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Measure Qualifies for November Ballot

Voters to Decide on Marijuana Legalization

By Timmen Cermak, MD, CSAM President

In 1996, when California voters were facing Proposition 215 — the Compassionate Use Act — that established "medical marijuana" and gave rise to the proliferation of Cannabis Clubs, CSAM sat on the sidelines while over 55% of voters voiced approval. We had no Public Policy Committee at that time, and no internal mechanism for either establishing or expressing opinions on significant matters such as Prop 215.

I was embarrassed that the primary physician organization representing addiction medicine in California was mute in the face of an issue that had such immediate bearing on our area of expertise, and such pervasive impact on the health of our state. Failing to understand how volunteer organizations really work, I raised the question of CSAM's silence about Prop 215 at a business meeting and quickly discovered that I had volunteered to head a marijuana task force.

With CSAM members representing a wide divergence of perspectives on marijuana, I was able to produce two White Papers for CSAM – one on cannabis and its potential for medical uses and another on adolescents and marijuana. In the process it became painfully apparent that considerably more agreement existed than we had suspected. I say "painfully" because we all became aware of the lack of internal dialogue we had fallen into in response to the government's pressure not to deviate from the War on Drugs rhetoric being promulgated.

2010 brings California again to the brink of voting on a proposition to alter the legal status of marijuana in a fundamental way. Sufficient signatures have been gathered to place at least one proposition on this November's ballot calling for the legalization of

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Editor's Commentary

CSAM Members Speak Out on Medical Marijuana

By Itai Danovitch, MD

This issue of the CSAM Newsletter focuses on medical marijuana, and features a pilot e-survey. The e-mail based survey was developed to gauge the beliefs, attitudes, and practices of CSAM members around this controversial subject. While the survey is not representative of CSAM as a whole, it offers a unique window to the opinions of a substantial group of members. Physicians, with their busy schedules, are a notoriously difficult group to survey, and the response rate suggests an exciting level of willingness to take part in this discourse.

What does the survey tell us? First and foremost, the almost unanimous agreement that addiction medicine should be involved in drafting public policy on drugs of abuse is a resounding endorsement of CSAM's directive to be "the voice of addiction medicine specialists on public policy and clinical issues in California." Second, the near even split of responses to the question on whether marijuana should be made legal, and the relatively high undecided response rate on that matter, reflects the complexity of this issue. Addiction associations such as CSAM have had difficulty taking positions on medical marijuana legislation, in large part

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IS MARIJUANA AN ACCEPTABLE MEDICAL INTERVENTION FOR ANY MEDICAL CONDITION?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	**54.7%**	**58**
NO	**29.2%**	**31**
UNDECIDED	**16.0%**	**17**
	ANSWERED QUESTION	**106**

CSAM President's Message: Voters to Decide on Marijuana Legalization

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marijuana use for individuals 21 years and older. As president of CSAM I am committed to our society's playing an active and constructive role in shaping the upcoming debate about marijuana legalization.

This newsletter presents two statements – one on Medical Marijuana and the second on Medical Aspects of Marijuana Legalization – produced collaboratively and unanimously accepted by CSAM's Executive Council. A survey of the membership, conducted after the statements were created, appears to confirm that we have generally represented our chapter's views on the topics.

We chose to bifurcate the two topics of medical marijuana and legalization in order to create more clarity for each. Rather than promote a specific pro or con recommendation regarding legalization (neither of which would express a majority of the membership's perspective, as revealed by the survey), we struck a more educational/advisory posture. We feel CSAM has a responsibility to inform the public of scientific data on cannabis as it makes its decision regarding legalization. And there are ethical principles guiding medical practice that we feel CSAM should reiterate and strongly support in regards to the use of marijuana for medical purposes.

The two statements have been sent to the American Society of Addiction Medicine (ASAM) for review, although we are confident that they contain nothing that deviates from currently stated ASAM policies. The ASAM Board has charged a task force with reviewing data regarding medical uses of marijuana that plans to issue a report soon. This task force has brought to our attention that the Public Policy Statement on National Drug Policy calls for ASAM to "oppose any changes in law… that would lead to a sudden significant increase in the availability of any dependence-producing drug." I believe that California has already drifted over the past 14 years into a state of de facto legalization of marijuana. Whether total legalization is wise or not is a matter for the public to decide, but it would not represent "sudden" change, not in California.

CSAM faces issues related to marijuana within a very different environment than the rest of the country. The drug is

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CSAM Members Speak Out on Medical Marijuana

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because the membership they represent have such compelling, but counterbalancing, points of view on the subject. But if addiction associations are to effectively represent practitioners of addiction medicine, then these disparities may point the way forward. Third, the strong response rate, particularly given the absence of incentives, suggests that e-mail based surveys may be a viable tool for gauging the beliefs, attitudes and practices of many CSAM members.

In addition to the survey questions, there was an opportunity to link to a dialogue box and submit free form comments. Many members took the time to voice their experiences, impressions, and concerns about medical marijuana. Their entries were thoughtful, articulate and compelling, and making selections for this newsletter was quite challenging. The brief editorials printed here offer a range of perspectives pertaining to the medical, public health, and criminal justice ramifications of marijuana legislation.

The survey should be viewed with consideration of its limitations. Psychometric parameters, such as measures of reliability and validity, were not established. The survey was disseminated by email to all registered CSAM members (N= 400) on February 11, 2010, with two follow-up reminders but no incentives. An impressive 106 members responded, a response rate of 25%, but the findings may be skewed by selection bias. While some characteristics of responders may be inferred (such as utilization of email), the survey did not assess demographics (specialization of practitioner, type of practice, age, etc.), so it is not possible to draw conclusions about subgroups of the CSAM membership.

The issue of marijuana legalization is rife with controversy, particularly within the field of addiction medicine, and the willingness to publish the survey and commentary in this forum reflects CSAM's substantive commitment to transparent, open dialogue. Underlying that commitment is a belief that dialogue, communication, and mutual education is a means through which complicated medical and public health issues can be first clarified, and eventually resolved for the betterment of our patients. We hope this encourages your continued active participation. As always, your contributions are welcome.

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HAVE YOU EVER RECOMMENDED MARIJUANA TO A PATIENT?

ANSWER OPTIONS	RESPONSE PERCENT	RESPONSE COUNT
YES	28.3%	30
NO	68.9%	73
UNDECIDED	2.8%	3
	ANSWERED QUESTION	106

Results of E-Survey

CSAM Members Speak Out on Medical Marijuana

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SHOULD MEDICAL PHYSICIANS BE PERMITTED TO RECOMMEND MEDICAL MARIJUANA?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	**61.9%**	**65**
NO	**22.9%**	**24**
UNDECIDED	**15.2%**	**16**
	ANSWERED QUESTION	**105**

SHOULD MARIJUANA BE DECRIMINALIZED?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	**69.2%**	**72**
NO	**22.1%**	**23**
UNDECIDED	**8.7%**	**9**
	ANSWERED QUESTION	**104**

SHOULD MARIJUANA BE LEGALIZED?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	**39.6%**	**42**
NO	**43.4%**	**46**
UNDECIDED	**17%**	**18**
	ANSWERED QUESTION	**106**

IS THERE A DIFFERENCE BETWEEN DECRIMINALIZATION AND LEGALIZATION?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	**67.9%**	**72**
NO	**14.2%**	**15**
UNDECIDED	**17.9%**	**19**
	ANSWERED QUESTION	**106**

"Marijuana is a raw botanical of unknown content. The term reflects this generic reality. To equate it with the known concentration of an FDA approved drug, regulated and tested for potency and content, and supported by a rigorous evidence-based scientific inquiry is not valid. We know that the compound chemicals in marijuana, including THC, can lead to addictive disorder in a substantial part of our population and that youth are particularly at risk. We do not know how to test for 'sober' levels of THC as yet and there is no established method for law enforcement to assess sobriety with chemical analysis as yet. For public safety reasons, we should be very cautious about increased availability of this botanical at this time."

— **Lee Snook, MD**
Metropolitan Pain Mgt., Sacramento

"I've been practicing addiction medicine for over 38 years and have yet to see a patient with a valid indication for medical marijuana. The public should not pre-empt what should be an FDA function in deciding about whether a drug has valid medical use."

— **Richard Merrick, MD, FASAM**
Kaiser, Carson

"As it stands in my geographical area I rarely see a legitimate medical marijuana prescription request. But I do see bogus and irresponsible prescriptions that interfere with proper addiction treatment. Addiction physicians should stick to evidence-based medicine. I believe that the general population will respect (may not like) the opinion and lead of physicians and scientists who understand all the implications and have a balanced approach to this issue and err on the side of caution and safety, not popular demand. We have the potential of recommending beneficial or ruinous medicine."

— **Edgar Castellanos, MD**
Community Human Services, Salinas

"Legalization of marijuana does not mean encouragement of drug abuse. There is an epidemic of boredom among teenagers that often leads to experimentation with substances and processes

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Results of E-Survey

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IS POTENTIAL INCARCERATION AN EFFECTIVE DETERRENT TO DRUG USE?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	31.1%	33
NO	60.4%	64
UNDECIDED	8.5%	9
	ANSWERED QUESTION	106

WOULD LEGALIZING MARIJUANA REDUCE CRIME?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	51.4%	54
NO	31.4%	33
UNDECIDED	17.1%	18
	ANSWERED QUESTION	105

WOULD INCREASED AVAILABILITY OF MARIJUANA INCREASE ADDICTION?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	63.7%	65
NO	22.5%	23
UNDECIDED	13.7%	4
	ANSWERED QUESTION	102

WOULD INCREASED AVAILABILITY OF MARIJUANA INCREASE CRIME?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	14.2%	15
NO	61.3%	65
UNDECIDED	24.5%	26
	ANSWERED QUESTION	106

that might be relatively safe but illegal or socially unacceptable… There is no other substance available that would make teenagers so giggly, foolish, humorous and at the same time creative - distinct quality of euphoria associated with marijuana intoxication. Medical benefits outweigh the risk. Punishment for use or urine drug screens makes users more angry, secretive and defiant, even if they are highly functional and motivated individuals. On the other hand there is a withdrawal syndrome, impairment of judgment, short term memory, attention and motivations… I already signed a public petition with a request to legalize it. I never used illicit drugs, have no interest to try, and advocate sobriety."

— **Yana M. Van Arsdale, MD**
Santa Barbara

"Another important aspect is to establish laws and regulations on the operation of vehicles and other safety sensitive functions after the use of marijuana. If it is legalized, criteria for impairment need to be established. Urine toxicologies cannot be used to establish impairment. Zero tolerance should remain the standard for many occupations such as physicians, firemen, policemen, etc."

— **Raymond Deutsch, MD**
Bayside Marin, San Rafael

"The criminalization of drug use and the 'war on drugs' has failed us. What measures have worked to help patients stop abusing recreational drugs? I would argue that treatment and education that takes place in the context of treatment does work and has been shown to work in study after study. Addiction medicine physicians and researchers have demonstrated the commonality among the addictive disorders in neurobiology and natural history. We have methods for screening to identify persons at risk or suffering from addiction. We know that cognitive behavioral therapy, group therapy, 12 step programs, and medicines for selected addictive disorders can have positive impact on personal and societal suffering from addiction. We also know that incarcerated individuals who do not get treatment tend to relapse at a very high rate, often within hours and days of release. In short, treatment works better than incarceration. I would generalize this to state that the criminalization of drug use and the vast

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Results of E-Survey

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WOULD INCREASED AVAILABILITY OF MARIJUANA INCREASE USE AMONG UNDERAGE YOUTH?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	67.9%	72
NO	16%	17
UNDECIDED	16%	17
	ANSWERED QUESTION	106

SHOULD PUBLIC POLICY ON MARIJUANA DIFFER FROM PUBLIC POLICY ON OTHER DRUGS OF ABUSE?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	52.4%	55
NO	33.3%	35
UNDECIDED	14.3%	15
	ANSWERED QUESTION	105

SHOULD PHYSICIANS SPECIALIZING IN ADDICTION MEDICINE BE INVOLVED IN DRAFTING PUBLIC POLICY ON DRUGS OF ABUSE?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	95.3%	101
NO	3.8%	4
UNDECIDED	0.9%	1
	ANSWERED QUESTION	106

SHOULD ALL DRUGS OF ABUSE BE MADE LEGAL?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	8.5%	9
NO	74.5%	79
UNDECIDED	17%	18
	ANSWERED QUESTION	106

resources used to prevent trafficking, police drug use, and incarcerate drug users, could be put to much better use in treatment and education on/of drug abuse. Improved screening and treatment of school-age children and new resources to conduct these efforts would likely reap benefits far into the future. Robust education and treatment would also likely improve societal understanding on the risk factors and neurobiology of addiction that would serve to allow increased screening to proceed.

Currently the issue of marijuana in California has come to the forefront. It seems efforts at marijuana abatement and criminalization have failed and this failure has been amplified by Prop 215 legalization of marijuana for medicinal use. I live and work in Mendocino County, at the center of the subversion of this law, to the benefit of growers and distributors/sellers of marijuana. Perhaps this law has alleviated a modicum of legitimate suffering. Largely though it has served to create a large black market economy promoting the growing and distribution of very potent marijuana, mostly used for marginal or concocted medical indications, or simply just 'used'. Mendocino County has a long history of growing marijuana and many members of the community have unsubstantiated beliefs regarding the health benefits of marijuana that far surpass any science on marijuana's medicinal value. Nonetheless, in the context of medical or addiction treatment I have found that discussions about the health consequences of regular marijuana use have been well received. Many of my clients have eliminated or reduced their use of marijuana when I and my behavioral health colleagues approach the issue of marijuana using motivational interviewing principles. When patients are assisted in looking at the real effects of marijuana on their daily lives they often begin to see the decreases in motivation and performance that usually impact regular users."

— Michael Carnevale, DO
Mendocino Community Health Clinic, Ukiah

"MJ does have some medical use. MJ use does not always lead to addiction. MJ addiction is wide-spread. MJ is widely grown in CA. I do not

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Results of E-Survey

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WOULD YOU SUPPORT LEGALIZATION OF MARIJUANA IF PROFITS WERE TAXED TO SUPPORT TREATMENT?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	52.8%	56
NO	31.1%	33
UNDECIDED	16%	17
	ANSWERED QUESTION	106

WOULD YOU SUPPORT LEGALIZATION OF ALL DRUGS OF ABUSE IF PROFITS WERE TAXED TO SUPPORT TREATMENT?		
ANSWER OPTIONS	**RESPONSE PERCENT**	**RESPONSE COUNT**
YES	14.3%	15
NO	68.6%	72
UNDECIDED	17.1%	18
	ANSWERED QUESTION	105

Private Practice Opportunity

Interested in the private practice of addiction psychiatry? I have a successful practice in Marin County and San Francisco and am in the early stages of planning to reduce my workload over the next few years. I would like to explore contracting with one or more individuals looking for an opportunity to receive additional training, referrals and a collegial relationship as they enter private practice. Experience in adolescent psychiatry would be welcome, but is not required.

I have practiced in San Francisco since 1984 and in Mill Valley, where I have been primarily based since 1989. Selected by Best Doctors, the practice is an excellent platform for new addiction psychiatrists entering the county. To inquire further, please email your CV and a cover letter to tcermak@aol.com.

Respectfully submitted by Timmen Cermak, MD

encourage its use BUT I believe that the current laws have negatively affected more lives than MJ has. Thus, I believe that MJ should be legally grown, rather heavily taxed, and its use governed by strong fines and not by incarceration."

— Max Schneider, MD, FASAM
Chapman Medical Center, Orange

"I actually believe that legalizing or state-directed drug sales with tax would be beneficial, overall, to society. Much less crime, less dangerous drugs, perhaps taxing to support treatment, nations with legalized drugs do not seem to have more addiction. HOWEVER, the information regarding marijuana at the last CSAM conference regarding the permanent impairment of young brains exposed to cannabis makes me a strong antagonist to the legalization of the drug for those under age 25."

— Stephen Hansen, MD
San Diego Freedom Ranch, San Diego

"Misinformation about marijuana and lack of treatment resources is one of the main reasons that we are not ready to legalize it. Until a clear concise public health statement can be made about the dangers of marijuana and easily accessible treatment is available it would be insanity to legalize it. The reason many more teens are using marijuana is because society is giving them very mixed messages about its safety. Any type of legalization at this point is only going to add fuel to the fire of this growing epidemic. As our kids are becoming increasingly addicted to marijuana at a young age, they are being setup for more hard core addictions as their ability to cope with their marijuana-related problems continues to deteriorate. Until our society can take more responsibility for the problems that marijuana is causing, particularly our teen population, it would be irresponsible to legalize it."

— Dagmar Liepa , MD
Los Angeles

CSAM's Position on Medical Marijuana

The California Society of Addiction Medicine remains troubled by several aspects of the current framework within which marijuana is considered and distributed as medication in California.

Issues requiring further attention include:

- Marijuana has never been submitted to the FDA process to determine its safety profile, to outline its side effect profile, and to validate its efficacy in a variety of disease conditions;
- A lack of standardization and lack of information regarding strength and dose;
- The most common mode of administration (smoking) remains problematic for most physicians, who have been trained to discourage smoking in all forms;
- Marketing that surrounds marijuana (e.g., "cosmic super weed") remind physicians of historic forms of snake oil medicines that promised to cure whatever ails you; and,
- Members of our society of addiction medicine have considerable experience with individuals who seek us out to help with their addiction to marijuana, which (along with strong data from research laboratories) leaves us quite skeptical of marijuana users' claims that their medicine is without any harmful effects or addictive potential (much as Purdue Pharma was guilty of minimizing the risk of addiction associated with OxyContin).

Nevertheless, two basic facts remain regarding medical marijuana that CSAM considers important enough to issue formal statements clarifying our position:

I. Physician Role in Recommending Medical Marijuana

The California Society of Addiction Medicine strongly urges all physicians who recommend the medical use of marijuana be held to all accepted medical standards of practice adopted by the California Medical Board in 2004 for recommending or approving any medication, including:

1. History and good faith examination of the patient
2. Development of a treatment plan with objectives
3. Provision of informed consent including discussion of side effects
4. Periodic review of the treatment's efficacy
5. Consultation, as necessary
6. Proper record keeping that supports the decision to recommend the use of marijuana

Furthermore:

- If a physician recommends or approves the use of medical marijuana for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.
- It is incumbent upon a physician recommending marijuana to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
- The physician should determine that medical marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.

Failure to meet these standards of medical practice when recommending marijuana, an addictive psychoactive substance, should be treated by the California Medical Board with the same level of concern as failure to meet standards of medical practice in prescribing other addictive medications.

RATIONALE:

1. "There is no question marijuana can be addictive; that argument is over. The most important thing right now is to understand the vulnerability of young, developing brains to… cannabis"[1]
2. 9% of those who try marijuana develop dependence[2]

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CSAM Statement on the Medical Aspects of Marijuana Legalization

Reasonable dialogue regarding marijuana use has historically proven extraordinarily difficult. Fortunately, scientific research has uncovered a great deal about the effects of marijuana on the basic working of the brain that can form the foundation for a reasonable exchange.

The question of whether to legalize marijuana creates a difficult struggle between our longing for civil liberties and our need for public health, between desire and prudence, and between continuing policies of de facto legalization (via cannabis clubs) mixed with incarceration for others and the opportunity to identify a new tax revenue stream to help balance the state budget.

Each individual, each family, politician, and each community must struggle with these competing agendas. When the decision is made on the basis of scientific information as much as possible, rather than one side being able to overwhelm the other side by political strength alone, the end result achieves a better long-term and sustainable outcome.

The California Society of Addiction Medicine (CSAM) seeks to educate the public so that each voter can make an informed

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Preview of President Obama's Drug Control Policy

By Timmen Cermak, MD, CSAM President

I had the pleasure of dining with Tom McLellan, MD, Deputy Director of the White House Office of National Drug Control Policy (ONDCP) and then listening to his policy address at the recent ASAM Conference in San Francisco. He began by explaining ONDCP's three roles: crafting the President's drug control policy, exercising authority over the budgets of agencies (e.g., HHS, Labor, SAMHSA) within the executive branch to assure that these drug control policies are properly funded, and working with these agencies to roll out policies.

McLellan then took pains to reorient the audience to a much broader perspective on substance use than addiction alone. ONDCP's goal is to eliminate the "segregation" of substance use disorders (SUDs) from the rest of medicine in concert with the new healthcare reform bill's intent to integrate a range of strategies into the core of primary medical care. These strategies include: **Prevention** for those who use little or no substances. **Intervention** for those in an unhealthy, problematic relationship with alcohol or other drugs – high-risk users who do not meet the criteria for a formal diagnosis but could still benefit from reducing their use. And **Treatment** for the 23-25 million Americans who suffer from drug and alcohol dependence (only 10% of whom receive treatment today).

The five priorities outlined by the President's drug control policy that focus on demand reduction are:

1. Prevention
2. Intervention
3. Treatment
4. Special focus on the 5.5 million individuals with substance use disorders in the community who are currently in the criminal justice system
5. Information systems improvements to better manage SUDs

Prevention efforts will focus on adolescents, as they carry the highest risk of developing SUDs. The goal is to create "prevention prepared communities" by combining prevention messages addressing a full range of wellness issues with parent training and environmental strategies.

Intervention will focus on improving medical care by promoting SBIRT services in all medical settings.

Treatment moves away from conceptualizing SUDs as "problems," and rather views them as an opportunity to offer "solutions." According to McLellan, healthcare reform will impact SUDs more than any other diagnosis. Since 20% of all healthcare dollars are currently spent on the consequences of untreated SUDs, integrating intervention and treatment with core medical services will eventually significantly lower the cost of healthcare.

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CSAM members who attended the ASAM Med-Sci Conference in San Francisco April 15-18, gathered to discuss current issues of interest.
Pictured from left front: Joan Kotun, MD, Tim Cermak, MD, Karen Miotto, MD, Max Schneider, MD, Gail Jara.
From left middle: Nancy McCarthy, MD, Barry Solof, MD, C.Y. Angie Chen, MD, Steve Hansen, MD, Glen Taylor, MD.
From left back: Jeff Wilkins, MD, Lori Karan, MD, David Mee-Lee, MD, Daniel Glatt, MD, Francis Riegler, MD, William Kevin Costello, MD, and Merrill Swiney, MD.

CSAM's Position on Medical Marijuana

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3. Approximately half of the individuals who enter treatment for marijuana use are under 25 years of age[3]
4. Marijuana withdrawal symptoms include irritability, anger, depression, difficulty sleeping, cravings, and decreased appetite [4]
5. Withdrawal symptoms adversely impact attempts to quit and motivate use of marijuana or other drugs for relief [5]

II. The Basis for Cannabinoid Therapeutics

Scientific research has discovered an extensive system of nerves within the brain that communicate with each other using the same basic chemistry found in marijuana. The THC (tetrahydrocannabinol) and similar molecules in marijuana are able to affect the brain by mimicking our natural neurotransmitters and flooding receptor sites with stimulation. All the cannabinoid-based areas of the brain are subsequently activated beyond normal physiological levels. This is generally enjoyable for most people.

The question of whether there is medicinal value in stimulating, or reducing, activity in cannabinoid-based portions of the brain depends on three things:

1. Specific areas of the brain where cannabinoid chemistry is concentrated and the functions served by these areas
2. The specific disease and symptoms being treated
3. Side effects produced by the treatment — essentially a "medical cost/benefit analysis"

In addition there are also cannabinoid receptors found throughout the body, on nerves, blood cells, on organs, and throughout all stages of embryonic development. The potential for cannabinoid therapeutics must also look at the direct impact on these receptors as well.

The following statement identifies physiologic functions that are naturally controlled by our body's internal cannabinoid system, and therefore can potentially be modified by medicinal use of cannabinoid stimulants and blockers in order to relieve the suffering caused by disease. It also provides CSAM's perspective on the most effective framework for medicalizing cannabinoid therapeutics.

A. CSAM recognizes that a role has been established for the body's natural cannabinoid chemistry in regulating many facets of memory, pain, emotions, appetite, motor activity, digestion, attention, higher order executive functions, reward/addiction, the immune system, and reproductive activity.

B. Multiple illnesses affecting these functions, such as dementia, chronic pain, anxiety, PTSD, wasting syndrome, spasticity, diarrhea, irritable bowel syndrome, the nausea/vomiting of chemotherapy and applications still being explored in research labs, are likely to benefit from medications based on our body's inherent cannabinoid chemistry.

C. The new cannabinoid medications being developed will range from ones that directly stimulate cannabinoid receptors (similar to THC), to ones that prolong the effect of our natural cannabinoid chemistry (similar to how most antidepressants work), to ones that block the receptors in order to reduce the activity of our cannabinoid system. Medications will also be developed that can target only portions of our cannabinoid system without affecting the whole system (for example, reducing pain in the body without affecting the brain).

D. Therefore, CSAM views "medical marijuana" as a flawed concept for multiple reasons.

1. Administering any medication via drawing hot smoke into the lungs is inherently unhealthy
2. While use of vaporizers, sprays and tinctures solve problems inherent in smoking, treatment of illness without standardized dose or content of the medication remain a safety issue
3. If the public wants to legalize marijuana, there is no reason to force physicians to be gatekeepers in a manner that enables liberal access to marijuana but generally fails to uphold accepted standards of practice for recommending a potentially addicting medication/drug.

E. CSAM supports a bifurcation of the two concepts of legalizing marijuana, leaving that question to the California voters, and the medical value of cannabinoid-based medications, leaving that question to the Food and Drug Administration. We are convinced that eventually properly researched medications, with well-researched indications and side effect profiles will become available to physicians for use in the treatment of disease and the relief of suffering.

F. If the citizens of California choose to legalize marijuana for 21-year-old adults, then physicians would no longer be forced to act as de facto gatekeepers to legitimize anyone's use as "medical." CSAM will strongly oppose access to marijuana for anyone under 21 for public health reasons, based on the continuing neurological development of the adolescent brain and its increased risk of addiction. ■

1 - Nora Volkow, NIDA Director, *Los Angeles Times*, 4/26/04

2 - Budney, Alan, et al, Marijuana Dependence and Its Treatment, *Addiction Science & Clinical Practice*, Dec, 2007

3 - Dependence and Its Treatment, *Addiction Science & Clinical Practice*, Dec, 2007)

4 - Budney, Alan, et al, Review of the Validity and Significance of Cannabis Withdrawal Syndrome, *Am J Psychiatry* 2004; 161:1967–1977

5 - Copersino et al., Cannabis Withdrawal Among Non-Treatment-Seeking Adult Cannabis Users, *Am J Addiction*, 2006 Jan-Feb; 15(1):8-15

We Need to Decriminalize Addiction, But How?

By Judith Martin, MD, CSAM Past President

In the early 1970s when I was in medical school, I read a green paperback book called *Licit and Illicit Drugs* published by Consumer Union Reports. The book describes the effects of various addictive substances, and also the unintended damage done by prohibition. Around the same time I did my first medicine rotation as a medical student at the Philadelphia VA Hospital. Most of our patients were veterans from the second world war, some from the first world war, and a very few from the Spanish-American War. Most of them had severe lung or liver disease. Patients stayed in the hospital longer then; utilization review didn't start until my residency, about five years later. At the VA Hospital the wheelchairs had aluminum ashtrays welded to the arms. Patient with emphysema would disconnect their oxygen and smoke cigarettes in the hospital. I saw my first cases of ascites, and of Wernicke's psychosis, and spiders and caput medusa. I was taught the treatment of cirrhosis, but not the treatment of addiction. Alcohol use and cigarette smoking were part of the "social history" of the patient, and the accepted standard of care was to tell the patients to stop smoking or drinking. Just to give context, medications were not so rapidly adopted, and even drugs that had been around 10 or so years were still considered "new." Isoniazid was a "new" drug, and acetaminophen was a pediatric medication. Diazepam was thought to be vastly superior to barbiturates, since it didn't depress respiration and wasn't addictive. My attendings told stories about treatment of psychosis before Thorazine, and about young people dying of SBE before IV antibiotics. Drug companies served alcohol to medical students on Friday afternoons, nicknamed "liver rounds."

My first job, sort of a moonlighting assignment in my last year of medical school, was to do physical examinations on addicted patients who were being screened for treatment. These patients were addicted to "street" drugs. I learned to assess needle marks, tracks, abscesses and signs of withdrawal. I learned the rationale for methadone maintenance treatment. I also learned there was a street value to benzodiazepines, and that some of the patients I saw were dependent on valium. Just a few years later it would become the most prescribed medication in the US.

Since that time our culture has changed in some ways. Some things have become more restricted. Sex used to be dangerous because of back-alley abortions, not because of HIV. Now smoking is banned and nicotine dependence is aggressively treated, and smokers complain about being treated as pariahs. Of course they are not locked up as many of my heroin-using patients have been. This "licit" drug is known to be a major killer. The legalization debate has been repeated over and over in my lifetime, until I sort of tune it out. When I first started becoming an addiction medicine physician and going to professional meetings, a debate about legalization was almost always on the agenda. Locking up addicted persons because of their drug use has always seemed cruel. But I considered the legalization debate useless since I would probably not see legalized heroin, cocaine or marijuana in my lifetime. Or so I thought.

> *"When the medical marijuana initiative passed in California it made me angry. I thought it used doctors in a very cynical move, putting us in the middle of this legalization debate. All of a sudden using marijuana was all about 'health benefits', not about having a good time."*

When the medical marijuana initiative passed in California it made me angry. I thought it used doctors in a very cynical move, putting us in the middle of this legalization debate. All of a sudden using marijuana was all about "health benefits", not about having a good time. I was concerned that children would learn that going to doctors with particular complaints was the way to get what they needed to get high. I thought the voters should be more clear about what they wanted – either it should be legal or not, without having me caught in the middle.

In retrospect, I'm not sure that children really did learn anything new about doctors in 1997. Today "licit" prescription opioid drugs can be added to the list of major killers. Poisoning deaths from accidental overdoses, mostly opioids, have surpassed gunshot deaths, and in some areas have surpassed auto accident death rates.

Today most of my patients come in because they are addicted to heroin. I have seen many patients suffer when they are locked up or shunned or treated badly because of their addiction, and because they are "criminals" when they use heroin. I'm glad we have some good medical treatment for their addiction. And the treatment works for those who are addicted to oxycodone or hydrocodone or morphine or fentanyl as well. Whether or not addictive substances are "licit"' or "illicit", our field can make a contribution to patient well-being. And whether or not drugs are legalized, the persons who are addicted to them should not be criminalized. ■

CSAM Statement on the Medical Aspects of Marijuana Legalization

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decision if asked to vote on legalization of marijuana. There are three basic facts that each voter should know about marijuana and the brain to be adequately informed:

1. The normal brain relies on the same cannabinoid chemistry found in marijuana to regulate much of the body's physiology. Marijuana mimics our brain's natural molecules and frequent use significantly disrupts the brain's delicate chemical balance.
2. Marijuana is addicting to approximately 9% of people who begin smoking it at 18 years or older. Withdrawal symptoms are subtle (irritability, anxiety, sleep disturbance), but are real and do contribute to relapse. Another way to say this is that at least 90% of those who begin smoking marijuana at 18 or older do not experience addiction.
3. Because the brains of adolescents are still undergoing significant structural development, onset of marijuana smoking earlier than 18 results in increasingly higher rates of addiction (up to 17% within 2 years) and disruption to an individual's life. The younger the use, the greater the risk.

Therefore, while the public should decide the issue of marijuana legalization through the legislative process, CSAM strongly recommends that any legislation legalizing the use of marijuana should contain the following essential components:

I. Effective restrictions need to be created to minimize access to marijuana for anyone under 21 years old.

RATIONALE:

1. Marijuana is a mood-altering drug that mimics the brain's own chemistry and causes dependency when used frequently in high doses.
2. Because brain development, including areas targeted by marijuana, is not complete until 24 years old, child and adolescent use of marijuana is accompanied by far higher risk than adult use. Therefore, adolescents should be strongly encouraged to avoid, or delay, use. [1]
3. The percentage of marijuana users who develop abuse or dependence within the first two years of their use is highest among those who begin using in early adolescence, falling from over 17% at 13 years old to 4.4% with those who start using at 21 years old.[2]
4. Cognitive function is abnormal up to 30 days into abstinence in adolescents who use marijuana heavily.[3]
5. Adolescents who have smoked more than 100 times leave school 5.8 times more often, enter college 3.3 times less often, and graduate from college 4.5 times less often. [4]

II. Treatment for adolescent marijuana abusers should be universally available, not punishment

It would be inconsistent to legalize marijuana for those over 21 and continue a punitive approach for those under 21 when the rationale for restricting access for those under 21 is a public health concern. Roughly 17% of 18/19 year olds have smoked marijuana during the past month in the current atmosphere of marijuana's illegality.[5] CSAM strongly supports evidence-based treatment programs focused on helping individuals under 21 years of age discontinue, or at least reduce, their marijuana use. Punishment should only be used as an avenue to treatment. If California chooses to legitimize marijuana further for adults by voting for legalization and potentially make marijuana more available to adolescents, treatment for adolescents abusing marijuana should be universally available.

III. Revenue stream for treatment should be funded by fees and taxes from marijuana sales

Of the 250,000 adolescents needing treatment for chemical dependence in California today,[6] only 1 in 10 currently receives any services. [7] Taxes on alcohol and tobacco have never paid for more than a small fraction of the damage caused by these two drugs. If the citizens of California choose to legalize another addictive substance, CSAM strongly urges all tax and fee revenue from the sale of marijuana to be placed in a "Drug Abuse Prevention and Treatment Funding Account", the proceeds of which should be dedicated to the prevention and treatment of physical and mental illnesses and substance abuse problems linked to the use of cannabis. Currently, 16% of admissions for substance abuse treatment are for marijuana dependence. [8]

IV. Warning labels on smokeable products

Careful consideration needs to be given to the potential harm to the public's health that would be created by introducing a new legal smokeable product onto the market. Given the difficulty linking cancer to tobacco smoking and subsequently changing the public's attitude regarding tobacco smoking, we recommend caution regarding authorizing the advertising and sale of additional smokeable products. Guidelines regarding warning labels or dedication of tax revenues for smoking cessation programs need to be created before introduction of a new legal smokeable product.

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CSAM Statement on the Medical Aspects of Marijuana Legalization

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V. Regulation of Marketing (Advertising), Distribution, and Sales

Since research has already shown that children develop brand recognition for beer by age six, it is important to consider how to regulate advertising that children and adolescents will be exposed to. A mechanism for ongoing oversight of advertising and regulation of outlet location and density should be considered.

VI. Evaluation component to document impact of legalization

It is not known whether legalizing marijuana would increase or decrease adolescents' access to marijuana. It is known that any increase would represent harm to public health. It is difficult to have confidence that relying on the same policies and procedures currently in force to limit underage drinking will effectively limit underage marijuana use. Any move to legalize marijuana for individuals over 21 should contain provisions to ascertain whether the rate of adolescent marijuana use increases, decreases, or remains stable after its passage. A substantial research component is required to document the current status of marijuana use and abuse among different demographic groups in California and then to follow changes after implementation of marijuana legalization. A stable funding stream for this research must be secured. Fees from the sale of marijuana are the logical source for such funding.

VII. Technical difficulties documenting driving under the influence

The issue of prohibiting driving while under the influence of marijuana is technically complicated by the fact that urinary THC levels remain positive far longer than acute impairment. Guidelines for cutoff THC blood levels to determine whether an individual's impaired driving is due to marijuana intoxication require further definition and clarification. Other safety sensitive professions will also face difficult civil liberty issues for which there are no easy answers in attempting to regulate their workforce. Research to clarify these issues requires funding. ■

[1] - Gogtay, N., Giedd, J. N., Lusk, L., Hayashi, K. M., Greenstein, D., Vaituzis, A. C., Nugent, T. F., 3rd, Herman, D. H., Clasen, L. S., Toga, A. W., Rapoport, J. L. and Thompson, P. M. (2004) Dynamic mapping of human cortical development during childhood through early adulthood. Proceedings of the National Academy of Sciences of the United States of America 17, 17

[2] - *W*inters, Ken, and Lee, Chih-Yuan, Likelihood of developing an alcohol and cannabis use disorder during youth: Association with recent use and age, *Drug and Alcohol Dependence* 92 (2008) 99–247

[3] - Medina, K.L., Hanson, K., Schweinsburg, A.D., Cohen-Zion, M., Nagel, B.J., & Tapert, S.F. (2007). Neuropsychological functioning in adolescent marijuana users: Subtle deficits detectable after 30 days of abstinence. *Journal of the International Neuropsychological Society*, 13(5), 807-820

[4] - Fergusson, Horwood and Beutrais: "Cannabis and educational achievement," *Addiction*, 98, 1681-1693, 2003

[5] - *Substance Abuse and Mental Health Data Archive* – 2007, http://www.icpsr.umich.edu/SAMHDA/

[6] - Estimate based on *UCLA DART*, 2001 in Little Hoover Report, 2003

[7] - Schwab Report, *The Need to Invest in Adolescent Treatment,* 2004

[8] - 2007 *Highlights: Treatment Episode Data Set* (TEDS)

Preview of President Obama's Drug Control Policy

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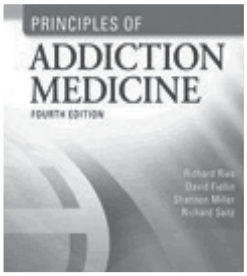
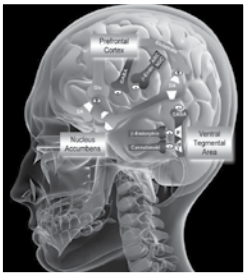
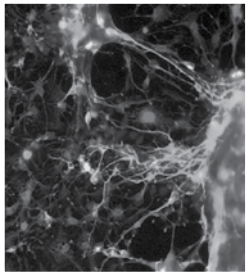
ONDCP is more interested in building community-based infrastructure for combating SUDs than continuing to offer temporary block grants and funding projects that come and go within a few years. The goal is to revolutionize how medicine perceives and responds to substance users. Perhaps the clearest symbol of this revolution is the creation of an Office of Recovery in ONDCP. Approximately 20 million Americans self-identify as being in recovery. By giving them a voice, by raising their profile, the country will be given a model of how substance use can be handled that differs from the models highlighted for decades by the War on Drugs.

Most unfortunately, Dr. McLellan has announced his resignation from ONDCP effective within a few months. He assures me that the decision is personal. He is simply not cut out to work in government. As a scientist, he suffers from endless meetings and partisan bickering. But he is leaving a legacy that will grow in importance over the years; and all of us — addiction medicine, our patients, and the country as a whole — will be the beneficiaries. ■

Addiction Medicine Review Course and ABAM Certification Exam Preparation Track





October 27 - 30, 2010
Newport Beach Marriott Hotel & Spa, Newport Beach, CA

Nationally recognized for its overall educational quality and high-caliber speakers, the CSAM Review Course brings presentations by top experts in the field together with small-group facilitated case illustrations to give the learner the opportunity to apply key concepts to real world clinical situations.

The Review Course offers an overview of addiction medicine for those new to the field, those in primary care and other fields seeking an introduction to substance use disorders, as well as specialists in addiction medicine who wish a refresher course with information from top experts in the field.

The Review Course has a proven record in preparing participants for the American Board of Addiction Medicine (ABAM) Certification Exam. For those who wish to have additional focused exam preparation, CSAM offers a Certification Exam Preparation Track. It also provides additional hours devoted to test-taking strategies, sample questions, high-yield exam content, and tips on how to prepare for the exam.

Medical Aspects of Cannabis

Pre-conference workshop at CSAM Addiction Medicine Review Course

Wednesday - October 27, 2010

The workshop concludes with a review of CSAM's formal statements on Medical Marijuana and the Medical Aspects of Cannabis Legalization.

SPEAKERS:

Alan J. Budney, PhD | Timmen Cermak, MD

J. Hampton Atkinson, MD | Krista Medina, PhD

NEW DIRECTIONS IN DEMAND REDUCTION: A VIEW FROM THE ONDCP

A. Thomas McLellan, PhD is currently Deputy Director for Demand Reduction at the Office of National Drug Control Policy and has played a key role in reshaping national drug policy in the Obama administration. He has announced he will leave that position in the summer of 2010. His work has promoted a better understanding of the factors that lead to treatment success, and has fostered greater understanding of addiction as a chronic illness, reduced its stigma, and provided means for earlier identification and prevention.

PHARMACOLOGY AND RECEPTORS

Francis Vocci, PhD is currently President of Friends Research Institute. Prior to his current position, he served as Director of the Division of Treatment Research and Development at the National Institute on Drug Abuse. Dr. Vocci has published over 80 articles in neuropharmacology and the treatment of substance abuse and its consequences.

METHADONE AND BUPRENORPHINE IN OPIOID-DEPENDENT PREGNANT WOMEN

Karol Kaltenbach, PhD is Clinical Associate Professor of Pediatrics, Psychiatry and Human Behavior at Jefferson Medical College, Philadelphia. Dr Kaltenbach is currently a Principal Investigator of the NIDA MOTHER clinical trial comparing the use of methadone and buprenorphine in opioid-dependent pregnant women.

Addiction Medicine Review Course and ABAM Certification Exam Preparation Track

NEUROBIOLOGY OF ADDICTION

Eliot Gardner, PhD is the Chief of the Neuropsychopharmacology Section, Intramural Research Program (IRP) of the National Institute on Drug Abuse. He is a contributing author to *Principles of Addiction Medicine*.

TREATMENT OF ADOLESCENTS

Marc Fishman, MD is Professor of Psychiatry at the Johns Hopkins University School of Medicine. His clinical specialty is in the treatment of adolescents with substance abuse and co-occurring disorders. His work has focused on models of care and treatment outcomes. He is the contributing author to the chapter on adolescent treatment in *Principles of Addiction Medicine*.

CANNABIS: WHAT THE LATEST RESEARCH SHOWS

Alan J. Budney, MD is Professor of Psychiatry and a Research Scientist in the Center for Addiction Research at the University of Arkansas. He is the Principal Investigator of three NIDA-funded research grants on marijuana treatment and withdrawal.

CO-OCCURRING PSYCHIATRIC AND ADDICTIVE DISORDERS

Richard Ries, MD is Professor of Psychiatry at the University of Washington Medical School and serves as Associate Director of the University of Washington Addiction Psychiatry Residency Program. Dr. Ries was chosen to chair the first official Treatment Improvement Protocol on dual disorders by the Center for Substance Abuse Treatment. He is the senior editor of *Principles of Addiction Medicine, 4th edition*.

OPIATE DEPENDENCE TREATMENT OF PAIN AND SAFE PRESCRIBING PRACTICES

Daniel Alford, MD is Associate Professor of Medicine at Boston University School of Medicine. Dr. Alford has worked to expand opioid agonist treatment to primary care settings and developed guidelines for general healthcare providers for managing pain with methadone maintenance patients. He is a contributing author to *Principles of Addiction Medicine*.

TREATMENT AND BRAIN IMAGING OF CIGARETTE SMOKERS

Arthur Brody, MD is Professor-in-Residence in the UCLA Department of Psychiatry at the David Geffen School of Medicine. He is an assistant editor for the journal *Addiction*. He is also the director of the Greater Los Angeles VA Smoking Cessation Programs.

Pre-conference Workshops Wednesday, October 27

FULL-DAY WORKSHOPS:

Pain, Opioids and Treatment Across the Lifespan - What You Need to Know

Advanced Topics in the Clinical Use of Buprenorphine

The Art of SBIRT: Motivating Patients and Teaching it Effectively

HALF-DAY WORKSHOPS:

Medical Aspects of Cannabis

Medical Detoxification: Real World Cases

Resources for California Physician Well-Being Committees

OTHER PLENARY SPEAKERS:

John Mendelson, MD
INHALANTS/HALLUCINOGENS/CLUB DRUGS

Jeffrey Roth, MD
THE "PHARMACOLOGY" OF 12-STEP PROGRAMS

Steven Batki, MD
STIMULANTS

Anthony Albanese, MD
ALCOHOL

Judith Martin, MD
MEDICAL CONSEQUENCES OF ADDICTION

Nancy Goler, MD
SUBSTANCE ABUSE DURING PREGNANCY AND FETAL DEVELOPMENT

Sharone Abramowitz, MD
INTRODUCTION TO MOTIVATIONAL INTERVIEWING

David Kan, MD
ETHICS/CONFIDENTIALITY

HOTEL

The conference hotel is the Newport Beach Marriott Hotel & Spa (900 Newport Center Drive, Newport Beach). A limited number of rooms are available at the conference rate of $199 per night for single or double rooms until October 4. After this date, the hotel may offer any remaining rooms at the prevailing rate. To make reservations, phone 800/228-9290 or 949/640-4000. Identify yourself as a CSAM registrant to receive the conference rate.

CREDIT

The California Society of Addiction Medicine (CSAM) is accredited by the Institute for Medical Quality/California Medical Association to provide continuing medical education for physicians. CSAM takes responsibility for the content, quality and scientific integrity of this CME activity.

CSAM designates this educational activity for a maximum of ***30 AMA PRA Category 1 Credits™***. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

CONFERENCE FEES

	Half-day Pre-conference workshop on Wed.	Full-day Pre-conference workshop on Wed.	Review Course Thursday - Saturday	ABAM Certification Exam Preparation Track (Wed. - Sat.)
CSAM OR ASAM MEMBERS	$120	$240	$620	$275
NON-MEMBER PHYSICIAN	$140	$280	$720	$275
NON-PHYSICIAN	$120	$240	$620	$275
RESIDENT OR FELLOW	$50	$100	$250	$275
MEDICAL STUDENT	$20	$20	$75	$275

Register now at csam-asam.org

CONFERENCE PLANNING COMMITTEE

Mason S. Turner, MD, *Conference Chair*

Marianne Aldridge, MD

William S. Brostoff, MD

Steven Eickelberg, MD

Susan Ferguson, MD, MS

Murtuza Ghadiali, MD

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Karen A. Miotto, MD

Suma C. Singh, MD

Emjay Tan, MD

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Welcome New CSAM Members!

Lynn Bertram, MD - *Orinda*

Nazar Al-Bussam, MD - *Downey*

John Fullerton, MD - *Fairfax*

William Stiers, MD - *Pleasanton*

Miguel Alvarellos, MD - *Orange*

Mario San Bartolome, MD - *Santa Maria*

Francis Riegler, MD - *Palmdale*

Angela Barr, MD - *South San Francisco*

Vidhya Koka, MD - *San Jacinto*

Karen Wexman, MD - *Mill Valley*

SPECIAL EVENTS:

Thursday - October 28

Dessert Reception: An Insider's View on the Treatment of Celebrities with Addictions

Friday - October 29

Friday Evening Poolside BBQ

Join us to unwind, southern California-style, at a pool-side BBQ in the hotel's stunning outdoor veranda overlooking Newport's Harbor.

CSAM President's Message: Voters to Decide on Marijuana Legalization

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the same; but the public's attitude toward the drug presents a challenge. We have chosen to address the California public primarily with scientific data and solid research that clearly argues against anything that would increase access to marijuana for adolescents. We believe that a balanced educational approach will find a far more receptive audience than one that begins with telling voters how we think they should vote. ■

California Society of Addiction Medicine
575 Market Street, Suite 2125
San Francisco, CA 94105

A state-wide public policy conference

New Directions California:
A Public Health and Safety Approach to Drug Policy

Thursday, July 8, 2010 • 9:30 am - 4:30 pm
The Center for Healthy Communities at The California Endowment
1000 N. Alameda Street, Los Angeles

Sponsored by the California Society of Addiction Medicine and the Drug Policy Alliance

With 30,000 people locked up for a nonviolent drug offense in California, prisons are bursting at the seams and busting our budget. And yet drug prevention and treatment funding is suffering devastating cutbacks, making treatment harder to find than ever. California is overdue for a new approach to drug policy.

New Directions California will convene a range of stakeholders and explore a comprehensive, balanced approach to drug policy, which recognizes that successful strategies include prevention, harm reduction, treatment and public safety. Join us to begin moving our state's drug policy in a new direction.

This event is free but registration is requested. For more information or to register go to www.NewDirectionsCa.org.