

## President's Message

# Addressing Prescription Opioid Abuse, Starting with Efforts to Prevent Overdose Deaths

BY JEFFERY WILKINS, MD, CSAM PRESIDENT



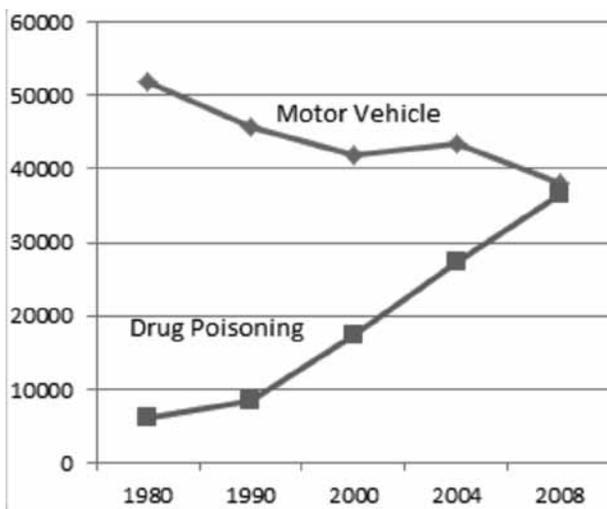
JEFFERY WILKINS, MD

The rise of prescription opioid abuse during the last decade has produced a significant increase in deaths from opioid overdose. Methadone, with 4 million prescriptions written for pain in 2009, has now joined oxycodone, hydrocodone, fentanyl, and morphine as the primary agents<sup>1-3</sup>. Overdoses of prescription opioids have also changed the U.S. landscape for poisonings. In the last 3 decades medication contributions to poisoning rates have risen from 55% (1980) to 90% (2004 and 2008)<sup>1</sup>, with over 40% of medication related poisonings stemming from prescription opioids<sup>2</sup>. Recently, much was made by the media when vehicle traffic deaths were exceeded

by drug overdose deaths (Figure 1 below), the impetus for this dramatic shift being the rise of prescription opioid abuse (Figure 2 below). In addition to the majority of deaths occurring in 45 to 54 year olds, increases have also occurred in children/adolescents and the elderly<sup>1</sup>. While CSAM is committed to addressing the significant problem of prescription opioid abuse, CSAM is also aware that it is vitally important to prevent as many of these overdoses starting immediately — primarily for humane reasons but also for creating opportunities for access to treatment. As described below, the best immediate chance of doing this comes from CSAM's support of California Assembly bill AB 472 that will encourage people experiencing or witnessing an overdose to call 911 without fear of arrest.

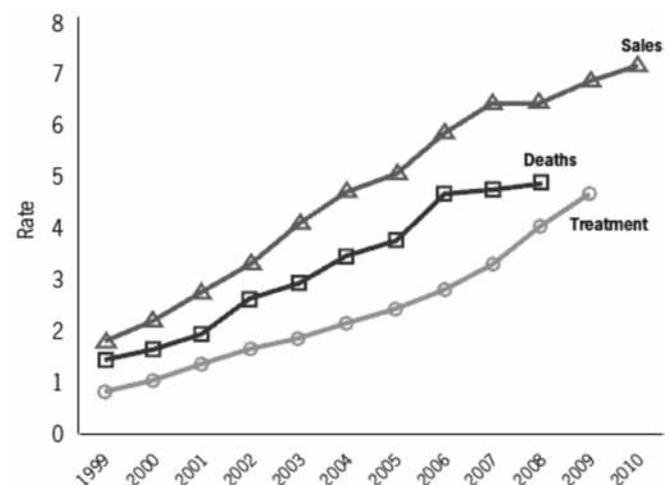
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**Fig. 1. United States Deaths from Motor Vehicles & Drug Poisoning (1980 to 2008)**



Warner, M., Chen, LH, Makuc, DM, Anderson, RN and AM Minino. Drug Poisoning Deaths in the United States, 1980–2008. [www.cdc.gov/nchs/data/databriefs/db81.htm](http://www.cdc.gov/nchs/data/databriefs/db81.htm)

**Fig. 2. Prescription Painkiller Sales, Deaths & Substance Abuse Treatment Admissions (1999-2010)**



National Vital Statistics System, 1999–2008; Automation of Reports and Consolidated Orders System (ARCOS) of the DEA 1999–2010; Treatment Episode Data Set, 1999–2009

## President's Message

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To save lives now while working towards solutions for prescription opioid abuse, CSAM is actively supporting California Assembly bill AB 472 that provides limited immunity from arrest for victims and bystanders of overdose seeking aid in an overdose event. In particular, this bill addresses the negative and fear-based expectations of witnesses of overdose that if they reach out to help themselves or someone else that they will be arrested. Further, the bill would help those who manifest an alcohol or drug-related adverse reaction that, in the absence of medical treatment, will result in their death. In addition to the fact that 7 other states and the District of Columbia have already enacted similar laws, study results lend support to the rationale for this bill by demonstrating:

- Studies of overdose have shown that death rarely occurs immediately from a drug-related overdose, and most deaths occur 1 to 3 hours after the initial dose of drugs<sup>4</sup>.
- Overdoses are frequently witnessed, including up to 80% in one study<sup>5</sup>.
- Over 50% of persons interviewed have reported they did not call 911 during an overdose due to their fear of police involvement<sup>6-8</sup>.
- One year after passage of a similar bill in Washington State, 88% of opioid users indicated that they had become aware of the law and would be more likely to call 911 during future overdoses<sup>9</sup>. Similarly, there was a significant increase in students contacting emergency services after Cornell University put in place its Good Samaritan policy for alcohol use<sup>10</sup>.

At least five states have passed laws that, like California AB 472, provide limited immunity for people seeking medical assistance during an overdose from prosecution for possession of controlled substances: including New Mexico (2007), Washington (2010), New York and Connecticut (2011), and Illinois (2012). Four other states extend limited immunity with regard to underage alcohol consumption and possession, including Colorado (2005), New Jersey (2009), Texas and Pennsylvania (2011). Other states considering Good Samaritan laws include Massachusetts, Michigan, Hawaii, Florida and Rhode Island<sup>11</sup>.

### Save the Date!

CSAM State of the Art in Addiction Medicine

Sheraton San Diego Hotel & Marina

**October 16-19, 2013**

Conference Chair: *Sharone Abramowitz, MD*

### What California's AB 472 will do:

- This bill will provide limited criminal immunity to individuals for being under the influence, or in possession of drugs for personal use or drug paraphernalia if they seek medical attention to save the life of someone experiencing an overdose.
- Save lives of persons who have overdosed on opioids, including lives of persons who would die from other forms of drug abuse adverse reactions; gives people who abuse opioids a chance to get help for their addiction.
- Increase the likelihood that witnesses will call 911 during an overdose.

### What California's AB 472 will not do:

- This bill will not protect people from prosecution for other offenses, including the trafficking of drugs or driving under the influence and this bill prohibits obstruction of medical or law enforcement personnel.
- Does not interfere with law enforcement securing the scene at an overdose.
- Does not prevent prosecution for drug trafficking.
- Does not prevent prosecution for outstanding warrants.

CSAM works through its Committee on Public Policy, chaired by Christy Waters, MD, to support bills that support access to treatment and humane care for all Californians. With regard to supporting AB 472, I recently joined CSAM policy advisor Robert Harris for meetings in Sacramento with key government officials to discuss this bill. We met with the Governor's deputy legislative secretary Lark Park and also with members of Assembly Member Tom Ammiano's staff. Also presented at these meetings was that a nonprofit founded by attorney Robert Shapiro, the Brent Shapiro Foundation for Drug Awareness (BSFDA), supports AB 472. The BSFDA is very supportive of efforts to encourage 911 calls by young people if and when their friends develop problems following drug ingestion; the foundation was founded following the death of his son who died after drug ingestion.

CSAM members can also support these efforts by sending letters of support for AB 472 to:

Governor Jerry Brown  
c/o State Capitol, Suite 1173,  
Sacramento, CA, 95814  
Fax: (916) 558-3160

Or call the Governor's office at: 916/445-2841

Or email: <http://govnews.ca.gov/gov39mail/mail.php>

California exceeds all states in annual rates of deaths from drug overdose with an average of 10 per day (3,646 in 2006). AB 472 has already passed the California Assembly. When

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## Addiction Treatment under Health Care Reform

By DAVID PATING, MD, COMMISSIONER, CA MENTAL HEALTH SERVICES AND OVERSIGHT COMMISSION



DAVID PATING, MD

For decades, individuals with alcohol and drug addiction have been underserved. By all measures — health, services, social outcomes — they receive inadequate and inappropriate care. Currently, 20 million Americans need addiction treatment but are unable to receive adequate care due to inadequate coverage. Only one in 10 youth receive needed treatment, which they often only receive after they've been incarcerated<sup>1</sup>. This is horrible!

Fortunately, the Affordable Care Act (ACA 2010) includes treatment for addictions as one of 10 essential categories of service, which must be covered in all plans at parity with medical and surgical benefits. Finally, the promise of decent addiction care for everyone reaches our field! CSAM believes this watershed moment cannot go unnoticed by addiction medicine physicians. For this reason, I offer this first of several count-down articles to the 2014 implementation of the Affordable Care Act (ACA 2010).

Collectively known as Health Care Reform, the ACA and its attendant legislation promote broad changes in our health care system by expanding health insurance coverage and altering financial reimbursement. The ACA drives towards a model of care that seeks to:

1. Reduce the cost of care;
2. Improve the care experience and;
3. Improve the health of individuals and communities.

This is accomplished through state Health Insurance Exchanges, which are authorized to guide the development of standardized "essential" health insurance benefits packages. The ACA also authorized a huge expansion in Medicaid and Medicare, as well as individual and employer mandates to purchase or offer insurance under the threat of penalty. Together, these initiatives will newly insure about 4.1 million Californians of the 7 million who are un-insured, many of whom have addictions. This is wonderful!

### U.S. Supreme Court Upheld the Constitutionality of the ACA

On June 28, 2012, the Supreme Court largely upheld the constitutionality of the Obama Administration's health care law. The mandate was upheld as a tax. Congress acted within its powers under the Constitution when it required most Americans to have health insurance or pay a penalty.

The justices made some changes to the Medicaid portion of the law. The decision avoids disruptions for hospitals, physicians, and employers who have spent more than two years preparing for changes in the law. Twenty-six states filed suit against the law, and lower courts have issued conflicting rulings since then.

The Obama Administration has been moving ahead with implementing the law as it waited for the Supreme Court's ruling. It has been negotiating with states to set up exchanges where consumers can purchase subsidized insurance plans, and to sign up lower-income Americans for Medicaid. Texas and Florida were among the states that refused to cooperate, because they expected the law to be overturned by the court.

The exchanges are scheduled to open in 2014, when insurers must accept all customers, regardless of their medical histories. People will have to show when they file tax returns for 2014 that they had coverage during that year, or else they will have to pay a tax penalty. The penalty will increase over time, and will reach a maximum of several thousand dollars annually.

*"ACA is undoubtedly a boon for substance abuse treatment and life-saving for persons with addiction."*

Companies with more than 50 workers will have to pay penalties starting at \$2,000 per employee if they don't offer a set level of health benefits, starting in 2014.

Frankly, with this ruling, health care as a whole dodged a bullet. If the act was overturned, our U.S. health care system would be thrown into chaos as states, counties, health plans and providers have already invested billions in preparation for Health Reform, including major changes to financial systems, moves to integrate and align treatment systems, and broad scale updating of electronic health records. Instead, the only provision in the law that appears jeopardized is the Federal government's ability to withhold federal funds if states do not participate in the expansion of Medicaid. The Medicaid and Medicare expansion in the ACA is the largest public funding shift to the poor in decades. Since 90-100% of this expansion is paid for by federal dollars, it is unlikely that

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# Opportunities for Increasing Access to SUD/MH Treatment Through Health Care Reform

CSAM member **David Pating, MD**, chairs the California Coalition for Whole Health (CCWH) and CSAM is a prominent voice in the Coalition. The Coalition's vision for Substance Use Disorders (SUD) and Mental Health Care (MH) in California is that there must be integrated care for SUD/MH into primary care medical homes and systems of care that link SUD/MH specialty and primary care services.

The California Coalition for Whole Health (CCWH) represents the state's largest mental health and alcohol/drug treatment associations. Comprised of county directors, physicians, providers, consumers and family members, CCWH provides consensus recommendations for legislation and action by the California Health Benefits Exchange required to implement the Affordable Care Act (ACA 2010) in California. The ACA explicitly includes mental health and substance use disorders (SUD/MH) as one of 10 categories of service that must be covered as essential health benefits. This inclusion reflects the clear understanding that meeting the needs of individuals with SUD/MH is integral to achieving the "triple aim" objectives of health care reform:

- Reduce the cost of care
- Improve the experience of care
- Improve health of individuals and communities

Consistent with these aims, CCWH asserts: "There can be no health without behavioral health." Below are the core messages CSAM is voicing through its involvement in the Coalition:

Effective care for SUD/MH is premised on the understanding that these disorders are chronic conditions for which ready access to both acute and continuing care is essential. Similar to hypertension, asthma and diabetes, SUD/MH can be successfully treated through effective chronic care. Half of all individuals with chronic medical conditions also have co-occurring SUD/MH, resulting in higher costs and poorer outcomes. When SUD/MH is treated, the total cost of care for these individuals — and their families — is greatly reduced and overall health is significantly improved.

To realize the savings associated with improved health outcomes, insurance benefits for individuals must provide all medically necessary care across a continuum that meets changing care needs over time. Care levels can and should be determined using nationally recognized professional standards and include rehabilitative as well as residential services. With a continuum of care ranging from risk assessment and prevention, to early detection, effective intervention and maintenance treatment, individuals with SUD/MH can lead healthy and productive lives.

Health plans need clear guidelines and regulations from the California Health Benefits Exchange to assure compliance

with the Mental Health and Substance Abuse Parity Act (Parity 2008), which preempts disparate application of "non-quantitative" treatment limits for SUD/MH. Under Parity, medical necessity definitions and criteria, utilization management practices and provider network management practices cannot be more restrictive for SUD/MH than for medical or surgical conditions. Moreover, health plans must assure the availability of an adequate number of qualified providers, across all levels of

*"The California Coalition for Whole Health (CCWH) represents the state's largest mental health and alcohol/drug treatment associations."*

care, who are within reasonable geographic access and available to see new patients in a timely manner. For persons with SUD/MH conditions, any delay in access results in de facto denial of care.

Given these findings, CCWH believes the Kaiser Small Group Health Plan, as selected by AB 1453 and SB 951, provides a reasonably effective and efficient benchmark template as required by the ACA and can serve as a starting point to define essential health benefits for SUD/MH. This plan provides many levels of medically necessary care, although the range of services within those levels should be enhanced. Supplementation of these benefits will be required to provide medication-assisted addictions therapy, such as methadone as a treatment modality, in order to comply with parity and medical necessity standards. In addition, residential mental health benefits, extent of coverage for mental health case management, prevention and wellness benefits and recovery benefits must be clarified.

With full access to medically necessary care for SUD/MH, provided optimally in integrated health systems and settings, California stands ready to realize substantial financial savings through improved population health. There is good evidence — from both commercial health plans as well as public health systems — of overall cost-effectiveness and improved health when SUD/MH is appropriately treated.

With the above recommendations, CSAM through the CCWH, is sharing the message that effective and efficient coverage of mental health and substance use disorders is within reach for California. ■

# Policy Committee Advocating For Our Patients

By CHRISTY WATERS, MD, CHAIR, COMMITTEE ON PUBLIC POLICY



CHRISTY WATERS, MD

CSAM's Committee on Public Policy reviews and weighs in on more than 30 pieces of California legislation each year. Allied treatment organizations often contact CSAM seeking to know its positions. This year, CSAM actively educated the public and policy makers about SB 1506 (Leno) which would have revised the penalty for drug possession for personal use from a felony to a misdemeanor. Unfortunately the bill was defeated, but had it passed, it would have saved \$200 million a year, reduced jail overcrowding and eliminated barriers to successful reentry that accompany a felony conviction, including barriers to housing, employment and education. CSAM plans to continue to work with its allied partner organizations toward achieving the intent of this bill. Another bill CSAM is supporting is AB 472 (Ammiano), also known as the "Good Samaritan Bill," which addresses the needless

overdose deaths that occur when witnesses to an overdose hesitate to contact emergency services because they fear arrest for themselves or for the overdose victim.

## Development of a Statewide Physician Health & Well-Being Program

CSAM is co-sponsoring SB 1483 (Steinberg) and is working alongside a wide variety of state medical societies and organizations (California Psychiatric Association, California Medical Association, California Hospital Association, etc.) to form a new physician health program in California to take the place of the program that was eliminated by the Medical Board of California (MBC). If signed into law this year, the bill would establish a statewide intervention program for physicians with substance and/or mental health issues. California is one of only 5 states that lacks such a program. CSAM has been working since 2008 to gain passage of this legislation and this year looks like the most positive chance for passage. ■

## You Are Invited to Attend!

### SUBSTANCE ABUSE TREATMENT PARITY: A FIELD HEARING

with

The Honorable Mary Bono Mack | The Honorable Patrick Kennedy | The Honorable Grace Napolitano

At this field hearing, state and local representatives, providers, and consumers will speak about parity implementation and enforcement.



SEPTEMBER 18, 2012 | 6:30 pm – 8:30 pm

#### Location:

The Chicago School of Professional Psychology  
617 West 7th Street, Los Angeles, CA 90017

This public hearing will focus on the implementation and enforcement of the Mental Health Parity and Addiction Equity Act of 2008. The Act requires equality between insurance coverage for medical/surgical treatment and mental health/substance abuse treatment. The regulations require health insurers to ensure that financial requirements (deductibles, co-pays, etc.) and treatment limitations (visit limitations, medical review procedures) for mental health and substance abuse treatment are no more restrictive than requirements or limitations that are applied to medical/surgical benefits.

CSAM's President-elect **Itai Danovitch, MD**, along with local consumers will testify on the barriers that they continue to face in accessing mental health care and addiction treatment through their health insurance — barriers they do not encounter with other forms of health care. Individuals and families denied coverage for mental health and/or addiction treatment are expected to call on federal regulators to issue final regulations to prevent persistent and ongoing insurance discrimination against those needing behavioral health benefits.

For more information, visit: [www.parityispersonal.org](http://www.parityispersonal.org) • Follow @ParityCoalition (on Twitter)

# Access to SUD Treatment Limited by MBHCO's Excluding Addiction Physicians

BY THOMAS J. BRADY, MD, MBA, CHAIR, ACCESS TO TREATMENT COMMITTEE



THOMAS J. BRADY, MD

Several managed behavioral health care organizations (MBHCOs) do not permit physicians who are certified in addiction medicine but are not board certified psychiatrists to become in-network providers and treat member patients diagnosed with substance use disorders. Why is this a problem?

MBHCOs, by providing substance use disorder health care treatment benefits, obligate themselves to facilitate high quality and readily available addiction treatment. MBHCO mission statements uniformly state the guiding principle of ensuring the right treatment at the right time in the right place, all while using resources efficiently.

Excluding addiction medicine physicians and limiting provider panels to psychiatrists undermines this principle by limiting access to those most skilled in the treatment of these disorders. General psychiatrists may have had little didactic or clinical training in addiction treatment during their residency training and minimal supervised experience treating such patients. Physicians specializing in non-psychiatric specialties such as Internal Medicine, Family Practice, Obstetrics-Gynecology, and Pediatrics, who have had special post-residency training in addiction, and especially those who have met the requirements for certification by the American Society of Addiction Medicine (ASAM), the American Board of Addiction Medicine (ABAM), or the American Osteopathic Association (AOA), generally have more training and treatment experience in addiction treatment than general psychiatrists.

Patients presenting with addiction or other substance use disorders often already face barriers to obtaining successful treatment because of stigma, ignorance, societal and professional denial, limited access to treatment, and insufficient quality of care. In 2006, 21.1 million of the 23.6 million people needing treatment for an illicit drug or alcohol use problem, approximately 9 out of 10, did not receive treatment. By comparison, only 24 percent of people with diabetes do not receive care. The costs of untreated addiction and drug abuse per 2007 data were substantial at more than \$484 billion annually in direct and indirect costs, higher than the cost of coronary heart disease (\$151.6 billion), diabetes (\$131.7 billion), and cancer (\$171.6 billion) combined. This includes health care expenditures, lost earnings, and costs associated with crime and accidents. Timely high-quality addiction treatment saves lives, money, and increases employee productivity and reduces absenteeism. Several conservative estimates found that every \$1 invested in addiction

treatment yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When reduced overall health care costs are included, addiction treatment produces average total savings exceeding cost of treatment by a ratio of 12 to 1<sup>1</sup>.

MBHCOs should include non-psychiatrist addiction physicians certified by ASAM or ABAM in their in-network provider panels to treat member patients diagnosed with addiction and other substance use disorders. Also, MBHCO physicians who conduct utilization review of addiction treatment cases and detoxification cases should have expertise in addiction. Restricting MBHCO physician panels to psychiatrists, even while this includes well-trained subspecialist addiction psychiatrists certified by the American Board of Neurology and Psychiatry (ABPN) or the American Osteopathic Board of Neurology and Psychiatry (AOBNP), limits patient access to quality addiction treatment. Such a discriminatory policy precludes MBHCO member patients from being provided the most effective and efficient treatment, delivered by the most skilled providers, and consistent with the best clinical outcomes.

*"MBHCOs should include non-psychiatrist addiction physicians certified by ASAM or ABAM in their in-network provider panels to treat member patients diagnosed with addiction and other substance use disorders."*

ASAM and CSAM are joining together to conduct a campaign to correct this inequity, both by directly approaching both those MBHCOs that exclude non-psychiatrist addiction physicians, and also state government regulatory agencies that oversee the MBHCOs, including the California State Department of Managed Health Care. If you are an addiction physician who is not also a psychiatrist and have been turned away from joining an MBHCO provider panel, please send your story to the CSAM's Access to Treatment Committee at [csam@csam-asam.org](mailto:csam@csam-asam.org). ■

*Dr. Brady is board certified in addiction medicine, and general, child and adolescent, and forensic psychiatry.*

<sup>1</sup>Principles of Drug Addiction Treatment: A Research-Based Guide, 2nd Ed., National Institute on Drug Abuse, 2009

# Understanding CSAM's Governance Process

BY TIMMEN CERMAK, MD, IMMEDIATE PAST PRESIDENT



TIMMEN CERMAK, MD

In 2011 the CSAM Executive Council and membership accepted the *Youth First* report, a discussion of marijuana policy in California with recommendations to regulate and tax marijuana with revenues earmarked for adolescent prevention and treatment services. The creation of *Youth First* was guided by a new process of governance being adopted by much of the non-profit world. That governance process is called "Knowledge-Based Decision Making" (or KBDM). KBDM is a strategy to improve the quality of organizational decision-making. It supplements Robert's Rules of Order, a top-down, parliamentary set of governance practices traditionally followed by professional associations. Why would such a significant change in governance structure be indicated?

In the last century, before the advent of the Internet, a major function of voluntary professional associations was to create, gather and distribute information to association members. For example, the CSAM staff would follow budgetary and legislative events in Sacramento, and then pass this information on to members.

Today with the Internet, any member with an interest in Sacramento can now retrieve data directly just as fast on the Internet as by contacting the CSAM staff. In order to remain relevant, associations have to do more than mere database management.

KBDM keeps associations relevant by moving beyond information and creating knowledge specific to the organization's mission. This process can be summarized in several questions:

1. What are the members' needs and perspectives?
2. What is the capacity of the association?
3. What are the current realities of the association's environment?
4. What information is available and what is still required?
5. What are the ethical implications of the association's choices?

The goal of Knowledge-Based Decision Making is to create maximum dialogue before making decisions. All who are affected by any decision need to be given access to all the information needed to make an informed decision. And they need to be given an opportunity to have input before decisions are made. Making a good decision — a decision that builds consensus through a process that builds community — is more important than who makes the decision.

CSAM's *Youth First* report was developed in accordance with KBDM principles, and thus exemplifies this process in action: The issue of marijuana and policies governing marijuana was identified through feedback on potential topics from conference attendees. Speakers on basic science, clinical and policy aspects related to marijuana were included

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## Notice to CSAM Members Regarding ASAM's Associate Member Proposal

Membership in ASAM and CSAM is restricted to physicians, however, recently the ASAM Board of Directors proposed changing its bylaws to allow non-physicians to join ASAM and in turn, to join CSAM, its largest state chapter.

CSAM's Executive Council notified the ASAM Board of Directors that it is strongly opposed to allowing non-physicians to join ASAM, a position CSAM has espoused for many years. On June 6, 2012, CSAM's President **Jeffery Wilkins, MD** conveyed CSAM's position to the ASAM Board of Directors in a letter. The following is the text of that letter:

*"It is our (CSAM's) position that this is a time that, more than ever, requires addiction medicine physicians to embrace our identity and cohesion as we face a rapidly changing medical landscape. We must be united and focused in order to treat*

*and protect the rights of our patients. On a national level, it's crucial that ASAM preserve our hard-fought role as the physician voice of addiction medicine on legislative and regulatory matters. For the safety of our patients, we must also protect our ability to effectively advocate on scope of practice issues, and similar challenges at the state level. By retaining our identity as addiction medicine physicians we will maintain our role as the authoritative source of knowledge on evidence-based addiction treatment. We must maintain our strong educational programs while creating new resources, including resources that support addiction medicine. CSAM urges ASAM to focus its efforts, first and foremost, on addressing the needs of its physician members and the patients we serve." ■*

# Addiction Medicine Review Course 2012 and American Board of Addiction Medicine Certification Exam Preparation Track

September 5-8, 2012 | Hyatt Regency San Francisco Embarcadero

By ANTHONY ALBANESE, MD, CHAIR, CSAM REVIEW COURSE 2012



ANTHONY ALBANESE, MD

**J**oin us for a stimulating and rewarding educational experience that will advance your understanding of addiction medicine and improve your clinical practice. Whether you are preparing for the American Board of Addiction Medicine Certification Exam, refreshing your knowledge of the field, or newly learning about the diagnosis and treatment of addictions, this course has something to offer.

The conference includes a roster of the preeminent leaders in the field of addiction research and treatment including the following:



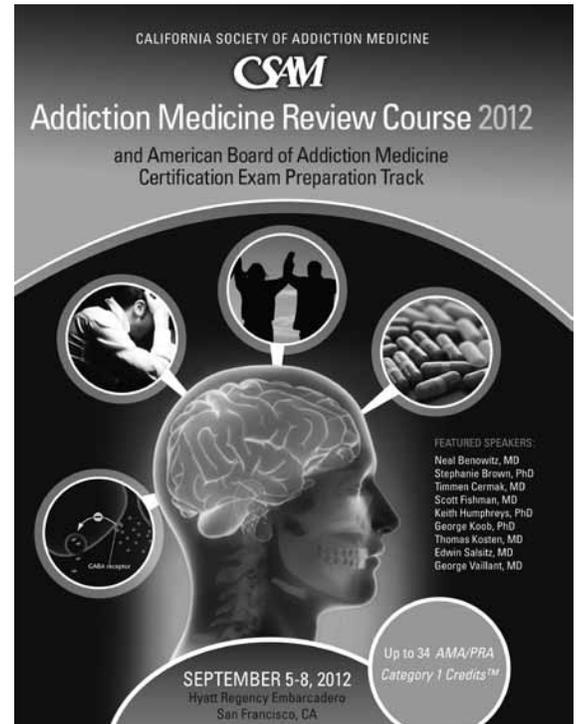
### **George Vaillant, MD** **The Natural History of Alcoholism**

In *The Natural History of Alcoholism*, first published in 1983 and updated in 2006, Dr. George Vaillant reported on the results of a study carried out from 1940 through 1980 involving 660 men during their maturation from adolescence to late middle life. The book has been acclaimed as perhaps the single most important contribution to the literature on alcoholism. Dr. Vaillant took on the crucial questions of whether alcoholism is a symptom or a disease, whether it is progressive, whether alcoholics differ from others before the onset of their alcoholism, and whether alcoholics can safely drink. In addition, his work has focused on individual adult development and, more recently, he has been interested in positive emotions and their relationship to community development.



### **George Koob, PhD** **Neurobiology of Addiction**

Dr. Koob is one of the world's authorities on the neurobiology of drug addiction. He has contributed to the understanding of the neurocircuitry associated with the acute reinforcing effects of drugs of abuse and on the neuroadaptations of these reward circuits associated with the transition to dependence. He has validated key animal models for dependence associated with drugs of abuse and has begun to explore a key role of anti-reward systems in the development of dependence. The identification of specific neurochemical systems within the basal forebrain system of the extended amygdala involved in motivation has significant impact. Identification of a role for dopaminergic, opioidergic, GABAergic, glutamatergic and corticotropin-releasing factor systems in excessive drug taking provides a neuropharmacologic basis for the allostatic changes hypothesized to drive the process of pathology associated with addiction, anxiety, and depression.



### **Gabor Maté, MD** **Thursday Evening Dessert Reception**

Based on Dr. Gabor Maté's bestselling book, *In The Realm of Hungry Ghosts: Close Encounters With Addiction*, this talk will explore how addictions are neither consciously chosen nor genetically determined, but are the psychological and neurobiological outcomes of life experience, most commonly childhood trauma and how in such experiences the neurobiology of the brain's reward pathways develops and the emotional patterns that lead to addiction are wired into the unconscious.



### **Nancy Goler, MD** **Substance Abuse in Pregnancy and Fetal Development**

Dr. Goler is recognized for her groundbreaking work in evaluating Kaiser Permanente's Early Start program, designed to reduce negative maternal and neonatal outcomes associated with prenatal substance abuse by making education and early intervention accessible to pregnant women. Her research showed that the program improved infant outcomes leading to lower overall costs by an amount significantly greater than the costs of the program.

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**Neal Benowitz, MD**  
**Nicotine**

Dr. Benowitz's research focuses primarily on the human pharmacology of nicotine and other stimulant drugs.

Dr. Benowitz's laboratory has conducted studies on the disposition kinetics, metabolism and pharmacodynamics of nicotine, with an emphasis on the role of nicotine and maintaining nicotine addiction in causing tobacco-related diseases. He has studied the human pharmacology of nicotine, including metabolism, effects on the heart and circulation, and role in addiction. He studies the questions related to the safety of low-tar cigarettes, safety of medications used to treat nicotine addiction, smoking and heart disease, smokeless tobacco, and the genetics of nicotine addiction.



**Keith Humphreys, PhD**  
**Behavioral Interventions and Psychosocial Treatment**

Dr. Humphreys has been extensively involved in the formation of federal policy and served as senior policy advisor at the White House drug policy office in 2009-2010. His work has bridged the worlds of clinical research, clinical practice, social policy and the lived experience of addiction recovery. His studies, perhaps more than the contributions of any other scientist, have illuminated the role of community, particularly indigenous recovery communities, in recovery initiation and long-term recovery maintenance. Since 2004, Humphreys has also volunteered as a consultant and teacher in the multinational humanitarian effort to rebuild the psychiatric care system of Iraq, for which he recently won the American Psychological Association's Award for Distinguished Contribution to the Public Interest.

**Other plenary speakers:**

- **Anthony Albanese, MD:** Alcohol
- **Timmen Cermak, MD:** Cannabis
- **Paula Lum, MD:** Medical Complications of Addiction
- **Edwin Salsitz, MD:** Opioids
- **Francis Vocci, PhD:** Receptors, Pharmacology and the Medical Management of Addiction
- **Marc Fishman, MD:** Assessment and Treatment of Substance Abuse in Adolescents, Inhalants
- **Greg Skipper, MD:** Drug Testing
- **Scott Fishman, MD:** Pain and Safe Prescribing
- **Stephanie Brown, PhD:** A Clinicians Guide to 12-Step Programs
- **Thomas Kosten, MD:** Stimulants
- **John Tsuang, MD:** Psychiatric Comorbidities
- **Sharone Abramowitz, MD:** Motivational Interviewing: Stages of Change
- **Mel Pohl, MD:** Sedative-Hypnotics
- **David Kan, MD:** Ethics and Confidentiality
- **Silas Wheelock Smith, MD:** Club Drugs, Hallucinogens and New Drugs of Abuse
- **Kent Olson, MD:** Emergency Room Presentations of Addiction

For more information, go to: [www.csam-asam.org](http://www.csam-asam.org)

# Welcome New CSAM Members!

- Gilbert Andersen, MD** - Lompoc
- Kamal Artin, MD** - Irvine
- Asma Asyyed, MD** - Emeryville
- Reham Attia, MD** - Glendale
- Peter Barnett, MD, MPH** - Tahoe City
- Christine Bell, MD** - Sacramento
- Joseph Cabaret, MD** - Camarillo
- Paul Casedy, MD** - Laguna Hills
- Sudhakar Cherukuri, MD, MPH** - San Jose
- Richard R. Cicinelli, MD** - Redwood City
- Ralph W. Clark, MD** - Loma Linda
- Godfrey David Dyne, MD** - Santa Barbara
- David Friedman, MD** - Culver City
- Nickolas Fuller, MD** - Beverly Hills
- Robert Gorney, MD** - San Diego
- Terry R. Grand, MD, PhD** - North Hollywood
- David Gunn, MD** - Sacramento
- Timothy Hall, MD** - Los Angeles
- Brian Hunt, MD** - Folsom
- Mark Jaffe, MD** - Hermosa Beach
- Michael Jaffe, MD** - Menlo Park
- Charles Lewis Johnson, MD** - Santa Cruz
- Sandra Johnson, MD** - Davis
- Corby Kessler, MD** - Napa
- Melody S. Law, MD** - Antioch
- Gary Levinson, MD** - Rancho Mirage
- Richard Lindenbaum, MD** - Santa Monica
- Richard Lynton, MD** - Folsom
- Morris Mesler, MD** - Woodland Hills
- Lenton J. Morrow, MD** - Sacramento
- Long H. Nguyen, MD** - San Francisco
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## Countdown to 2014: The Promise of Adequate Care

continued from page 3

states will opt out.

So what does all this mean? For California, our state has been the national leader — we were first out of the gate to implement the ACA. In 2011, California made an “all-in” commitment to reform health care. There is no part of our state public and commercial health care system that has not been touched: services, hospitals, pharmacy benefits, eligibility, accountability, and reimbursement. If you practice medicine, your practice will/has been affected — for better or worse. This is why half of all physicians still remain ambivalent about the ACA (Younger MDs — Yes; Older MDs — No). Regardless, if we step outside our self-interest, the ACA is undoubtedly a boon for substance abuse treatment and life-saving for persons with addiction. It’s about recovery!

### Let’s Play Ball!

And CSAM has been a major player. As a steering member of the California Coalition for Whole Health (CCWH), CSAM has joined and led California’s most prominent mental health and alcohol and drug stakeholder organizations to improve addiction treatment through health reform. Collectively, this coalition identified three key positions essential for effective care: adequate addiction treatment benefits, the need for enforcement of addiction treatment parity, and the need for linking addiction treatment professionals with consumers to assure effective means for insurance enrollment. Regarding parity, consistent vigilance is needed by all addiction physicians to assure that insurers do not apply disparate non-quantified treatment limits (e.g., overly restrictive medical necessity criteria, preauthorization or fail-first approaches) that differ from those utilized for medical or surgical conditions. As physicians specializing in addiction medicine, we

all must assure our patients have timely access to their benefitted health services. CSAM’s Committee on the Access to Treatment has been actively involved in advocating on this and I recommend that if you have questions or need help, you contact that committee.

We must be more vigilant than ever in our advocacy work for our patients. We must work together to ensure that addiction coverage expands enough to be meaningful and that the treatment field will be ready for the expanded demand. We must ensure that methadone is a covered benefit. We need to ensure access to both outpatient and residential treatment where appropriate. And finally, we need to ensure that utilization review is reasonable and not onerous.

We are entering a new frontier that requires that physicians who practice Addiction Medicine must adapt to a new system of care. The debates in Washington and Sacramento are about defining the rules of this new game. Whether we stay in play as addiction medicine physicians will depend on our capacity to adapt to new systems of care that will evolve with new funding<sup>2</sup>. I’ll cover some of these new models of care in the next issue. For now, I’ll leave you with this mantra: *There can be no effective health care without behavioral (addiction) care.* This is our battle cry. *We have less than 18 months to go* — it’s time for addiction medicine physicians to step up to the plate. Are you with us? ■

<sup>1</sup> “Addiction Medicine: Closing the Gap Between Science and Practice,” June 2012, [www.casacolumbia.org](http://www.casacolumbia.org), accessed June 27, 2012 for a comprehensive briefing on the state of current addiction treatment.

<sup>2</sup> Pating D., Miller M., Goplerud E., et al, “New Systems of Care for Substance Use Disorders: Treatment, Finance, and Technology Under Health Care Reform,” *Psychiatr Clin N Am* 35 (2012) 327-356, for a look into the future of HCR.

## Support MERF

*Educating Scholars. Creating Champions.*



The Medical Education & Research Foundation (MERF) provides scholarships for mentored learning experiences at the California Society of Addiction Medicine (CSAM) annual conferences and new in 2012, MERF is providing grant-funded opportunities for faculty development and curriculum enhancement in Substance Use Disorders (SUD). MERF is a non-profit, public benefit corporation qualifying for tax-deductible contributions under Section 501(c)3 of the Internal Revenue Code.

MERF’s good work is funded by private donations from foundations, associations, and individuals. CSAM provides a \$5,000 annual contribution to support MERF and CSAM members serve as mentors and participate in all the activities without honorarium. MERF supporters are persons who have seen first hand the benefit of immersing physicians in this specialized and personalized environment of learning about addiction.

You can support MERF by spreading the word, volunteering, or with a financial contribution. Donations to MERF are deductible as a charitable contribution. MERF’s Tax ID number is 94-2788893. Go to: <http://www.merfweb.org/donate.vp.html> to complete the donor form and mail it with your contribution to MERF, 575 Market Street, Suite 2125, San Francisco, CA 94105.

# CASA Columbia releases New Report

## Addiction Medicine: Closing the Gap between Science and Practice

CASA Columbia\* released its five-year study, *Addiction Medicine: Closing the Gap between Science and Practice*, which reveals that 40 million Americans ages 12 and older have addictions involving nicotine, alcohol or other drugs, a disease affecting more Americans than heart conditions, diabetes or cancer, and another 80 million Americans are risky substance users — using tobacco, alcohol and other drugs in ways that threaten health and safety.

The CASA Columbia report finds that addiction treatment is neglected by the U.S. medical system and exposes the facts that:

- Most medical professionals who should be providing treatment are not sufficiently trained to diagnose or treat addiction.
- Most of those providing addiction treatment are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of evidence-based services.

“This report shows that misperceptions about the disease of addiction are undermining medical care,” said Drew Altman, PhD, President, The Henry J. Kaiser Family Foundation, who chaired the report’s National Advisory Commission. The

report finds that while doctors routinely screen for a broad range of health problems like high blood pressure or high cholesterol, they rarely screen for risky substance use or signs of addiction, and instead treat a long list of health problems that result, including accidents, unintended pregnancies, heart disease, cancers and many other costly conditions without examining the root cause.

“Right now there are no accepted national standards for providers of addiction treatment,” said Susan Foster, CASA Columbia’s Vice President and Director of Policy Research and Analysis, who was the principal investigator for the report. “There simply is no other disease where appropriate medical treatment is not provided by the health care system and where patients instead must turn to a broad range of practitioners largely exempt from medical standards. Neglect by the medical profession has resulted in a separate and unrelated system of care that struggles to treat the disease without the resources or knowledge base to keep pace with science and medicine.” ■

\* *The National Center on Addiction and Substance Abuse (CASA) at Columbia University is a science-based, multidisciplinary organization focused on transforming society’s understanding of and responses to substance use and the disease of addiction.*



MONIKA KOCH, MD RECEIVING IMQ AWARD  
FROM KATHRYN KIRKMAN, MD

## Monika Koch, MD Named CME Chair of the Year

On Friday May 4, 2012 at its annual conference, the Institute for Medical Quality (IMQ) of the California Medical Association (CMA) presented **Monika Koch, MD**, Chair of CSAM’s Committee on Education, with one of its highest honors: the CME Chair of the Year Award.

This award recognizes a volunteer Chair of the Continuing Medical Education (CME) program who is an individual who provides outstanding leadership, tireless dedication and overall guidance to strengthen the entire continuing medical education effort within his or her organization.

The award was presented on behalf of the IMQ by **Kathryn Kirkman, MD**. In presenting the award, Dr. Kirkman cited Dr. Koch’s vision, creativity, dedication, leadership and passion. In particular, she pointed to Dr. Koch’s efforts in mentoring physicians to serve as conference chairs and in other leadership positions in educational planning, her role implementing new standards for evaluation of CME, and her efforts to integrate an educational component into the work of the Society in developing public policy. ■

## Understanding CSAM's Governance Process

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in conferences and pre-conference workshops over several years to provide the information needed to formulate improved marijuana policy.

When the environment in California made it likely that legislation and propositions calling for increasing the decriminalization, and perhaps even legalization, of marijuana, CSAM created a survey to establish members' perspectives on various aspects of marijuana policy. A majority favored regulation and taxation if the revenue were committed to treatment. A strong majority favored experts in addiction medicine being involved in policy decisions regarding marijuana.

A small task force was created to explore CSAM's capacity to influence state marijuana policy. A review of the "facts on the ground" in California concluded that adolescents are most at risk of being harmed by marijuana, that they have virtually unlimited access to marijuana, and that almost no system for treating adolescents exists. It was determined that CSAM might have the potential, the possibility, to sit at the table where new marijuana propositions were being written. In this position, CSAM could work to influence future propositions in the direction of enhancing adolescent health, and perhaps eliminating the framework of "medical" marijuana — both of which would advance our members' agenda.

Before CSAM committed to *Youth First*, the report was circulated to the membership for what amounted to a vote of confidence. It was also presented to an audience of 400

attending CSAM's annual conference where it received nearly unanimous approval.

The question of whether *Youth First* is an ethical position has been explored at every step of its development. Given the realities on the ground in California, CSAM is making recommendations it believes will ultimately improve adolescent health. While CSAM's recommendations are not expected to "solve" the problem, they are intended to bring significant improvements.

Knowledge-Based Decision Making is designed to facilitate dialogue throughout an organization. In 2006, when conflicts arose at the upper levels of AI-Anon, the organization adopted KBDM in order to safeguard the unity of their fellowship. The process of HOW decisions are made was determined to be more important than WHAT decisions are made.

A process that identifies issues, encourages the gathering, dissemination, and examination of all relevant information, and discusses the pros and cons of every option before making motions and forcing votes, best nurtures the health of associations. Organizations are discovering that the Robert's Rules of Order framework of permitting motions to drive debate often arrives at premature action. Fostering full dialogue to define the issue before entertaining motions is more likely to lead to well thought-out decisions and a greater likelihood of achieving substantial unanimity. Shared knowledge is the best basis for decisions, not power. ■

## President's Message

continued from page 2

passed by the California Senate, CSAM strongly requests that the Governor sign this legislation as a humanitarian act that will save lives and provide opportunity for treatment to those who have overdosed and, if appropriate, to those who called 911 on their behalf. ■

<sup>1</sup> Warner, M., Chen, LH, Makuc, DM, Anderson, RN and AM Minino. Drug Poisoning Deaths in the United States, 1980–2008. [www.cdc.gov/nchs/data/data\\_briefs/db81.htm](http://www.cdc.gov/nchs/data/data_briefs/db81.htm)

<sup>2</sup> Paulozzi L, Mack K, Rudd R, Jones C. Vital signs: Overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR*, vol 60, 1487–92. 2011. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm>.

<sup>3</sup> Morbidity and Mortality Weekly Report (MMWR): Vital Signs: Risk for Overdose from Methadone Used for Pain Relief—United States, 1999–2010

<sup>4</sup> Davidson, Peter J. et al., "Witnessing heroin-related overdoses: the experiences of young injectors in San Francisco," *Addiction*. 2002, December. 97 (12):1511.

<sup>5</sup> Tracy, Melissa et al., "Circumstances of witnessed drug overdose in New York City: implications for intervention," *Drug and Alcohol Dependence*. 2005, (79) 181-190.

<sup>6</sup> California Department of Alcohol and Drug Programs, Overdose Deaths in California. [http://adp.ca.gov/oara/pdf/overdose\\_dths\\_2006.pdf](http://adp.ca.gov/oara/pdf/overdose_dths_2006.pdf).

<sup>7</sup> California Department of Alcohol and Drug Programs, Accidental or Intentional Poisoning (Overdose) Deaths. [http://www.adp.ca.gov/oara/pdf/overdose\\_dths\\_2003.pdf](http://www.adp.ca.gov/oara/pdf/overdose_dths_2003.pdf)

<sup>8</sup> California Department of Alcohol and Drug Programs, Overdose Deaths in California. [http://adp.ca.gov/oara/pdf/overdose\\_dths\\_2006.pdf](http://adp.ca.gov/oara/pdf/overdose_dths_2006.pdf)

<sup>9</sup> Banta-Green CJ, Kuszler PC, Coffin PO, Schoeppe JA. Washington's 911 Good Samaritan Drug Overdose Law - Initial Evaluation Results. Alcohol & Drug Abuse Institute, University of Washington, November 2011. URL: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2011-05.pdf>

<sup>10</sup> Lewis, Deborah K. et al., "Safety first: A medical amnesty approach to alcohol poisoning at a U.S. university," *The International Journal of Drug Policy*. 2006, (17) 329-338.

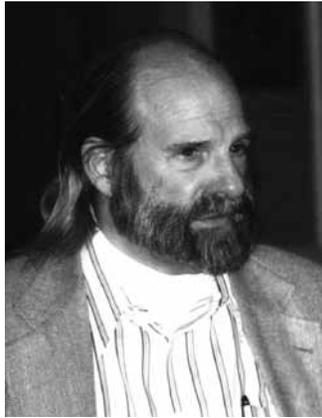
<sup>11</sup> Call 911 Good Samaritan Policies . <http://ssdp.org/campaigns/call-911-good-samaritan-policies/>

# In Memoriam

## Two Heroes of the Treatment Community Pass Away on Same Day



JACK SANOW



LYMAN BOYNTON, MD

Both **Jack Sanow** and **Lyman Boynton, MD** passed away on the June 18, 2012 and similarly, each had battled personal addiction and fought vigorously for humane treatment for others who suffered from the disease, through their work in physician groups and through the establishment of diversion programs. Each of them had been honored by CSAM for their contributions to the professional community by bringing many people to treatment and supporting them in recovery. Mr. Sanow received the CSAM Community Service Award in 1999. Dr. Boynton received the Vernelle Fox Award in 2010.

Jack saved untold lives and families through his counseling and his work in diversion programs for lawyers, judges, medical professionals, doctors, nurses and pharmacists. Lyman secured recognition for addiction medicine within the treatment system at Kaiser Permanente Medical Group and was the first Chief of Addiction Medicine at Kaiser in San Francisco where he established the first program for physician well-being that has set an excellent example for other such programs. Longtime friend **Gary Nye, MD** said of Lyman: "He was one of the real pioneers and led one of the most durable of the Bay Area physician recovery groups in Oakland. He helped so many people and made a distinctive and enduring contribution. He will be missed." And colleague **David Pating, MD** said this of Lyman: "He will be remembered by his many friends for his vivacious life, tireless advocacy for addiction recovery — and long rides into the sunset on his big Harley-Davidson." ■

CSAM News is published two to three times per year by the Communications Committee. Itai Danovitch, MD serves as Editor. Chwen-Yuen (Angie) Chen, MD, John Harsany, MD and Monisha Vasa, MD are members of the committee.

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# Methadone-Associated Deaths: Implications for Methadone Maintenance Treatment

By PETER BANYS, MD, MSC



PETER BANYS, MD, MSC

In December 2011, Berens and Armstrong published a series of articles in the *Seattle Times* analyzing deaths related to methadone. They reviewed 376,075 coroner's reports from 2003 to 2010, and they extracted 2,173 deaths indexed as related to methadone. They further found that low income geographic areas showed three times the death rates as more affluent areas.

By 2010 methadone accounted for less than 10% of opioid analgesic prescriptions but over 50% of the deaths. They blamed a change in Washington state law in 2004 that shifted opioid pain medication prescribing practices from more expensive opioids such as OxyContin (oxycodone) to a much cheaper, longer-acting medication, methadone.

In the United States, methadone is available in liquid and tablet form. Methadone Maintenance Clinics treating addiction utilize cherry-colored liquid; whereas, pain doctors utilize tablets. This difference has allowed attribution of deaths in other locales to be made according to stomach contents and clinical context (see sections below). Berens and Armstrong, working from a large database, could not make this distinction, and their text describes overdoses in chronic pain patients.

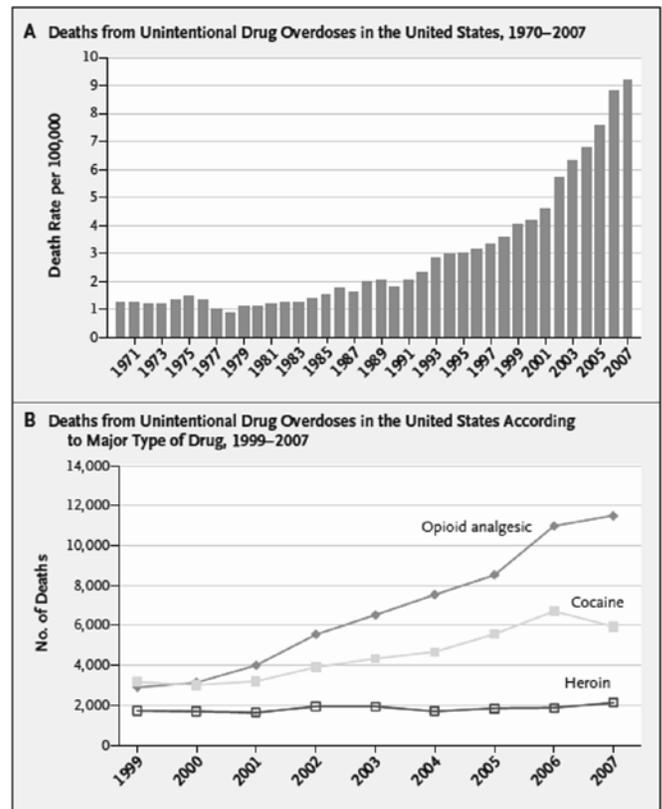
**US Experience With Pain Medications:** According to Dr. Susan Okie writing in the *New England Journal of Medicine*, "methadone sales for chronic pain have increased partly in response to pressure from insurers and Medicaid programs, because the medication has been viewed as a cheaper and potentially less abusable alternative to other long-acting pain relievers<sup>1</sup>."

About 4 million individuals receive long-acting or extended-release opioids in the US each year<sup>1</sup>. Unintentional overdoses from prescription pain medications have been of increasing concern to the Food and Drug Administration (FDA) in the United States<sup>2</sup>. The FDA wants to see more specific physician training about opioids and more widespread patient education.

Deaths have been rising steeply since the early 1990's<sup>3</sup>, as the included graphs on the right from Dr. Okie's NEJM article show. The CDC has separately reported that overdose deaths from opioid pain relievers now exceed deaths from heroin and cocaine combined<sup>4</sup>.

A Vermont state study of methadone-related fatalities (2001-2006) concluded, "Methadone maintenance therapy for heroin dependence in our population comprises an insignificant number of the methadone-related deaths (3% of the decedents). In Vermont the populations most at risk are those taking methadone for chronic pain and those obtaining diverted methadone for abuse"<sup>5</sup>. In another study in West Virginia, investigators found that only 5% of decedents were enrolled in a MMT program<sup>6,7</sup>.

In mid-2011, partially in response to Methadone-related deaths, Washington state wrote a new law that mandates opioid prescribers to enter clinical information into a statewide database and to consult a pain specialist when doses of opioids exceed certain levels. But the new rules will not apply to cancer patients.



U.S. Rates of Death from Unintentional Drug Overdoses and Numbers of Deaths, According to Major Type of Drug.

Shown are nationwide rates of death from unintentional drug overdoses from 1970 through 2007 (Panel A) and the numbers of such deaths from opioid analgesics, cocaine, and heroin from 1999 through 2007 (Panel B). Data are from the National Vital Statistics System, Centers for Disease Control and Prevention.

In some post-mortem studies in the US it has been a helpful fact that pain doctors prescribe methadone tablets whereas MMT programs prescribe liquid. Tablet fragments of methadone in decedent stomach contents helps to clearly distinguish methadone prescribed for pain from methadone prescribed for addiction, even in the absence of any clinical history.

**Methadone as an Analgesic:** Opioid analgesics have always been a mixed blessing. They are potent pain relievers, but carry with them the well-known risk of respiratory depression and death. Opioid-related overdoses have been increasing in the US for a number of years. As an analgesic for treating pain, methadone is considered second-line, generally being used after

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drugs like morphine, meperidine, or hydromorphone. Deaths in the early days of methadone maintenance treatment (MMT) programs were generally reported from respiratory arrest during the induction phase while blood levels were still rising, and deaths were most often found in the context of additional poly-substance abuse<sup>11</sup>. When used in MMT programs, the duration of action of withdrawal-prevention by methadone is generally around 24-36 hours.

When used for pain management, methadone may need to be given 2-4 times each day, although generally in lower total daily doses than for addiction treatment. In other words it is a long-acting drug for reducing craving, but not much longer acting than morphine for reducing pain. It takes 2-4 hours to achieve peak blood levels, but blood levels continue to rise for about 5-7 days following any dose increase. This delayed accumulation is thought to be the main causal factors in unintentional overdose deaths in pain patients.

Chronic pain patients are a uniquely vulnerable population. As a group they tend to be older, suffering from multiple medical problems, and being prescribed a large number of other medications. Some may have cognitive decline or forgetfulness about dosing. And, in the context of pain, they have a natural tendency to exceed physician-recommended dose limitations.

Methadone and QTc: Methadone carries a black box warning for its association with a potentially lethal cardiac arrhythmia called Torsade de Pointe (TdP) that is very rarely associated with high daily doses and a prolongation of the QTc interval on an EKG<sup>14-16</sup>. Because of its rarity and disagreements among experts about the real-world risks, QTc monitoring via EKG's is not considered a standard of care in methadone treatment at this time (2012)<sup>17, 18</sup>. A complicating factor is that scores of medical drugs and psychiatric drugs are known to increase QTc intervals as well<sup>19</sup>.

**Expert Reviews:** GAO Report (2009): Congressional concern about the rising tide of opioid analgesic deaths in the US led to a Government Accountability Office (GAO) Report on Methadone-Associated Overdose Deaths in 2009<sup>20</sup>. This comprehensive 51 page report (GAO-09-341) reviews methadone regulations, factors associated with methadone-related deaths, and steps taken to prevent overdose deaths. Because of its increasing use in pain management, Methadone prescriptions grew from 531,000 in 1998 to 4.1M in 2006. SAMHSA has established a physician clinical support system for methadone and new information about dose induction has been included in packaging materials. The report finds that, the large increase in use of methadone for pain management and "Increased availability combined with lack of knowledge and abuse of diverted methadone have contributed to increasing methadone-associated deaths." (p.18) To limit diversion of methadone, SAMHSA maintains well-established guidelines for Take-Home doses of Methadone (p.17): **Criteria used to determine whether a patient is responsible in handling opioid drugs for unsupervised use SAMHSA regulations at 42 C.F.R.8.12(h)(4)(i)(2):**

1. Absence of recent abuse of drugs, including alcohol.
2. Regularity of Opioid Treatment Program (OTP) attendance.
3. Absence of serious behavioral problem problems in the OTP.
4. Absence of known recent criminal activity (e.g., drug dealing).
5. Stability of the patient's home environment and social relationships.
6. Length of time in comprehensive methadone maintenance treatment.
7. Assurance that take-home medication can be safely stored within the patient's home.
8. Whether the rehabilitative benefit derived from decreasing the frequency of OTP attendance outweighs the potential risks of diversion.

SAMHSA expert panel reviews have found that, carefully done studies do not support the popular belief that take-home medications increase the risk of methadone-related mortality. In fact, for patients doing well in treatment, take-home medication is a reward for positive progress and a source of motivation to continue in the recovery program<sup>21</sup>.

**Pain Expert Panel (2011):** A panel of pain experts was more recently convened to review root causes of opioid analgesic deaths in the US. Reporting in 2011, they found that although, methadone represented less than 5% of opioid prescriptions dispensed, one third of opioid related deaths nationwide implicated methadone. Root causes identified by the panel were physician error due to knowledge deficits, patient non-adherence to the prescribed medication regimen, unanticipated medical and mental health comorbidities, including substance use disorders, and payer policies that mandate methadone as a first-line therapy. Other likely contributors to all opioid related deaths were the presence of additional central nervous system-depressant drugs (e.g., alcohol, benzodiazepines, and antidepressants) and sleep-disordered breathing<sup>22</sup>.

**Conclusions:** Pain patients are particularly vulnerable to unintentional overdoses, in part due to age and illness, in part due to other medications already in their bodies, in part due to forgetfulness about total intake, and in part due to renewed attempts to eliminate the chronic pain.

In contrast, it must be noted that deaths attributable to methadone alone are exceedingly rare in MMT programs. When MMT patients overdose and die, they typically do so during major relapse episodes with mixed drug ingestions implicating additional drugs like heroin, oxycodone, benzodiazepines, and alcohol. Patients on stable methadone doses are secondarily protected from simple opioid overdoses by their high level of tolerance induced by methadone. (This is why injecting heroin over a maintenance dose of methadone is usually neither dangerous nor rewarding.) It generally takes additional sedative drugs to make for a lethal combination. ■

[Refer to [www.csam-asam.org](http://www.csam-asam.org) for full article and references.]



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**CSAM Members Invited...  
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 Friday, September 7, 2012  
 at 6:30 pm  
 Hyatt Regency San Francisco**

All CSAM members and their guests are invited to attend the signature dinner and social event during the CSAM Addiction Medicine Review Course. It will be an evening to remember featuring unique themed food stations and live music. The menu features a variety of favorites from the "City by the Bay" including shrimp cocktail, clam chowder, sourdough bread, pastas, Chinatown fare, and much more. Come meet and mingle with conference attendees and CSAM colleagues! Tickets are \$50 per person. To reserve tickets, call CSAM at 415-764-4855 or email: [csam@csam-asam.org](mailto:csam@csam-asam.org)