organizations and anti-drug and anti-alcohol groups. Opponents include the California Grocers Association, which says that self-service checkout stations already have a mechanism that requires a clerk to verify a customer's age before an alcohol purchase can be completed.

Florida: Governor Signs Prescription Monitoring Program into Law

Governor Rick Scott has signed into law a bill authorizing creation of a prescription monitoring program (PMP) in the State. The legislation also imposes new penalties on physicians who overprescribe certain medications and imposes stricter rules for operating pharmacies.

Governor Scott previously opposed the PMP legislation because of concerns over its cost and patient privacy. In part to allay privacy concerns, the law requires that administrators of the database undergo FBI background checks, and limits law enforcement's use of the PMP information to active investigations.

Illinois: Senate Reduces Addiction Program Funding

On May 30th, the Illinois Senate approved a \$33.2 billion budget for fiscal year 2012, or about \$2 billion less than the amount proposed by Governor Pat Quinn. The Senate budget eliminates \$1.5 million in funding for a youth methamphetamine treatment program in Franklin County and cuts funds for psychotropic medications for mental health patients by \$666,000. The budget now goes to the Governor for action.

Kansas: Ignition Interlock Devices Required

Under legislation signed into law by Kansas Governor Sam Brownback, first-time offenders convicted of drinking and driving offenses will be required to use ignition interlock devices on their cars. The law also requires the State to set up a central database of cases involving driving under the influence (DUI).

An ignition interlock device requires a driver to take a breath test before starting a car and prevents the car from starting if the operator has a blood alcohol level above a pre-set level.

The new measure, which becomes effective in July, strengthens the current law, which suspends the license of a first-time DUI offender for 30 days and gives judges the option to order use of an ignition interlock device for up to 330 days. The new law mandates that the interlock device be used for 180 days after a license suspension.

Federal statistics showed that alcohol-related traffic deaths increased in Kansas in calendar year 2009 even as they dropped nationwide.

Louisiana: Cigarette Tax May Help Fund Health Services

On May 24, the Louisiana House approved legislation (HB 591) that would maintain the State's current cigarette tax and allocate part of the resulting revenues to health care costs.

Under current law, four cents of the state's 36 cent per pack cigarette tax will expire in July 2012. The bill would maintain the current tax and allocate \$12 million annually in cigarette tax revenue to the State's health care budget. The bill now goes before the Louisiana Senate.

Minnesota: Loss of Funds = Fewer School Drug and Alcohol Counselors

The ranks of school drug and alcohol counselors are thinning as grant funding to pay for the positions declines, according to a report in the St. Paul Pioneer-Press.

While some school administrators argued that drug and alcohol programs are luxuries the school system can no longer afford, Martha Harding of the Hazelden Foundation told the newspaper that alcohol and drug counselors hired by Minnesota schools in the mid-1990s played a big part in driving down rates of teen alcohol and drug use. She says she is concerned that as school programs disappear, some of those gains will be lost.

Chris Otto, head of the Minnesota School Counselors Association, said that drug counselors who remain in schools are doing everything from administering tests to monitoring lunchrooms, in addition to their counseling duties.

New York: In-School Alcohol and Drug Clinic Opens

A public high school in Long Island, New York, is opening an in-house drug and alcohol abuse clinic. According to Daytop Treatment Services, which will run the clinic, it is the first such facility in New York State and possibly in the United States.

The clinic is opening in response to a jump in rates of substance abuse among students. It is expected to open in August at the William Floyd High School in Mastic Beach, New York. The clinic will provide counseling, but will not dispense methadone or other medications.

The clinic will serve students who self-refer, as well as those referred by the school as an alternative to suspension, and those ordered by a judge to undergo treatment. The school's teachers and administration will not be told which students are participating in the program.

The clinic will serve an otherwise typical high school. Recovery high schools offer another approach to helping high school students struggling with substance abuse issues. Since the first recovery high school was established in 1987 in Minnesota, 22 such schools have been established in nine states.

North Carolina: Sales of K2 and Bath Salts Banned

Two newly popular synthetic drugs, K2 and bath salts, have been outlawed in North Carolina.

Barbara Correno, a spokeswoman for the Drug Enforcement Administration (DEA), told the *Winston-Salem Journal* newspaper that North Carolina has joined 17 other States that ban the sale and use of synthetic marijuana. She said that bath salts (which mimic the effects of cocaine) are more challenging and added that the DEA is weighing whether to regulate bath salts at the Federal level.

Figures from the American Association of Poison Control Centers show at least 2,700 persons have been sickened by synthetic drugs since January 2011, compared with fewer than 3,200 in all of 2010. At that rate, medical emergencies stemming from synthetic drugs could rise nearly fivefold by the end of 2011. The drugs are suspected in at least nine deaths in the U.S. in 2011.

Tennessee: Senate Approves Pain Management Oversight Bill

On May 19, the Tennessee Senate unanimously approved legislation (SB 1528) intended to improve oversight of pain management clinics to reduce prescription drug abuse.

Beginning January 1, 2012, the bill would require Tennessee Department of Health (DOH) certification for pain management clinics, with a \$1,000 daily fine for noncompliance. It also would bar clinics from accepting cash for anything other than copayments, coinsurance, or deductibles.

In addition, under the bill, clinics' medical directors must be licensed physicians and must be present on site for at least 20% of the facility's operating hours.

People in the News

Dr. Lewis Receives Lifetime Achievement Award

ACMHA: The College for Behavioral Health Leadership, has presented its Saul Feldman Award for Lifetime Achievement to David C. Lewis, M.D. — the first person in the addictions field to receive the honor. The award honors the sustained, significant contributions of an individual to leadership and policy in the mental health and addictions recovery field. It is given in honor of Saul Feldman, D.P.A., CEO Emeritus of United Behavioral Health, and former president and co-founder of the College.

Dr. Lewis is Professor of Medicine and Community Health Emeritus and the Donald G. Millar Distinguished Professor Emeritus at Brown University's Center for Alcohol and Addiction Studies, a program he founded in 1982 and directed until 2000. Over years of service, Dr. Lewis has led almost every organization working at a national level to increase access to effective addiction treatment. He was chairman of the board of directors of the National Council on Alcoholism and Drug Dependence and the founder and a member of the board of directors of Physicians and Lawyers for National Drug Policy. He serves on the executive committee and is former executive director of the Association for Medical Education and Research in Substance Abuse (AMERSA). He currently chairs the executive committee of the Coalition on Physician Education in Substance Use Disorders (COPE).

In 1997, Dr. Lewis received the American Medical Association's Education and Research Foundation Award for outstanding contributions and leadership in championing the inclusion of alcohol and other drug problems into the mainstream of medical practice and education. In 2002, he was recognized for "Distinguished Contributions in the Addictions" by Harvard Medical School. In 2004, Dr. Lewis received ASAM's John P. McGovern Award and Lectureship for his contributions to the treatment of substance use disorders.

Dr. Gold Named Distinguished Alumni Professor

Mark Gold, M.D., the Donald Disney Eminent Scholar, Distinguished Professor and Chair of Psychiatry, has been selected as Distinguished Alumni Professor for the University of Florida. It is the first time that a faculty member from the College of Medicine has been chosen for this honor.

Criteria for selection include having a stellar reputation among students and alumni as a superior and influential teacher with an immeasurable positive impact on students, contributing to the distinction of UF through service to the university, state and nation.

Also a member of the UF McKnight Brain Institute, Dr. Gold will serve as the distinguished professor for a two-year term beginning in July. In addition to being a voting member of the UF Alumni Association Board of Directors, he will serve as an ambassador for the Alumni Association, promote the academic accomplishments of the university, and share expertise and advice with Alumni Association board and committee members from a faculty perspective.

In announcing the award, Michael Good, M.D., Dean of the University of Florida College of Medicine, said: "Dr. Gold's knowledge and insights into the brain's response to addictions has led to hundreds of academic papers, dozens of books and numerous appearances in the mainstream media as well as academic and professional conferences. Most importantly, he has helped countless patients deal with addictions throughout his career."

From the Institutes

Alcohol, Impulsivity and Violence

Research led by scientists at NIAAA shows that a genetic variant of a brain receptor molecule may contribute to violently impulsive behavior when people who carry it are under the influence of alcohol. A report of the findings, which include human genetic analyses and gene knockout studies in animals, appears in the December 23, 2010, issue of *Nature*.

Working with researchers in Finland and France, David Goldman, M.D., Chief of the Laboratory of Neurogenetics at NIAAA, and colleagues studied a sample of violent criminal offenders in Finland. The hallmark of the violent crimes committed by individuals in the study sample was that they were spontaneous and purposeless.

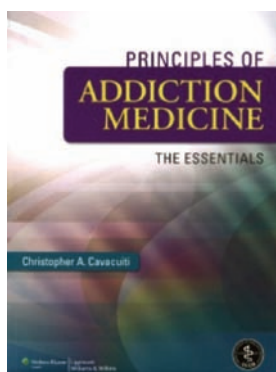
The researchers sequenced DNA of the impulsive subjects and compared those sequences with DNA from an equal number of non-impulsive Finnish control subjects. They found that a single DNA change that blocks a gene known as *htr2B* was predictive of highly impulsive behavior. *Htr2B* encodes one type of serotonin receptor in the brain. Serotonin is a neurotransmitter known to influence many behaviors, including impulsivity.

"Interestingly, we found that the genetic variant alone was insufficient to cause people to act in such ways," said Dr. Goldman, explaining that "carriers of the *htr2B* variant who had committed impulsive crimes were male, and all had become violent only while drunk from alcohol, which itself leads to behavioral disinhibition."

The researchers then conducted studies in mice and found that, when the equivalent *htr2B* gene is knocked out or turned off, mice also become more impulsive. Taken together, the findings could lead to a better understanding of some aspects of impulsivity and ultimately may lead to strategies for diagnosing and treating some clinically important manifestations of impulsive behavior. The researchers caution, however, that impulsivity is a complex trait with multiple genetic and environmental causes. The article abstract can be found here: "A Population-Specific HTR2B Stop Codon Predisposes To Severe Impulsivity" ([HTTP://WWW.NCBI.NLM.NIH](http://www.ncbi.nlm.nih.gov)). Source: NIAAA Spectrum, Vol. 3, No. 1, 2011.



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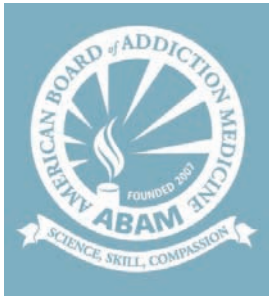
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Principles of Addiction Medicine: The Essentials is an excellent reference for a wide variety of addiction medicine professionals, including psychiatrists, psychologists, psychiatric nurses, social workers, internal medicine/primary care physicians, and substance abuse counselors.

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Member News

631 Physicians Earn Certification, Recertification in Addiction Medicine

The American Board of Addiction Medicine has announced that it Certified or Recertified 631 physicians in Addiction Medicine in 2011. Of that number, 523 earned initial Certification and 108 were Recertified. All of the Certified or Recertified physicians passed a rigorous examination and met additional qualifications specified by ABAM. ASAM offers congratulations to all the newly Certified or Recertified physicians on their achievements.

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