



Members Vote to Ratify “Youth First” Report from CSAM Marijuana Policy Task Force

By TIMMEN CERMAK, MD AND PETER BANYS, MD, CO-CHAIRS, CSAM’S MARIJUANA POLICY TASK FORCE

Over 100 CSAM members registered their opinion in an online survey and many offered valuable comments about the Youth First Report submitted to the membership for a vote by CSAM’s Executive Council, which unanimously accepted the report at its meeting on October 14, 2011. The number of survey responses received was similar to the 106 responses received for a marijuana survey conducted almost two years ago in which 53% supported “legalization of marijuana if profits were taxed to support treatment.”

Through the recent online survey, 80% of the CSAM membership approved of the Youth First Report, 17% disapproved and 3% abstained. 108 total responses were received which represents roughly one-third of CSAM’s total membership.

Upon receiving this clear vote of support from the membership, the CSAM Executive Council sent the report to ASAM’s Board of Directors for presentation at their October 30 board meeting by **David Pating, MD** (ASAM Region II Director)

and **Judith Martin, MD** (ASAM Director), both members of CSAM’s Executive Council and past presidents.

The ASAM Board supported the following goals contained in CSAM’s Youth First Report as follows:

- Limit access to marijuana for those under 21
- Keep youth in school
- Provide schools with resources to identify and help students using marijuana
- Construct a community-based evaluation and intervention system to address youth under 18 who are using marijuana
- Provide treatment to youth who have become dependent on marijuana

ASAM supports CSAM’s perspective that if marijuana should ever be legalized to any extent, sufficient revenue should be sequestered upfront from any taxes and fees generated by the sale of marijuana to fund the following structure and services:

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President’s Message: Addiction Training of Primary Care Physicians May Reduce Stigma

By JEFFERY WILKINS, MD, CSAM PRESIDENT



JEFFERY WILKINS, MD

Data from the National Findings of the 2002 National Survey on Drug Use and Health revealed that approximately 18.6 million persons aged 12 or older needed treatment for an alcohol problem, and yet 17 million received no such treatment. Of interest, is that only 4.5% of the 17 million had any recognition of a treatment need. Thus, 95.5% had no recognition of their alcohol problem or the need to seek treatment for their alcohol problem. Consistent with the writings and sayings of leaders of the alcohol treatment community past and present, I would posit that the primary reason for this lack of awareness

results from shame largely derived from stigma. The responses from the 4.5% of the 17 million who did perceive an unmet treatment need support this hypothesis. Of these 761,000 apparently self-aware individuals, 24% reported that stigma associated with seeking treatment contributed to their not seeking treatment, 12% cited lack of knowledge as to where to seek treatment, 40% indexed cost of treatment as the barrier and, not surprisingly, half reported they were not ready to stop using alcohol¹.

David L. Rosenbloom, Ph.D., Director of Join Together and a professor of public health and contributor to the HBO series on Addiction notes that “Society imposes stigma on

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A Year in Review — Milestones

JANUARY: Initial planning meeting takes place for CSAM State of the Art in Addiction Medicine Conference.

FEBRUARY: CSAM Executive Council and the Committee on Education hold annual in-person meetings in San Francisco; CSAM commits additional funding to CA Public Protection and Physician Health Program (CPPPH) to support creation of mandated statewide program.

MARCH: CSAM sponsors bill to allow medical detoxification in residential facilities (AB 972-Butler) and Committee on Public Policy reviews and recommends positions on nearly 40 other pieces of legislation.

APRIL: CSAM presents report: "Expansion of Substance Use Disorder Treatment Within Reach Through Health Care Reform" to CA Senate Select Committee on Substance Abuse; CSAM Committee on Access to Treatment contacts Blue Shield about SA reimbursement issue.

MAY: CSAM Nominating and Awards Committees select candidates to recommend to the Executive Council.

JUNE: CSAM's Biennial Leadership Development Retreat takes place at Asilomar.

JULY: CSAM awarded grant from Drug Policy Alliance (DPA); CSAM responds to national media, such as NPR, regarding marijuana legislation ballot initiatives forming in other states.

AUGUST: CSAM meets with the Governor's office regarding anticipated physician health program legislation.

SEPTEMBER: CSAM Marijuana Task Force issues: "Youth First: Reconstructing Drug Policy, Regulating Marijuana, and Increasing Access to Treatment in California Report."

OCTOBER: CSAM awarded full 4-year accreditation to provide Continuing Medical Education (CME) by the Institute of Medical Quality (IMQ); CSAM State of the Art Conference in Long Beach; Executive Council elected.

NOVEMBER: Blue Shield responds to CSAM's earlier request with change in reimbursement practice; CSAM awarded grant from The Open Society Institute (OSI) for MERF program expansion.

DECEMBER: Initial planning begins for 2012 Addiction Medicine Review Course to take place September 5-8 at the Hyatt Regency Embarcadero, San Francisco.

President's Message

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addicts and their families because many of us still believe that addiction is a character flaw or weakness that probably can't be cured. The stigma against people with addictions is so deeply rooted that it continues even in the face of the scientific evidence that addiction is a treatable disease and even when we know people in our families and communities living wonderful lives in long-term recovery."

Thus, in the face of extraordinary advances in the science and treatment of addiction, addiction's stigma accompanied by the consequential intolerance of addicts, has, by-in-large, remained intransigent. This entrenchment is all the more impressive in the face of bravery and boldness of high profiled individuals such as Betty Ford and others over recent decades.

Yet, I propose that developments within addiction medicine are leading to change in the public perception of addiction, as well as legitimizing the acceptability of medical treatment for addiction. Three forces may herald this change, with the first two linked to the realm of medical education:

- 1) the efforts of the American Board of Addiction Medicine (ABAM) to achieve recognition of addiction medicine as a medical specialty by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME),
- 2) the ever increasing efforts across the country to teach the process of screening, brief intervention and referral to treatment (SBIRT) to physicians of varying specialties; and
- 3) the growing epidemic of prescription drug abuse that is increasingly creating an awareness of addiction amongst populations where it was previously ignored.

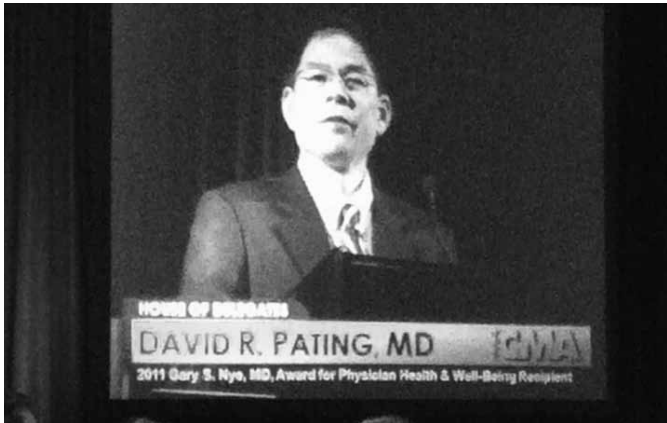
I am hopeful that the ABAM and SBIRT initiatives to train primary care doctors will not only improve their capacity to deliver basic addiction-related interventions, but will also improve the general recognition of addiction as a medical subspecialty. Of note, over 20 years ago leaders of the American Academy of Addiction Psychiatry (AAAP), with significant direction from high-level addiction academicians predominately from the east coast, blazed the trail of legitimacy for physician experts in addiction medicine by achieving board certification by ABMS as well as ACGME certification in addiction training.

I am proud to point out that both ABAM and SBIRT training are being actively addressed by CSAM. CSAM recently initiated a grant application for its sister organization, the Medical Education Research Foundation (MERF), which led to an award from The Open Society Institute for the purposes of broadening MERF's training of residency faculty and residents in the use of various interventions such as SBIRT. CSAM continues its pledge to support the integration of addiction medicine training in residency programs and ABAM's mission to establish residency programs in addiction medicine across the country. ■

References and Links:

¹ *Office of Applied Studies*. (2003). Results from the 2002 National Survey on Drug Use and Health: National findings (DHHS Publication No. SMA 03-3836, NHSDA Series H-22). Rockville, MD: Substance Abuse and Mental Health Services Administration. <http://www.abam.net> and <http://www2.aaap.org>.

Pating and O'Connor Recognized with Top Honors



DAVID PATING, MD ACCEPTS AWARD AT CMA TRUSTEES MEETING

Not only was **David Pating, MD**, the recipient of CSAM's highest honor, the Vernelle Fox Award, presented in October at the CSAM State of the Art Conference, he was also the recipient of the 2011 Gary S. Nye, MD Award for Physician Health and Well-Being, at the California Medical Association's (CMA's) House of Delegates meeting in Anaheim that same month. The CMA award is named after **Gary Nye, MD** who has been a leader in bringing attention and developing solutions to the issue of physician impairment and rehabilitation. Throughout his career, Dr. Nye has demonstrated commitment to his fellow physicians through service with organized medicine and well-being committees, and was instrumental in the development of the Medical Board of California's (MBC's) Physician Diversion Program. Similarly, Dr. Pating has dedicated himself to the issue of physician well-being and he has been particularly involved in the issue since the closure of the MBC's Diversion Program in 2007.

Dr. Pating also received the Vernelle Fox Award, which was established by CSAM in 1982 to recognize achievement in clinical, research, education, or prevention of chemical dependence. Dr. Pating was recognized for his many achievements made to the field of addiction medicine. He is a past president of CSAM and is Chief, Addiction Medicine, Medical Director, Chemical Dependency Recovery Program, Chair, Physician Well-Being and Wellness Committee, Kaiser Medical Center-San Francisco. He is also Regional Chair, Addiction Medicine Chiefs, Regional Chair, Chemical Dependency Quality Improvement Committee, Kaiser Permanente Northern California. He is an Assistant Clinical Professor, UCSF School of Medicine Site Director, VA Medical Center Fellowship in Addiction Medicine. In 2007, Dr. Pating was appointed by California's governor to the California Mental Health Services Oversight and Accountability Commission for the implementation of Proposition 63.

Dr. Pating is a member of the Board of Directors of the CA Public Protection & Physician Health Program (CPPPH). CPPPH was established in 2009 as an independent non-profit corporation dedicated to developing a statewide physician health program to respond to the needs articulated by physician health

committees. The board is currently working toward the passage of legislation to mandate a statewide physician health program. CPPPH is funded by California's specialty societies, the CMA and its component societies, the California Hospital Association, California's medical liability insurance carriers, and individual donors. CSAM has been a major contributor to CPPPH. For more about CA Public Protection & Physician Health (CPPPH), go to: <http://cppph.org>.



AT CSAM'S STATE OF THE ART CONFERENCE IN OCTOBER 2011, KAREN MIOTTO, MD PRESENTS GARRETT O'CONNOR, MD WITH A STUNNING GLASS STATUE COMMEMORATING HIS CEASELESS EFFORTS TO GIVE VOICE TO THOSE WHO HAVE BEEN SILENCED BY THE DISEASE OF ADDICTION.

Garrett O'Connor, MD, received an award on the opening evening of CSAM's State of the Art Conference at the Hyatt Regency in Long Beach, to honor the profound contributions that he has made to the field of addiction medicine.

O'Connor took the stage accompanied by his wife, Fionnula Flanagan, and told the tale of his life, weaving in notes about the evolution of CSAM over the past four decades. Anybody who has experienced a Garrett O'Connor speech knows there is no way to describe the impact he is able to achieve through spoken word. With his signature mix of honesty, wit, tenderness, and humor, he covered everything from biography and genetics to the ravages of addiction and the promise of fellowship. Dr. O'Connor's riveting presentation was followed by tributes from long-time CSAM colleagues, friends, and leaders. One by one, **Peter Banys, MD, Gail Shultz, MD, Timmen Cermak, MD, Jeffery Wilkins, MD, Gail Jara, Tom McLellan, MD, and Karen Miotto, MD** shared the ways in which Dr. O'Connor had personally and deeply moved them and influenced the practice of addiction medicine. CSAM presented him with a stunning glass statue commemorating his ceaseless efforts to give voice to those who have been silenced by their disease. The inscription read "*Garrett O'Connor, MD, who speaks for the 'invisible people' and inspires us to do the same.*" ■

CSAM's Biennial Leadership Development Retreat



CSAM'S INVITATIONAL LEADERSHIP DEVELOPMENT RETREAT BROUGHT TOGETHER CURRENT AND FUTURE LEADERS TO ADDRESS ORGANIZATIONAL AND PERSONAL DEVELOPMENT.



CSAM is always sensitive to the need to identify future leaders and looks for ways to match member strengths with CSAM's needs and opportunities, and CSAM's biennial Leadership Development Retreat is one of the most successful ways to do both. The weekend of June 10-12, 2011 at Asilomar Conference Grounds located on the beach near Monterey, CA was another memorable CSAM retreat.

During the retreat we identified our own communication styles and learned how to use our personal style to work most effectively in collaboration with others.

We walked through steps to analyze our own health and sense of professional and individual satisfaction, and were challenged to answer some probing and perceptive questions.

We spent an evening talking about marijuana in California — decriminalize and regulate it while making treatment more accessible?

We heard about what looms on the horizon for health care reform. From a presentation by **David Pating**, we got a preview of how our patients will receive care for addiction in the accountable care organizations (ACOs) that health care reform will create.

We planned a conference in 20 minutes and taught motivational interviewing to each other in role plays.

At the morning Tai Chi sessions, we learned that Lee Snook is/was a Tai Chi teacher.

At the first fireside chat, we learned that **Christy Waters** is an experienced Mah Jong player.

And on the final day, we learned that **Steve Eickelberg** is an excellent photographer.

We met some new CSAM members and welcomed **Rich Soper**, the chair of ASAM's State Chapter Committee, who traveled from his home in Nashville, TN to attend with the hope of creating a similar leadership retreat for ASAM.

All and all, there were 25 new and old colleagues discovering some new things about ourselves and others, and identifying worthy goals and areas for future collaboration. It was a spirited gathering, ensuring us that CSAM has the leadership to best serve the needs of its membership.

Personal Health and Professional Satisfaction

Peter Moskowitz, MD, who is both a practicing radiologist and Executive Director of the Center for Professional and Personal Renewal, spoke to us about life balance and living in sync with your own values. He used many questionnaires and exercises to make us name our values and then reflect on how they fit with the actual realities of our everyday lives.

Because time is the most precious resource, Dr. Moskowitz uses this time management exercise. You have 168 hours a week. (One hour equals 0.6% of the week.) Quantify how you actually spend your time in a typical week. What percent for:

- _____ % Sleep
- _____ % Maintenance activities such as bill paying, housework
- _____ % Personal Activities
- _____ % Couple Activities
- _____ % Family Activities
- _____ % Friends Activities
- _____ % Work/Career Activities
- _____ % Community Activities

Then consider if your time is invested in the areas in line with your personal values.

CSAM's Biennial Leadership Development Retreat

Communication Styles

Are you working with someone who listens carefully to you, speaks softly and slowly, giving you supportive responses? Perhaps it is **Steve Eickelberg, Rod Shaner, or Lee Snook** — they are “considerate.” What about a colleague who expresses opinions readily, with animation, and is persuasive, talking in general terms? This could be **David Pating, Judy Martin, Sean Koon, or Kerry Parker** — they are “spirited.” Are you on a team with someone who seeks information, presents material precisely, speaks efficiently and makes decisions on the facts? He or she might be **Monika Koch, Sharone Abramowitz, Bill Brostoff, or Dana Harris** — they are “systematic.” Do you interact with someone who gets right to the bottom line, speaking forcefully, maintaining eye contact and enjoying the challenge of competition? This person might be **Stephanie Shaner, Christy Waters, Mario San Bartolome or Steve Feinberg** — they are “direct.” Do you know someone who is all of the above? **Tim Cermak's** scores indicated a balance of all of the styles identified in the questionnaire from HRDQ, called “What’s My Communication Style?”

Dan Goldes, a San Francisco Bay Area organizational consultant, reviewed the strengths (“tells good stories”) and weaknesses (“doesn’t hear details”) of each of those communication styles. Then he guided us through simulation games where talking was forbidden but team effort was required, before revealing that he had changed the rules midstream to see how communication styles determined how each person would deal with that confusion.

Marijuana

One evening’s fireside chat centered on the ever present statewide marijuana debate. Discussion focused on the arguments for various positions, and which of those positions deserved CSAM’s support and why. There seemed to be consensus that one of CSAM’s goal should be to reduce harm to the lives of young people who are impacted the greatest with any use or possession of marijuana, as the consequences levied on this population can be disproportionate to their actions. For example: discipline can be expulsion from school, denied participation in sports or school activities, and mandates to enter the juvenile justice system. All of which can often cause more harm than rehabilitation. There was unanimous support that one CSAM objective should be to remove physicians from the gatekeeper’s role that was created by Proposition 215. (Under 215, patients need a physician’s recommendation to purchase from a medical marijuana supplier.)

CSAM — 2011 to 2013

Jeff Wilkins spent one evening’s fireside chat talking with the group about what areas he wanted to highlight during his tenure as president starting in October of 2011. His first interest, he said, is to contribute to prevention activities for children.

He started a discussion of how CSAM could respond to the imminent radical changes in health care delivery, a time when addiction medicine should be integrated into all specialties. One suggestion was for CSAM to establish specific, measurable objectives of reaching other specialty groups with its educational programs.

“The CSAM Way”: Advancing Our Educational Goals

One session focused on brainstorming for what CSAM should be teaching. “I rely on CSAM to keep me ahead of others about where the evidence is leading us,” said **Tim Cermak**, advocating that CSAM and its members can be at the forefront of educating our non-addiction medicine colleagues.

Judy Martin's comment was “our members should be fluent in areas that are coming up for them and their patients such as prescription drug abuse, treatment of chronic pain, changes in access to care as health care reform develops.”

“There is a yawning gap within addiction medicine between primary care and psychiatry,” said **Bill Brostoff**, recommending that CSAM should offer a whole day or two on psychiatric aspects for the addiction medicine internist. **Dana Harris** agreed, suggesting a similar intense review of detoxification for psychiatrists.

Peter Banys advocated for CSAM making education about smoking cessation a constant theme.

Mario San Bartolome recommended a CSAM “tool kit” with materials and information like screening instruments and instructions, patient agreements, directions for using CURES*, and recommended elements to be added to an electronic medical record system.

Looking Ahead

The 2011 Leadership Development Retreat was the beginning of new friendships, personal renewal, and the identification of opportunities that will serve CSAM well for many years into the future. CSAM members interested in participating in the 2013 Retreat are encouraged to contact Kerry Parker at CSAM at: csam@compuserve.com to indicate interest. ■

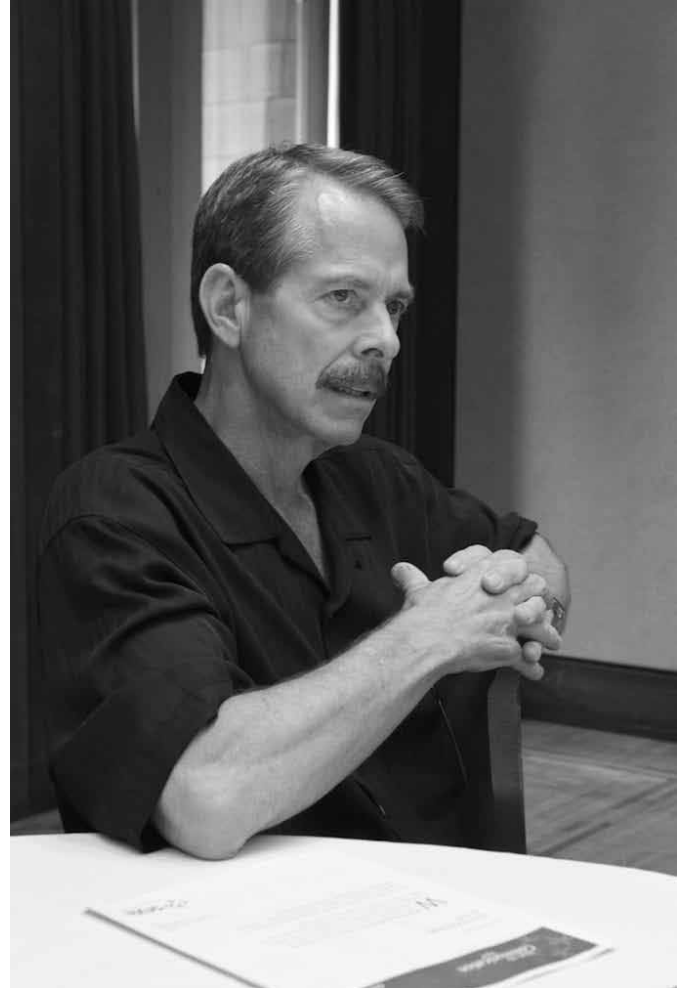
** CURES stands for the California Prescription Drug Monitoring Program and it is currently slated for closure due to the state budget crisis. CURES is an important tool that physicians, pharmacists, and other prescribers use to determine whether an individual is obtaining controlled medications from other prescribers. The ability to determine this is essential to safe prescribing to patients, to reduce the possibility of diversion, and to better protect the public health. The increasing morbidity and mortality associated with misuse of these drugs underscores the need to continue funding to the CURES program. It is urgently important that CURES continue to be available to prescribing clinicians so that we can provide the safest and most effective treatment to those needing pain medicines. CSAM notified members in December 2011 asking them to write letters to the California governor and attorney general requesting reinstatement of funding for this important program.*

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CSAM's Biennial Leadership Development Retreat



JUDITH MARTIN, MD AND SEAN KOON, MD IN DISCUSSION WITH DAVID PATING, MD, RICH SOPER, MD AND SCOTT SMOLAR, DO



STEVEN EICKELBERG, MD



PETER MOSKOWITZ, MD AND DANA HARRIS, MD



MONIKA KOCH, MD



SEAN KOON, MD AND JEFF WILKINS, MD

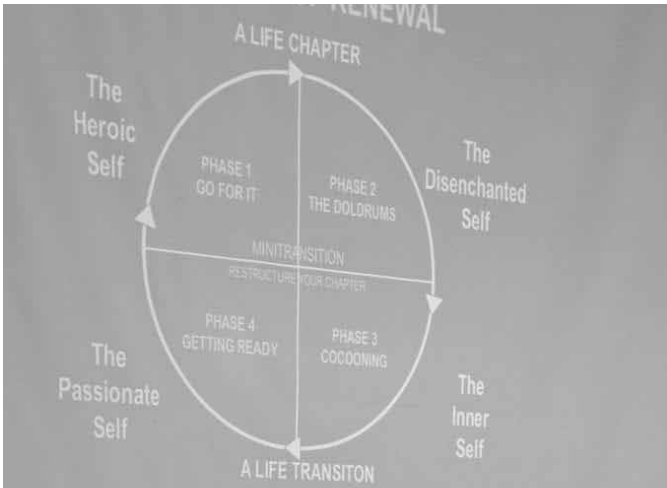
CSAM's Biennial Leadership Development Retreat



LEE SNOOK, MD



STEPHANIE SHANER, MD AND ROD SHANER, MD



PETER MOSKOWITZ, MD



DAVID KAN, MD, PETER BANYS, MD, TIM CERMAK, MD, STEVE EICKELBERG, MD AND DAVID PATING, MD

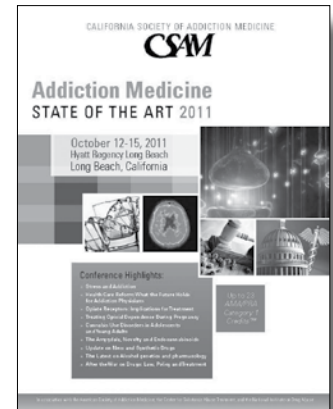


MARIO SAN BARTOLOME, MD

CSAM's State of the Art 2011 Conference in Long Beach

CSAM's annual conference, chaired by **David Kan, MD**, featured state of the art updates on the developments in addiction medicine. Held at the Hyatt Regency Long Beach on October 12-15, 2011, the course offered the latest research, as well as practical and clinical information on the following topics:

- **Francis Vocci, PhD** on medications in the pipeline and the latest on kappa opiate receptors
- **Timmen Cermak, MD** on amygdala, novelty and the endocannabinoid system
- **Paula Riggs, MD** on cannabis use disorders in adolescents and young adults
- **Silas Wheelock Smith, MD** on emerging drugs of abuse
- **Lara Ray, PhD** on the pharmacogenetics of alcohol abuse
- **Lisa Marsch, PhD** on the use of technology in the treatment of addiction
- **Linda Ferry, MD** on treating co-morbid high-risk tobacco addicts
- Optimizing office-based buprenorphine treatment
- Motivational interviewing for busy clinicians
- Monitoring physician health: mental illness, disruptive behaviors and substance abuse
- Chronic pain — optimizing treatment while mitigating risk: a clinical master class
- Treatment of addiction in adolescents and young adults: a clinical master class
- Stress and Addiction
- Health Care Reform: What You Need to Know
- After the War on Drugs



If you missed the conference or just want a refresher on a certain topic, you can download speaker presentations at no cost in MP4 format (audio and slides) at the CSAM website: www.csam-asam.org.



MEMBERS OF THE PLANNING COMMITTEE FOR THE 2011 STATE OF THE ART IN ADDICTION MEDICINE COURSE: JEAN MARSTERS, MD, TIM CERMAK, MD, PETER BANYS, MD, DAVID KAN, MD (CHAIR), MONIKA KOCH, MD, ITAI DANOVITCH, MD, TONY ALBANESE, MD, DAVID PATING, MD, KAREN MIOTTO, MD, MATT TORRINGTON, MD AND MICHAEL BARACK (CSAM CME COORDINATOR). NOT PICTURED: JUDITH MARTIN, MD

CSAM Receives Foundation Grant to Expand MERF



MERF SCHOLARS WITH MEMBERS OF THE MERF BOARD AND THE CSAM EXECUTIVE COUNCIL AT THE CSAM STATE OF THE ART CONFERENCE.

The Open Society Institute (OSI) has awarded CSAM a grant for \$150,000 over a two-year period to expand addiction medicine education for primary care physicians. The program is conducted through CSAM's sister organization, the Medical Education & Research Foundation (MERF). The grant will allow for expansion of the program to mentor and train pediatric and family physicians in addiction medicine in an effort to increase support for access to high quality, evidence-based screening and treatment.

Since 1986, MERF's important work has been funded primarily through private donations. The idea for grant writing started in June 2010 when the MERF Board of Directors met in Palm Desert at the Betty Ford Institute for a strategic planning day. There the Board focused on identifying new sources of funding for MERF and decided to explore new avenues which included applying for foundation grants, as well as beefing up

other efforts to raise donations. Now, just over a year later, it is very exciting to see that these efforts have borne fruit.

In addition, fundraising efforts were in full gear at the CSAM State of the Art Conference in Long Beach where **Gail Shultz, MD** threw down the gauntlet with his offer to match up to \$2,500 of MERF donations made at the conference. On top of this, conference chair **David Kan, MD** made compelling pleas from the podium where he was waving cash from his own pocket as he asked for donations, which together with the pre-conference donations raised a total of \$4,451 — far exceeding Dr. Shultz's challenge. All this, along with the steady annual donation of \$8,000 that comes from the R&S Johnson Foundation, thanks to **Steve Eickelberg, MD**, made this a banner year for MERF and has put the organization in an excellent position to further its mission. ■

Members Vote to Ratify “Youth First” Report from Task Force

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1. Marijuana Regulatory Structure
2. Adolescent Education, Marijuana Prevention and Smoking Cessation Public Education
3. School-Based Early Intervention, Community Youth Commissions and Treatment Systems
4. Ongoing System of Data Collection and Analysis

However, the ASAM Board of Directors currently considers any legalization of marijuana to be inconsistent with its public policy position as stated in item #9 in its statement of National Drug Policy:

“ASAM opposes any changes in law and regulation that would lead to a sudden significant increase in the availability of any dependence-producing drug. Any changes should be gradual and carefully monitored.”

The sense of the ASAM Board at their meeting on October 30, 2011 was that, while it recognizes that state chapters face significantly different histories and environments regarding marijuana, it remains critical for the Society as a whole to speak with one voice. Multiple public policy statements by ASAM and state chapters must be consistent.

In order to identify common ground and develop a position that is acceptable at both the state and national levels of ASAM, the ASAM Board of Directors has invited CSAM to enter into a dialogue with the purpose of developing language that permits the two entities to remain consistent in their policy statements. The ASAM Board expressed its willingness to explore modifying its own position in a direction that better embodies the public health perspective

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Policy Committee Seeks Involvement from Members

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



CHRISTY WATERS, MD

The Committee on Public Policy started the year tracking 38 different bills that had a possible role in the treatment of persons with chemical dependency. Some of the bills were new ones and some were familiar from previous years such as AB 154 (Beall). This bill sought to expand insurance coverage to include diagnosis and treatment of substance abuse on par with other medical illnesses. It has passed in previous years, but then was vetoed by the governor at that time. Unfortunately this bill is still being held in suspense during these very uncertain economic times.

We actively supported 12 of the 38 bills and wrote letters of support to the authors of the bills and sometimes appeared before Committee to testify during a hearing. CSAM's policy advisor **Robert Harris** helped us stay in touch with key staff personnel to maximize our impact and know what we needed to do next. Six of these bills have made positive movement toward becoming new programs, regulations or law. Three of the original 38 bills were actively opposed and we were successful in defeating them. One example of this included mandatory drug testing of CalWorks recipients.

We were very happy to support SB 39 (Padilla) which outlawed the sale of caffeinated beer beverages and recently passed successfully. This puts us in line with Kansas, Massachusetts, Michigan, New York, Utah and Washington who have all banned this drink which appeals to adolescents and makes it easier for young people to consume too much alcohol before registering the effects.

We also supported AB 472 (Ammiano) for protection of anyone who calls 911 during an overdose situation, however, it did not reach the governor's desk, but is expected to return next session.

AB 540 (Beall): Assembly member Beall had our support to establish Medi-Cal Alcohol and Drug Screening and Brief Intervention Services Program. This would allow establishment of and reimbursement for these services. It passed the Assembly 78-0, but stalled in the Senate Appropriations Committee.

SB 544 (Price): This was an especially egregious bill that appeared suddenly and required Robert Harris to work very quickly in concert with Randall Hagar from the CA Psychiatric Association to have the author cancel it. The bill would have allowed the Medical Board to take immediate action on any violation of law, state or federal, related to drug or alcohol as prima facie evidence of unprofessional conduct without due

process protection. This may reappear in a different form next year.

One of the most important bills that we supported this year was SB 742 (Yee) which is also known as the "Public Protection and Physician Health Program Act of 2011." **David Pating, MD** and **Lee Snook, MD** are very intimately involved in the development of this important program for our colleagues who are suffering from the disease of addiction. This is still in process and involved the establishment of a new, independent non-profit 501c3 organization. This was a "spot bill" for renewed efforts to secure the authority to receive funds from licensure fees from all California licensed physicians. It will also get the legislative recognition for establishment of a statewide program. Expect a bill to be introduced in the 2012 legislation session.

Nothing is easy in a state with the size and diversity of California. Taking an idea through legislation to become established as a regulation is about as different from the practice of medicine as it can be. There are a lot of people involved and they each have their own experiences, education, agendas and spheres of influence, a lot of steps within the legislative process itself, and a whole host of influencing variables which can change in hours. It seems to move so very slowly and is not at all rational, which can be frustrating to physicians who are always pushed for time/results. If you ever want to check on what is happening with a particular bill you can go to www.leginfo.ca.gov/bilinfo.html. There is an option to have email updates sent to you whenever an action is taken on the bill.

We also need physicians who can come to Sacramento and testify for CSAM before a committee. We are asked more and more by legislators to come and provide factual information. We can be proud of our reputation as a voice of evidence-based medicine. If you have an interest and could volunteer a very occasional afternoon, we can support you with the talking points and any other information that you would need. The committees usually want you to speak for two minutes and this can be done sitting down, with notes. Think about it! When we get a policy passed it has the potential to change thousands of lives which none of us can hope to do in our offices in that same amount of time. Treatment works and our patients need our help on many levels to make this happen. ■

Dr. Waters is Chair, Committee on Public Policy and a physician at Kaiser Permanente Department of Psychiatry, San Francisco. Contact her at: Christy.Waters@kp.org

A Report from Sacramento: SA/MH Services Fall to the Counties

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



DAVID PATING, MD

California's Department of Alcohol and Drug Program (CADP) may be in the process of being eliminated and its functions parsed out to other state agencies.

The *real* disaster is the significant reduction in funding for alcohol and drug treatment services at the county level, which has resulted in reductions (on average) of 20%+ budget cuts to county MH and ADP budgets from 2009-2011 due to statewide county shortfalls. The state has seriously exacerbated this problem for cash-strapped counties by retaining payment to counties for many federal entitlement programs (e.g., Healthy Families) for the past three years. This IOU kept the state budget intact at the expense of local services. Some state mandated programs (SACPA Prop 36) are permanently unfunded and removed from the state budget. And while I do not believe our Drug Medi-Cal reimbursement rate decreased, the lack of county funding meant that less capitated service was provided resulting in significantly reduced federal matching dollars. This was a triple insult to county MH/SA services: cash poor, unpaid for entitlements and unable to get federal match!

A bright spot has been \$1B spent for mental health under the Mental Health Services Act. Counties have used this to offset some of the services lost to the recession, although

these funds have many restrictions and cannot supplant core MH or ADP core programs. This has provided some "float" money, but it's on borrowed time and at a loss of staff. With many MH/SA layoffs, we may not recover the workforce once money returns to the system. This is a permanent crisis.

On a final more positive note, California counties are looking forward to expanded MH/SA benefits under Health Care Reform. The Affordable Care Act promises new dollars at a lower reimbursement rate. As part of a DHHS waiver (1115b Waiver), California is negotiating expanded MH and Drug Medi-Cal coverage as a "Bridge to Reform." In the short term, before ACA's 2014 implementation, it is unclear from where the new monies for the expanded "bridge" Medi-Cal coverage will come. Moreover, California's counties bear an even greater obligation for providing safety net care under this plan. In exchange, California's permanent "budgetary realignment" of all State General Mental Health Care Fund to counties is a rosy promise that will release counties from state oversight.

In short, statewide ADP services have decreased at the local county level. The changes are permanent and in high flux. California State DMH and ADP are quickly exiting the role of serving as intermediary for services and will develop financial pass-through mechanisms (realignment) to streamline funding. The hope is that with local control of funds, local needs can be better met. Until then, the gap is growing larger. ■

Blue Shield of CA Changes its Practice at CSAM's Urging *New Reimbursement Options for Physician-Administered, Extended Release Naltrexone for Medication-Assisted Treatment*

Thomas Brady, MD, Chairman of the CSAM Committee on Access to Treatment, achieved a success in late October 2011 in improving access for Blue Shield of California's patients to non-narcotic injectable naltrexone — VIVITROL(R) — by working with Blue Shield, on behalf of its contracted CSAM providers and their patients.

By letter Dr. Brady had alerted Blue Shield's Senior Vice President and Chief Medical Officer, **Meredith Mathews, MD**, to the patient and provider access and reimbursement issues posed by CA Blue Shield's prior policy mandating that physicians who wanted to provide VIVITROL(R) first purchase this medication and then seek reimbursement only after providing treatment (known as a "buy and bill" arrangement). Dr. Brady's dialogue with Blue Shield, which began formally

last April, pointed out VIVITROL(R)'s two FDA-approved indications (for alcohol dependence and for prevention of relapse in opioid dependence), and he indicated that this medication was of major importance to Blue Shield's contracted CSAM physicians and members.

Dr. Brady explained that even though CSAM members wanted to provide this medication, many CSAM physicians treating alcohol or opioid-dependent patients, who are often under-diagnosed and under-treated, do not have the infrastructure to handle a buy and bill arrangement such as the one that existed for Blue Shield providers of VIVITROL(R). He noted that this was problematic since the medication provides a documented medical benefit and is one of the few FDA-approved medications to treat substance dependence.

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Syringe Access in California Signed by the Governor

In October 2011, Governor Jerry Brown signed two bills to improve syringe access as part of the State's comprehensive approach to the prevention of HIV & hepatitis. **David Kan, MD**, Chair of CSAM's 2011 State of the Art in Addiction Medicine Conference, announced this as a public health victory to a crowd of over 400 physicians gathered for the conference. Kan was one of several CSAM members who participated with CSAM's Committee on Public Policy to gain passage of the bills. Over the summer, Kan testified before a legislative committee at the request of CSAM.

The two bills as signed go into effect on January 1, 2012 as follows:

Syringe Exchange (AB 604-Skinner). Health, social services and other programs may apply to the California Department of Public Health to add syringe exchange or the program may apply to their local city or county government for an authorization.

Pharmacists & Physicians Distribution of Syringes (SB 41-Yee). A physician or pharmacist may provide 30 or fewer syringes to an adult without prescription. An adult may possess up to 30 syringes for personal use, from a pharmacist, physician or authorized syringe exchange program.

The bills are supported by both state and federal agencies:

"Access to sterile syringes is unquestionably vital in the struggle to reduce the spread of HIV, HCV, and other blood-borne infections among IDUs, their sex partners, and their children." — **Office of AIDS, California Department of Public Health, September 2011**

"Several studies have found that providing sterilized equipment to injection drug users substantially reduces risk of HIV infection, increases the probability that they will initiate drug treatment, and does not increase drug use." — **National HIV/AIDS Strategy - White House, July 2010**

"Syringe service programs (SSPs) are widely considered to be an effective way of reducing HIV transmission among individuals who inject illicit drugs and there is ample evidence that SSPs also promote entry and retention into treatment" — **US Department of Health & Human Services, February 2011**

For more information, contact Alessandra Ross, Office of AIDS at 916-449-5796 or Alessandra.Ross@cdph.ca.gov. ■



DAVID KAN, MD ANNOUNCED THE SIGNING OF THE TWO BILLS DURING THE CSAM STATE OF THE ART CONFERENCE IN LONG BEACH.

MBC Seeks Expert Reviewers in Addiction Medicine

When complaints are made to the Medical Board of California (MBC) about a physician, the Enforcement Division evaluates them. Some cases require review by a physician experienced in the appropriate practice area, and for that the Medical Board maintains a roster of Expert Reviewers who are to provide impartial opinions to aid in the investigation and the enforcement functions.

In 2011, three to five cases per month were sent for review in matters related to addiction, but reviewers were not always readily available to make the evaluations and reports to the MBC. Now the Medical Board is seeking to add to their list of experts in addiction medicine.

"The mission of the Board is consumer protection," said Renee Threadgill, Chief of Enforcement. "The only way to accomplish that is if we have physicians involved who

can review for the standard of care and how it is applied. We rely on the expert reviewers to insure that we are doing the right thing."

Reviewers are paid \$150 per hour for conducting case reviews and \$200 an hour for providing expert testimony. Under the MBC system, Expert Reviewers also conduct oral competency exams (\$150/hour) and do physical or psychiatric examinations for the Medical Board with payment of usual and customary fees.

To see a description of the expert reviewer program and read sample (fictionalized) reports, go to http://www.mbc.ca.gov/licensee/expert_reviewer.html.

For information, contact Susan Goetzinger, the MBC Program Analyst in charge of the Expert Reviewer Program at 818-551-2129 or Susan.Goetzinger@mbc.ca.gov.

Blue Shield of CA Changes its Practice at CSAM's Urging

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He pointed out that given both the office-based practice arrangements of most CSAM members and the increasing need to care for these dependent patients, Blue Shield's buy and bill arrangement was creating an undesirable barrier for CSAM providers to provide a safe medication, with documented clinical effectiveness, for their patients. He asked that Blue Shield re-examine its prior policy and he proposed that Blue Shield offer a specialty pharmacy exception for VIVITROL(R).

Dr. Mathews and Blue Shield staff reviewed and granted this request for an exception which is a substantial change for this insurer as well as for CSAM prescribers and patients. Physicians can now prescribe VIVITROL(R) for their commercial Blue Shield members. Once the new arrangements are finalized, which are expected soon, physicians can either buy and bill as previously done or avail themselves of the new alternate specialty pharmacy option from Blue Shield. This new exception option allows physicians to order VIVITROL(R) from Caremark's specialty pharmacy at 1-800-238-7828. Blue Shield's existing authorization process remains in place. For insurers other than Blue Shield, CSAM VIVITROL(R) prescribers can use the Touchpoints system for rapidly enrolling patients, as well as obtain co-pay assistance for eligible patients and rapidly enrolling patients in VIVITROL(R) treatment. Touchpoints can be accessed via 1-800-VIVITROL.

Broader Coverage, Enhanced Access

The picture of insurance coverage for VIVITROL(R) prescribing in the State of California is improving. Blue Shield, Health Net, Medi-Cal and Aetna all provide VIVITROL(R) coverage under a medical benefit, while Pacificare/Secure Horizons provides it under a pharmacy benefit. UnitedHealth Group covers VIVITROL(R), as does Healthy Way LA, an LA Low Income Health Plan. Progress is being made on improving CSAM physician access to VIVITROL(R) and other medications used for treating addictions. As practice and processes improve, documentation of positive outcomes will build, and gradually patient and provider acceptance of these interventions will grow so that eventually demand for this type of evidence-based care will increase.

To contact CSAM's Committee on Access to Treatment to comment on this or other access issues, write to: csam@compuserve.com. ■

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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Study Finds that Methamphetamine Treatment Program, PROMETA™, is Ineffective

A recent study, published online in the scientific journal *Addiction* on November 14, 2011, has found that PROMETA™, a controversial treatment for methamphetamine addiction, is no more effective than placebo in reducing methamphetamine use, keeping users in treatment, or reducing cravings for methamphetamine. The study was funded by Hythiam, the company that owns the PROMETA™ protocol.

Methamphetamine, also known as meth, crystal meth, or ice, is the second most abused illicit drug in the world (cannabis is first), with 15-16 million regular users. The United States saw a rapid growth in methamphetamine addiction in the early 2000s. It was during that epidemic that PROMETA™ burst onto the public scene through an aggressive marketing campaign.

Since its introduction, the PROMETA™ protocol has been widely used in specialized private clinics in the U.S. as a treatment for methamphetamine addiction without going through the normal drug approval process. Normally, introducing a new medication requires approval by the U.S. Food and Drug Administration, including tests of product safety and a clinical trial to make sure the treatment produces the predicted effects. A loophole in this regulatory system allows a combination of previously approved medications to be marketed without review, whether or not the individual medications were originally approved as a treatment for the condition the new protocol targets. The manufacturer of PROMETA™, Hythiam, was therefore able to market and sell the new protocol with no federal review or clinical

trial evidence.

Private patients reportedly pay \$12,000 to \$15,000 for one month of treatment.

In 2006, several CSAM members voiced strong concerns that the marketing for this treatment was ahead of the evidence for both its safety and efficacy. While not every form of treatment can be researched with protocols that meet the gold standard for credible evidence, CSAM communicated the principle that those products and protocols that can be researched at high levels of evidence-credibility should be, before their benefits are promoted and adopted as proven forms of treatment. CSAM urged physicians to use caution when recommending unproven treatments for substance abuse. CSAM published a **“Statement of CSAM Principles Regarding Evidence-Based Medicine.”**

Hythiam used some of its profits to fund the clinical trials including this one, designed and led by CSAM member **Walter Ling, MD**, an expert on methamphetamine addiction. Ling and his fellow researchers found that the group of participants given the PROMETA™ treatment did not have better outcomes than those given placebo in terms of reducing methamphetamine use, retention in treatment, or reducing methamphetamine cravings. ■

Ling, W., Shoptaw, S., Hillhouse, M., Bholat, M. A., Charuvastra, C., Heinzerling, K., Chim, D., Annon, J., Dowling, P. T. and Doraimani, G. (2011), Double-blind placebo-controlled evaluation of the PROMETA™ protocol for methamphetamine dependence. *Addiction*. doi: 10.1111/j.1360-0443.2011.03619.x

Members Vote to Ratify “Youth First” Report from Task Force

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being pursued by CSAM.

The ASAM Board recognizes that time is of the essence for CSAM to be able to impact the political processes underway in California. Discussions with the ASAM public policy leaders are ongoing.

Trustees of the California Medical Association (CMA), which represents more than 35,000 physicians statewide, recently adopted a position calling for regulation and taxation of marijuana. The trustees acknowledged the health risk associated with marijuana use, and proposed that it be regulated along the lines of alcohol and tobacco. It is the first major medical association in the nation to urge regulation and taxation (i.e., elimination of criminal penalties) of the drug and the position is controversial. The CMA position calls for “earmarking” tax revenue from the sale of cannabis

“to reduce cannabis use among children, adolescents, and young adults.” CSAM has requested that the CMA adopt the Youth First Report to more fully address the treatment issues already associated with youth using marijuana.

Last November, California voters rejected Proposition 19, which would have legalized the possession and cultivation of limited amounts of cannabis and permitted local governments to regulate it and tax sales. The CMA took no public position on the measure, nor did CSAM. CSAM noted at the time that Proposition 19 was poorly written and incorrectly stated to the voters that there are no adverse health affects associated with marijuana use. CSAM anticipates there will be other ballot measures as well as legislation in the next session seeking to legalize and regulate marijuana. ■

Expansion of Substance Use Disorder Treatment Within Reach Through Health Care Reform

UNIQUE OPPORTUNITY

National health care reform provides California with the best opportunity to date to significantly expand and improve care for people requiring substance use disorder (SUD) treatment. All public and private health plans must include treatment for substance use disorders among basic benefits. Currently, most Californians requiring SUD treatment receive inadequate care. California has the capacity to design effective SUD treatment coverage for all Californians who need it.

What should treatment look like under health care reform?

Decades of SUD research has led three national scientific institutes to establish national standards for addiction treatment. The National Institute of Drug Abuse (NIDA), National Institute of Alcohol Abuse and Addiction (NIAAA), and the Institute of Medicine (IOM) have articulated explicit evidence-based guidelines for effective and efficient SUD treatment services. The cornerstones of these guidelines are:

- Addiction is a chronic disease
- Addiction is treatable
- Addiction treatment must be on-going and continuous
- No single treatment is effective for all individuals
- Co-occurring medical and psychiatric conditions must be addressed

Medically necessary care for substance use disorders

- **Entry to treatment:** "No wrong door" to access treatment. Treatment entry through health care, community-based programs and self-help groups.
- **Screening, brief intervention, and referral to treatment (SBIRT):** Full reimbursement in emergency rooms and primary care settings.
- **Medical detoxification:** Must be covered under medical benefits for inpatient or outpatient care.
- **Effective treatment dosage:** No limits; treatment as long as medically necessary.
- **Outpatient Treatment:** The mainstay of SUD treatment.
- **Inpatient treatment:** Medically necessary for higher risk patients.
- **Continuum of care:** Treatment must include medical detoxification, inpatient and outpatient treatment and aftercare, as well as appropriate medical and psychiatric care.

- **Bi-directional care:** SUD treatment must be available at primary care and mental health care, and primary care and mental health care must be available at SUD treatment.
- **Co-occurring disorders:** Treatment of the dually diagnosed mentally ill substance abuser must be comprehensive, continuous and integrated.
- **Medication-assisted treatment:** Medications for SUD treatment must be a covered benefit available through qualified physicians.
- **Adolescent treatment:** Extended integrated care must be provided through merging of substance use disorder treatment, mental health care and pediatric or family medicine.

State actions for effective treatment under health care reform

State government will play a critical role in planning and regulating SUD treatment benefits and services that Californians receive under health care reform. The following areas must be addressed:

- **Essential treatment coverage:** Statewide treatment standards as outlined above must be based on medical necessity without any limits, just like with any other chronic illness.
- **Effective outreach:** Robust efforts must be undertaken to enroll uninsured individuals in new Medi-Cal and private insurance plans.
- **Workforce training:** Treatment workforce must be readied for integration of SUD treatment with primary health care.
- **Prevention:** New federal funds for effective prevention must be sought.
- **New care delivery models:** Integrated behavioral health care models that promote effectiveness and efficiency need to be moved beyond pilot projects.
- **Enhanced research and outcomes:** Accountability and outcomes need to be measured statewide.
- **Oversight:** State agency-level commission should be established to ensure effective and efficient implementation of California SUD treatment standards.

Download the full text of this CSAM white paper entitled: "Expansion of Substance Use Disorder Treatment Within Reach Through Healthcare Reform," at: www.csam-asam.org.

CSAM Launches New Website

The CSAM website has been updated and improved. It now offers each member the ability to update his/her own profile information through a "Members-Only" area of the site. In addition, it includes an upgraded "physician locator" and previous conference presentations available for download. Be sure to visit the new site and update your profile.

Go to: www.csam-asam.org



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