

## CSAM's Forum for Dialogues in Addiction Medicine

### Health Care Reform: Single Payer or Universal?

BY TIMMEN CERMAK, MD, CSAM NEWSLETTER EDITOR

Welcome to the fourth installment in our FORUM series. Each newsletter, I am choosing an issue that would benefit from being elevated to the surface, where open discussion of different perspectives can advance our understanding of the issue, and of each other. Views are presented not in a pro-con, point-counterpoint framework, but rather as examples of differing perspectives. Dialogue is the most important goal for each FORUM. This issue focuses on "National HealthCare Reform." Previous issues have focused on "Medication-Assisted Therapy and Sobriety," "Prometa Protocols," and "the Medical Board's Physician Diversion Program." These can be found archived at: [www.csam-asam.org](http://www.csam-asam.org).



### Single Payer National Health Insurance

BY KEN SAFFIER, MD

With change as the theme for health care, single payer health care is hardly mentioned in the national health care debate. Yet, the California state legislature has twice passed single payer legislation in the last 4 years (both times vetoed by the governor). Curiously, the mainstream press has little to say, and the White House, despite President Obama's previous endorsement of single payer in 2003, distances itself from this topic. It is time to answer some basic questions that the press, the special interests and the politicians are too afraid to ask in public.

#### What is single payer?

Single payer health insurance is publically financed, privately delivered health care. It is social insurance, not unlike police and fire protection, covering the entire population, without exclusion. It distributes the costs of health care over all of the US population. Another way of describing it is improved Medicare for all.

#### Isn't this socialized medicine?

Socialism is when the government owns the health facilities and employs all of the workers, including the physicians. The Veterans' Administration system is an example of a socialized health system, as is Britain's National Health Service. However, with single payer, the government only pays the health care bill for services which are delivered privately.

#### Why have single payer?

Several reputable studies show that by avoiding the overhead costs and inefficiencies of private insurance companies, we can save \$350 billion per year which can provide the funds to care for the 47.5 million currently uninsured. Under the current system, 31% of private medical insurance pay for administrative costs which is in contrast to 3% for administration of Medicare. Addition-

ally, with an employer-based health insurance system, health insurance ends, as does the patient's relationship with their physician, if the employee loses their job. Single payer protects access and coverage, especially important in an unstable economy and job market.

#### Why is there a growing majority of US doctors and the US public in favor of a single payer health insurance system?

The crisis in US health care continues to worsen. Increasing numbers of people cannot afford insurance. In addition to the estimated 45.7 million who are uninsured, estimates of the underinsured range from 25-50 million. There is a disincentive for private insurers to spend money to cover patient's medical needs. We need cost effective universal health care that provides services to all of our population without regard to their ability to pay for them. Health care is a basic human right, not a privilege as reflected in our current insurance system. In recent national surveys, 59% of physicians and 60% of the public favored a nationally funded and administered system.

#### How is single payer different from traditional insurance?

Private insurers exclude many people with pre-existing illnesses or conditions. Often, coverage for addictions treatment, for example, is limited or non-existent. Single payer includes everyone regardless of a person's past medical history. One billing form would be submitted electronically. Hospitals and HMO's will be funded with yearly global budgets and the government can purchase larger amounts of medications for less. Hence, costs can be controlled.



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### **What is covered? What is not?**

All current, evidenced-based, professional services are covered. Addiction treatment is covered. Medications, counseling, out-patient, in-patient and preventive services are covered. All drugs that are proven to be effective and are part of a nationally approved formulary will be covered. Cosmetic surgery and other non-medically necessary services will not be covered.

### **How is single payer funded?**

A progressive tax structure will fund single payer health insurance. 60% of all health services are currently funded through taxes, with business and out of pocket payments making up the rest. Graduated individual and payroll taxes will make up this 40% with individuals paying less than they currently pay and getting coverage without fine print limitations and exclusions. Services will be paid for without co-pays, deductibles and out of pocket expenses.

### **Won't the costs of single payer be exorbitant and unaffordable?**

Our current system is the most expensive system in the world. In the US, we spend more per capita, and have poorer health outcomes than other developed countries. By eliminating insurance company administrative overhead costs, profits and "middlemen", we can save \$350 billion per year and provide more services to all US residents.

### **How can we trust the government to be responsible to make this system effective and pay for these services?**

Currently, health care decisions are made behind closed insurance company board room doors without transparency or public accountability. With HR 676, the United States National Health Insurance Act and S 703, the American Health Security Act of 2009, there will be representatives of consumers in a public and accountable system. Who and

which process would you trust more? A corporate closed board accountable only to private stockholders, or a public entity that is mandated to be accountable to taxpayers?

### **Economic and policy consequences of no insurance or underinsurance.**

Beside the compelling adverse effects of no insurance or under-insurance, 20,000 deaths per year, and the innumerable stories of human suffering, there are major economic and health policy consequences. Fifty percent of personal bankruptcies are due to medical bills, with 75% of these in people who had health insurance at the time of their serious illness. When the population is not covered for illness and lacks access to care, public health suffers as well as individual health. Infectious diseases such as tuberculosis, will remain undiagnosed and untreated, causing worse individual outcomes and spread to many more persons the longer care is delayed.

### **Summary — and why single-payer should be the only plan.**

There hasn't been a national side by side comparison of single-payer with other proposed reforms because it is too threatening to most politicians and the insurance industry. With single payer, there is no need for 1,300 private insurance companies. Social insurance that distributes risk over the whole population, includes all members of our society, excludes no one and allows us to see the provider of our choice is what we need. Private insurance companies will fight this to the end. This is why we all need to learn about and insist that single payer be our new equitable, economic and humane national health insurance. ■

*Ken Saffier, MD, is a family physician at Contra Costa Regional Medical Center and Health Centers and long-time member of CSAM and Physicians for a National Health Program.*

## **Understanding the Universal Health Care Proposal**

BY THOMAS BRADY, MD

### **What is the difference between universal health care, single payer health care, and socialized medicine?**

Universal health care is defined as health care coverage that is extended to everyone in a country or geographic region, such as a state, without regard to how that care is implemented. Universal health care is implemented in all of the wealthy, industrialized countries, except the United States. If the government owns all healthcare facilities, employs all healthcare workers, and pays all healthcare bills, the system is socialized medicine, as is the case with Great Britain's National Health Service and Canada's Medicare. If the government pays the bills, but permits the healthcare delivery system to remain in the private sector, one has a single-payer health care system. In other words, single-payer health care is the term to describe the payment to doctors, hospitals, and other health care providers from a single fund. It is also possible to provide universal health care by mandating and subsidizing health care through compulsory regulated pluralist insurance (public, private or mutual) meeting certain regulated standards, as is currently the practice in the state of Massachusetts. ■

*Thomas Brady, MD, is Vice President, CRC Health, San Jose, CA and Director-at-Large on the CSAM Executive Council.*



**IMPORTANT DISCLAIMER:** CSAM takes absolutely no responsibility for the opinions expressed by FORUM participants. Readers must evaluate each contribution for accuracy, bias, and integrity of scientific analysis. Inclusion of a perspective in the FORUM implies no endorsement of the author's opinion by CSAM.

# CSAM Leads the Way Toward Early Detection of Substance Abuse Risk

BY TIMMEN CERMAK, MD, CSAM NEWSLETTER EDITOR



In a Special Communication published in *JAMA* (October 4, 2000) Thomas McLellan et al examined evidence that chemical dependence satisfies the same criteria for being considered a chronic medical illness as diabetes, hypertension and asthma. Their review of the literature presented a strong argument on the basis

of diagnosis, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse). Medication adherence and relapse rates were also noted to be similar across all four illnesses.

Three primary implications were drawn at the conclusion of this classic paper. First, addiction screening, diagnosis, brief interventions, medication management, and referral criteria should be taught as part of medical school and residency curricula and routinely incorporated into clinical practice. Second, insurance parity initiatives should be supported. Third, like other chronic illnesses, the effects of drug dependence treatment are optimized when patients remain in continuing care and monitoring without limits or restrictions on the number of days or visits is covered.

In retrospect, it appears that the field of addiction medicine greeted McLellan's paper with open arms, appreciating its clear enunciation of principles that many had deeply held but not yet clearly stated. But then addiction medicine waited for the rest of medicine, and society as a whole, to be impacted by McLellan's message. Once chemical dependence is properly understood by other physicians as another chronic medical illness, addiction medicine hoped to be welcomed in as equal colleagues. Once society sees addiction as a chronic medical illness that creates multiple social problems as part of its symptoms, resources for treatment will be made available. And, to some degree, both of these impacts have begun happening.

However, addiction medicine has been far slower to permit implications of the chronic disease model of chemical dependence to impact the field itself, and as a result has permitted a flaw to continue existing at its very core. The flaw stems from the fact that early diagnosis is the key for treating any chronic medical illness, and addiction medicine has yet to commit itself to the early diagnosis of chemical dependence. We have not devoted ourselves to the early detection of substance abuse risk indicators among children, adolescents and young adults. We have not educated ourselves about the neurological and psychological developmental complexities of these stages of life. We have not expanded methods for intervening on and treating abuse and dependence in age appropriate ways. And we have only

partially relinquished our cherished position of waiting until patients achieve adulthood, hit bottom and come to us for help (with interventions and SBIRT only beginning to make inroads in the direction of earlier diagnosis).

Even though McLellan's paper virtually ignores adolescents, he clearly sets the stage for adding the long missing piece they represent. McLellan firmly locates both the genetic heritability and the pathophysiology of the disordered response to addictive chemicals in the brain, specifically in the brain's reward circuitry. The piece still missing from most

***"We have not devoted ourselves to the early detection of substance abuse risk indicators among children, adolescents and young adults. We have not educated ourselves about the neurological and psychological developmental complexities of these stages of life. We have not expanded methods for intervening on and treating abuse and dependence in age appropriate ways."***

everyone's view of addiction involves the neurologically immature state of most brains, not to mention the psychologically immature state of most minds, when first introduced to addictive chemicals. The onset of this chronic medical illness called addiction, like the onset of asthma, lies as often within the pediatrician's realm as it does within the internist's.

An analogy will help here. The majority of addiction medicine still resembles the operating room where gynecologists perform elaborate surgery on patients with cervical cancer. The procedures are complex, intricate, and immensely satisfying. However, from a public health perspective, cervical cancer is treated far more effectively with the less dramatic technique of annual Pap smears. Early diagnosis permits the detection and treatment of cervical dysplasia even before cancer has developed. Although mounting a public education campaign that encourages women to seek annual Pap smears, and conducting endless numbers of normal Paps for the occasional positive, may be less satisfying than scrubbing in to perform surgery, the end result for public health is a dramatic improvement. Early diagnosis for chronic medical illness is the key.

The current addiction medicine strategy is tantamount to gynecologists ignoring Pap smears in favor of waiting for patients to self-identify when they have developed florid cervical cancer. Perhaps our current emphasis on treating adults arose because the recovery movement was founded by adults helping adults. Certainly the vast bulk of treatment

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## CSAM Leads Way...

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to date has occurred between adult therapists treating adult patients. As a result, the basic fact that the majority of cases we treat could actually have been identified and their treatment started as adolescents – an age group most of us are personally ill-equipped to deal with comfortably – has been all but ignored. In effect, addiction is a chronic medical illness with a pediatric onset in the majority of cases!

Age of onset of use is one of the most significant predictors of risk for developing a substance use disorder. Anyone who has taken even a few chemical dependence histories is aware that many of the adults we treat were beginning to use by 12-13 years old – while still under the care of a pediatrician. Add this to the other factors that put adolescents at risk (e.g., family history of addiction, trauma, co-occurring psychiatric disorders, learning disabilities, temperamental dysregulation) and addiction medicine begins to have its “Pap smear” to identify individuals at high risk of developing the chronic medical illness we are responsible for treating.

OMG (Oh My God)! We aren’t thinking about stigmatizing kids, are we? Of course not. Medicine is entirely non-judgmental. We deal in facts, probabilities, suffering, and relief of suffering. When stigmatizing occurs, it always begins with people who do not want to hear the facts, or who do not like the facts. Medicine has only two arms: science and empathy. No mechanism for moral judgment exists in medicine.

The truth is that kids and risk simply go together – they roll over ‘til they fall off their beds, run into walls, twirl until they fall over, put things in their ears, run with scissors, ride

bikes down steep hills, jump off roofs, dive off high rocks, drive cars fast, experiment with cigarettes and drugs.... The public health perspective of medicine is a natural ally with parents. Both are interested in protecting youth from risks they do not comprehend and cannot manage. The goal is to present enough risk that adolescents are challenged to grow without their being overwhelmed and damaged - a delicate balance. Our job is to assess the risks in a child’s environment, assess the child’s understanding of risk, educate and step in when health and safety are jeopardized.

As physicians we simply stick to the facts, probabilities, suffering and relief of suffering. If others want to get into stigmatizing (like they did with HIV, and they still do with addictive disease), we just need to keep doing our work and relying on the truth to find its way to the surface, as it always does eventually.

Toward that goal, CSAM is expanding its Blueprint for Treating Drug and Alcohol Addiction in California to cover the unique needs of adolescents and young adults. Still in its draft form, the adolescent blueprint will be presented formally at the State of the Art Conference October 10, 2009 opening a new emphasis for CSAM on early diagnosis and treatment. It is time to bring more attention and resources to those in the early stages of this chronic, and too often debilitating disease. ■

## Book Review Corner

### *Overcoming Prescription Drug Addiction: A Guide to Coping and Understanding*

BY ROD COLVIN, M.S.



BOOK REVIEWED BY  
JOHN HARSANY, MD  
HEMIT, CA

I highly recommend this book to the Addiction Medicine specialist and also as an adjunct resource for patients and their families. The book offers a simplistic, yet insightful review of the process of prescription drug addiction. Especially helpful are the sections on “Seniors,” “Doctor Shopping,” “Pain and Addiction,” and “The Internet Pharmacy.” We use this book in our local recovery programs such as Seniors Outreach Over Alcohol and Rx (SOAR) in our aftercare plan. Good reading!!



CSAM members are invited to submit books and film reviews for consideration. Send email to: [csam@compuserve.com](mailto:csam@compuserve.com)

## Welcome New CSAM Members!

Sharone Abramowitz, MD  
Arde K. Anoshivani, MD  
Bob Aungkhin, MD  
Jerry Daniel Ayers, MD  
A. S. Devous, MD, MPH  
Dyan A. Dreisbach, MD  
Jennifer M. Firestone, MD  
Evaleen Jones, MD  
Stuart Douglas Klein, MD  
Nicole LaVelle, MD  
Catherine A. McDonald, MD, MPH  
Stephen Mandelbaum, MD  
John Louis Perry, Jr., MD  
Keith Quirino, (Medical Student)  
Srinath Samudrala, MD  
Robert Simpson, DO  
Eva Marie Smith, MD, MPH  
Michael Weiner, MD  
Robert Weinstock, MD  
Heywood Zeidman, MD



# CSAM Members in the News



CSAM President **Judith Martin, MD** received the AATOD Marie Award, named for Marie Nyswander, a psychiatrist and psychoanalyst who developed methadone maintenance for the management of heroin addiction in the 1960s with her husband, Vincent P. Dole, MD. The award was presented on April 28, 2009 at an awards banquet in New York City.

# CSAM



**Mark Hrymoc, MD** is coordinating a monthly discussion group for addiction professionals at Cedars-Sinai Medical Center, Thaliens Mental Health Center – Main Auditorium (Plaza Level). Meetings are held on the first Thursday of every month. CSAM members are welcome to attend. For information about future events, contact: hrymoc@gmail.com.



**David Kan, MD** presented a CSAM Northern CA regional dinner meeting entitled: "Smoking Cessation and Chronic Mental Illness" in May at the Delancey Street Restaurant in San Francisco. The meeting was coordinated by Jean Marsters, MD. For information about future Northern California regional meetings, contact: csam@compuserve.com.



**Thomas Brady, MD**, Vice President, CRC Health in San Jose, CA, has been appointed to the CSAM Executive Council Director-at-Large.



**Donald E. Kurth, MD**, who is Mayor of Rancho Cucamonga, announced he is running for State Assembly, 63rd District as a Republican. He has been endorsed by the CA Medical Association (CMA). Kurth was also recently elected to become President-elect of the American Society of Addiction Medicine (ASAM).



**Howard Richmond, MD** (below) appearing as "The Comic Shrink" entertained a group of CSAM members at the Leadership Retreat in San Diego in April. His motto is: "The weirder I am, the more normal you are."

## In Memoriam



On March 21, 2009, **Barry Rosen, MD** a member of the CSAM Executive Council, passed away at his home in Woodside, CA. Barry was diagnosed with Melanoma and underwent several brain surgeries over the past couple years. He fought this illness and despite difficulty speaking and moving, he traveled to the CSAM Review Course in Newport Beach in October to receive the CSAM Vernelle Fox Award, presented to him by **Garrett O'Connor, MD**. The award recognized his unrelenting determination to educate others about the disease of addiction, especially the challenges of treating pain and addiction, and his outstanding care of patients suffering from the disease. A memorial service was held in May 2009 on a mountaintop in Woodside. Barry will always be fondly remembered and will be sadly missed.



**David E. Smith, MD** now heads Newport Academy, a substance abuse treatment facility catering specifically to adolescent girls located in Orange County, CA. The facility combines the 12-Step approach with innovative programs including equine assisted therapy.

# CSAM Developing Skills of Future Leaders at Spring Retreat

CSAM physicians held a leadership development retreat in San Diego, April 17-19, 2009, for the purpose of training and preparing future physician leaders to speak out about policy issues in California. Twenty-seven invited physicians attended this weekend event and participated in skill-building workshops which included on-camera training in media interviews conducted by Jeff Stinchcomb of the Institute for Public Strategies, negotiating training led by Colette Carlson, and public relations/communications guidance by a media relations expert, Jim Gogek. They also participated in role-playing sessions about the legislative process, consensus-building, and working through difficult issues within a hypothetical hierarchical system. Joining the group on these exercises was Kathryn Jett, Director, Division of Addiction and Recovery Services within the California Department of Corrections and Rehabilitation (CDCR), Richard Conklin, San Diego Sheriff's Department, and Robert Harris, CSAM Public Policy Advisor. In addition, each physician had an opportunity to learn talking points on a host of topics and to rehearse the delivery of those in front of a group of their peers for feedback and support. It was a weekend for building the foundation of leadership and voices that will support CSAM's work in the future. ■

## The following CSAM members attended the retreat:

Peter Banys, MD  
Thomas Brady, MD  
Timmen Cermak, MD  
David Chim, DO  
Steven Eickelberg, MD  
Mary Eno, MD, MPH  
James Gagne, MD  
Ihor Galarnyk, MD  
Stephen Hansen, MD  
Mark Hrymoc, MD  
Lori Karan, MD  
Monika Koch, MD  
Donald Kurth, MD  
Judith Martin, MD

Larissa Mooney, MD  
Paul Michael Nerz, MD  
David Pating, MD  
Howard Richmond, MD  
Roderick Shaner, MD  
Stephanie Shaner, MD  
Lee Snook, MD  
Barry Solof, MD  
Philip Spiegel, MD  
John Tsuang, MD  
Mason, Turner, MD  
Susan Weinstock, MD  
Barry Zevin, MD



AT THE CSAM LEADERSHIP DEVELOPMENT RETREAT, DAVID PATING, MD INVITED JAMES HAY, MD, OF THE CA MEDICAL ASSOCIATION, TO UPDATE THE GROUP ON CMA INITIATIVES. DR. HAY THANKED CSAM FOR ITS COLLABORATION WITH CMA ON A NUMBER OF INITIATIVES INCLUDING THE EFFORT TO CREATE A NEW STATE-WIDE LEGISLATIVELY MANDATED PHYSICIAN HEALTH PROGRAM.



PHIL SPIEGEL, MD AND MARK HRYMOC, MD CONFER WITH CSAM POLICY ADVISOR ROBERT HARRIS AT THE CSAM LEADERSHIP DEVELOPMENT RETREAT.



RETREAT CHAIR DAVID PATING, MD AND PETER BANYS, MD AT THE RETREAT.



2009 CSAM LEADERSHIP DEVELOPMENT RETREAT, SAN DIEGO

# Voice of Addiction Medicine is Heard in Sacramento

CSAM physicians held a series of legislative visits at the California State Capitol on May 27, 2009 where members made personal scheduled visits to the offices of twenty-two (22) legislators and members of their staff to discuss and distribute educational resource materials about drug treatment and current issues.

Physicians who participated were: **Denise Greene, MD** (Carson/Long Beach) Chair, Committee on Public Policy, **Tim Cermak, MD** (San Francisco/Mill Valley), **Itai Danovitch, MD** (Los Angeles), **Don Kurth, MD** (Rancho Cucamonga), **Judith Martin, MD** (Berkeley), **Michael Parr, MD** (Sacramento), **David Pating, MD** (San Francisco), **Ken Saffier, MD** (El Sobrante), **Christy Waters, MD** (Sacramento/San Francisco), **Lee Snook, MD** (Sacramento), **Michael Stone, MD** (Tustin). ■



*The following is a briefing paper on AB 244 was one of four briefings distributed by CSAM members during legislative visits:*

## **AB 244 (Beall) Health Care Coverage**

**Policy Goal:** This bill brings fairness and equality (parity) to insurance coverage for mental health services, alcohol and drug addiction. It is a key reform that allows alcohol and drug addiction to be treated as the disease it is and requires the private insurance carriers to include this coverage in their plans.

Under existing California law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of "severe mental illnesses" of a person of any age. Existing law does not define "severe mental illnesses" for purposes of the mental health parity requirement. AB 244 would define mental illness for this purpose, with certain exceptions, as a mental disorder defined in the Diagnostic and Statistical Manual IV.

**Problems:** Currently, millions of people in the United States find that their health plans place strict limits on both inpatient and outpatient coverage for addiction treatment services. By failing to appropriately cover substance abuse insurance companies have pushed the costs of untreated substance abuse onto the public. In 1998, California spent almost \$11 billion to deal with substance abuse and addiction.[1] Nearly half of all Americans report knowing someone with an addiction problem.[2] As many as twenty million Americans each year experience alcohol or drug addiction.[3]

**Argument:** Addressing substance use disorders is essential to reducing the economic burden on California of untreated substance abuse. It would allow many more people to access treatment, reducing costs to taxpayers and businesses. The millions of people in recovery from addiction are living proof that treatment works. Yet less than half the people who need treatment can get it, and only 20% of adolescents can obtain treatment.[4] Parity will allow more people to get treatment when they need it.

**Evidence:** Economic data shows that every dollar spent on alcohol and drug treatment saves seven dollars in medical and other social costs.[5]

Adding full and equal coverage for alcohol and drug addiction only increases premiums by 0.2 percent, or about \$1 per month for most families.[6]

A RAND study found that addiction treatment services could be made available to employees for \$5.11, or 43 cents per month.[7]

Chevron reports that it saves \$10 for every dollar spent on coverage for addiction services.[8]

**Solution:** AB 244 -- It's fair, it's equal, and it's cost effective.

*References available on-line at [www.csam-asam.org](http://www.csam-asam.org)*

CSAM Legislative Briefing Papers on other bills are also available online, at [www.csam-asam.org](http://www.csam-asam.org)

# Addiction Medicine: State of the Art Conference

October 7-10, 2009, Hotel Kabuki, San Francisco



Join CSAM for a stimulating and rewarding educational experience that will advance your understanding of addiction medicine and improve your clinical practice.



KAREN MIOTTO, MD  
CONFERENCE CHAIR

This year, federal insurance parity for substance abuse treatment has become law and a new administration promises a reorientation of health care policies. At this juncture, so rife with potential for growth in our specialty, we are pleased to offer a program emphasizing the latest evidence-based innovations in our field. Join us for a stimulating and rewarding educational experience that will advance your understanding of addiction medicine and improve your clinical practice.



HOWARD FIELDS, MD, PhD

## THURSDAY, OCTOBER 8

CSAM is honored to have two central figures in addiction research with us at this conference. **George Vaillant, MD**, will provide both an update on more than 30 years of longitudinal studies on alcoholism and drug abuse and a review of the neurobiology underlying the success of twelve-step programs. **A. Thomas McLellan, PhD**, President Obama's nominee for Deputy Director of the White House Office of National Drug Control Policy will share his view of the new directions that drug abuse policy will take under the Obama administration.

The opening session also features three scientists on the cutting edge of addiction research. **Antonello Bonci, MD's** research focuses on how stress and chronic exposure to ethanol and cocaine produce long-term changes in neuronal plasticity. **Howard Fields, MD, PhD** will discuss alcohol genetics and its implications for pharmacotherapy, and **Dorit Ron, PhD** will address medication development for alcoholism with peptide and hormonal targets.

The Thursday afternoon session will provide the latest research and clinical insights in the science of spirituality, trust, and research enhancing twelve-step participation.



WALTER LING, MD

## FRIDAY, OCTOBER 9

The developing adolescent brain carries unique risks for drug abuse, yet many physicians feel unprepared to meet the challenge of treating adolescents and young adults. Friday morning's session will begin with **Sandra Brown, PhD** presenting on the sequence of brain development in adolescents. **Paula Riggs, MD** and **Marc DeAntonio, MD** will speak on innovations in the evaluation and treatment of adolescents with co-occurring mental illness and ADHD, and **Marc Fishman, MD** will discuss the treatment of teen opioid addiction.

Friday afternoon's sessions will focus on state of the art clinical practice related to treating chronic pain and addiction. **Allan Basbaum, PhD** and **Walter Ling, MD** will explore common neurological pathways underlying both chronic pain and addiction and outline their clinical implications. CSAT Director, **H. Westley Clark, MD, JD, MPH** will characterize the epidemic of prescription drug abuse and discuss proposed federal legislation which would establish new requirements for prescribing Schedule II medications. **Scott Fishman, MD** will explore the impact of these changes on pain management.



BARBARA MASON, PhD

## SATURDAY, OCTOBER 10

A half-day program on cannabinoid pharmacology and the treatment of marijuana use disorders will conclude the conference. **Tommy Pattij, PhD** from the Netherlands will present his work on the role of the brain's endogenous cannabinoid system in modulating executive function. **Barbara Mason, PhD** will present unpublished research on the role of gabapentin in treating cannabis withdrawal. **Krista Medina, PhD** will discuss her study which measured neurocognitive impairment in adolescent marijuana users with 30 days of sobriety.

Presented in Association with the American Society of Addiction Medicine (ASAM), the Center for Substance Abuse Treatment (CSAT) and the National Institute on Drug Abuse (NIDA)

CSAM gratefully acknowledges support received from Reckitt Benckiser helped fund this conference.

Register on-line at [www.csam-asam.org](http://www.csam-asam.org)

# Addiction Medicine: State of the Art Conference

October 7-10, 2009, Hotel Kabuki, San Francisco

## Keynote Speaker Profiles



GEORGE VAILLANT, MD

**George Vaillant, MD** brought unique skills to a unique opportunity. The opportunity began shortly after his birth when the Study of Adult Development, the oldest study of its kind in the world, began. First, there is a sample of 268 socially advantaged Harvard graduates born about 1920. Second, there is a sample of 456 socially disadvantaged inner-city men born about 1930. Third, there is a sample of 90 middle-class, intellectually gifted women born about 1910. Using periodic interviews and questionnaires, the three groups of elderly men and women have been studied continuously for six to eight decades.

For nearly four decades, Dr. George Vaillant, a Brigham and Women's psychiatrist, has tended these files, mining them for clues to happiness and fulfillment, particularly in old age. As the longtime former leader of the Study of Adult Development, perhaps the longest-running investigation of aging ever conducted, Vaillant acknowledged his privileged position. "It was like inheriting a gold mine," he said. "It's been like watching a group of men trample down the hill in front of me," he said.

Vaillant's unique skills, which include the gifts of eloquence and endless curiosity, enabled him to produce his valuable contribution to our field, *The Natural History of Alcoholism* and *The Natural History of Alcoholism Revisited*. No other studies have prospectively followed alcoholics throughout their lifetime and reported with scientific objectivity on their natural history. A true classic, clearly presented.

Beyond alcoholism, however, Vaillant has also studied the elements contributing to longevity. Without abandoning his scientific base, Vaillant has explored the role that positive emotions play in health and longevity. He will undoubtedly explore the role that AA and spirituality play in the depth and longevity of recovery as well in his second presentation at our conference.



A. THOMAS MCELLELLAN, PhD

**A. Thomas McLellan, PhD** is currently President Obama's nominee for Deputy Director of the White House Office of National Drug Control Policy (ONDCP) in charge of Demand Reduction and will play a central role in creating a new drug policy in the Obama administration.

Dr. McLellan is widely recognized for improving the quality of drug abuse treatment. He developed two of the most practical and widely used methods of assessing addiction severity and treatment success: the Addiction Severity Index (ASI) and the Treatment Services Review (TSR). They were created with the view that substance abuse and addiction could not be adequately understood and addiction treatments could not be adequately delivered if there were no relevant real-world methods to gauge them. The ASI and TSR have helped to revolutionize the delivery of treatment and helped researchers and clinicians gain more insight into the efficacy of treatment.

McLellan's work has also promoted 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.



H. WESTLEY CLARK, MD, JD, MPH

**H. Westley Clark, MD, JD, MPH** Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, leads the agency's national effort to provide effective and accessible treatment to all Americans with addictive disorders. Dr. Clark was the former chief of the Associated Substance Abuse Programs at the U.S. Department of Veterans Affairs Medical Center (DVAMC) in San Francisco, California and a former associate clinical professor, Department of Psychiatry, University of California at San Francisco (UCSF). In addition to his duties at the DVAMC, Dr. Clark served as a senior program consultant to the Robert Wood Johnson, Substance Abuse Policy Program, a co-investigator on a number of the National Institute on Drug Abuse-funded research grants in conjunction with UCSF.

Dr. Clark is a noted author and educator in substance abuse treatment, anger and pain management, psychopharmacology, and medical and legal issues. He has received numerous awards for his contributions to the field of substance abuse treatment, including a 2008 President of the United States Rank of Distinguished Executive Award in recognition of his personal commitment to excellence in government and public service; and a 2003 President of the United States of America Rank of Meritorious Executive Award in the Senior Executive Service for his sustained superior accomplishments in management of programs of the United States. ■

The CSAM website, [www.csam-asam.org](http://www.csam-asam.org), features full profiles of all conference speakers as well as selected articles.

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## Pre-Conference Workshops



### Wednesday, October 7

#### Full Day Workshops (9:00 am to 5:00 pm)

#### **Pain and Addiction: A Combined Workshop for Physicians Who Treat Pain and for Methadone Treatment Providers**

The morning focuses on pain management in a primary care practice or pain practice where there are patients who may be referred to a methadone maintenance treatment program for management of opioid dependence. It also addresses care of pain patients who are in methadone treatment, with emphasis on how to coordinate care between the physician prescribing for pain and the methadone program treatment staff.

For the afternoon, the audience selects one of two concurrent sessions. One provides, among other topics, a clinical overview of neck and back pain and considers pharmacological management of such chronic pain conditions in patients at risk for misuse or addiction. The other concurrent session addresses medical issues specific to methadone treatment.

**Faculty: Daniel Alford, MD; Joseph Graas, PhD; Paul Kreis, MD; John J. McCarthy, MD; Jerome Schofferman, MD; and Lee Snook, MD**

#### **What is SBIRT? How Do You Do It and Teach It Effectively?**

This workshop, for physicians who teach in residency training programs, is designed to improve your teaching skills about screening for and assessing alcohol and drug use, conducting a brief intervention and making referrals—even with patients who are resistant to the efforts. The majority of the time will be spent in role plays with patients, followed by feedback from clinicians experienced in SBIRT interactions and education specialists. Interested residents are welcome to register.

**Faculty: Richard Brown, MD, MPH; Jennifer Hetteema, PhD; Paula Lum, MD; MPH, Julie Nyquist, PhD; and Ken Saffier, MD**

#### Morning Workshop (8:30 am to 12:00 pm)

#### **Urban Trauma, Addiction, and the Search for Forgiveness**

Post-Traumatic Stress Disorder (PTSD) and substance dependence are closely interwoven. While it has long been recognized that addiction facilitates traumas, it is increasingly apparent that the pathophysiology of these two disorders is closely linked as well—with virtually all substances of abuse having important biological effects at multiple levels of the stress system (cortex, sub-cortex, and hypothalamic-pituitary-adrenal axis). Although the etiological relationship between PTSD and addiction has yet to be fully elucidated, clinicians must face the conundrum of managing these often unstable patients.

**Faculty: Lisa Najavits, PhD; Charlie Marmar, MD; and Peter Banys, MD, MSc**

#### Afternoon Workshop (1:30 pm to 5:00 pm)

#### **Too Much Sex, Gambling and Shopping: Addressing Out of Control Behaviors**

This workshop will address the diagnostic criteria and treatment options for “out of control behaviors” also known as impulse control disorders, behavioral addictions or process addictions. Faculty with extensive experience in treating these disorders will explore the features and treatment of pathologic gambling, compulsive shopping, and “sex addiction.” The workshop will conclude with a panel discussion and question/answer session.

**Faculty: Jon Grant, MD; Donald Black, MD; and Reef Karim, DO**





## CSAM State of the Art Conference Planning Committee

**Karen Miotto, MD, Conference Chair**  
**Peter Banys, MD, MSc**  
**Timmen Cermak, MD**  
**Itai Danovitch, MD**  
**Dana Harris, MD**  
**Reef Karim, MD**  
**Monika Koch, MD**  
**Jean Marsters, MD**  
**Ken Saffier, MD**  
**Suma Singh, MD**  
**Phuong Truong, MD**

## Conference Scholarships

The Medical Education and Research Foundation for the Treatment of Alcoholism and Other Drug Dependencies (MERF) offers scholarships for physicians in training and teaching faculty in residency training programs.

MERF provides a mentored learning experience. Activities for residents—such as case discussions, brief meetings with faculty members, a dinner meeting and a lunch meeting—are scheduled during each conference. Scholarship recipients sit together during the conference and participate in activities designed for them.

To apply for a scholarship visit the MERF website: [www.merfweb.org](http://www.merfweb.org) ■

## Special Conference Event

FRIDAY EVENING, OCTOBER 9, 2009

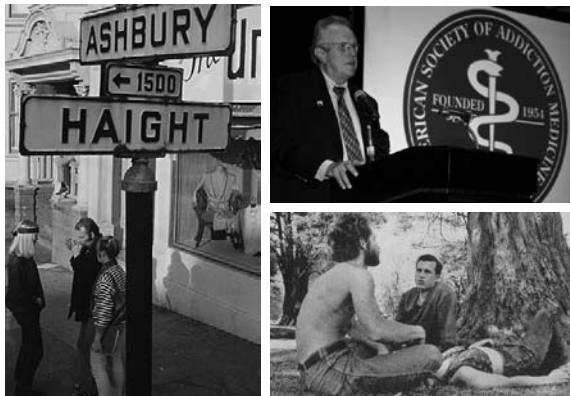
David E. Smith, MD

on

## \* SUMMER OF LOVE \*

**“The Summer of Love in the Haight Ashbury, the Evolution of Addiction Medicine and the Free Clinic Movement”**

*Featuring historic video footage, rock and roll photo exhibit, dinner and more.*



Register online at [www.csam-asam.org](http://www.csam-asam.org)

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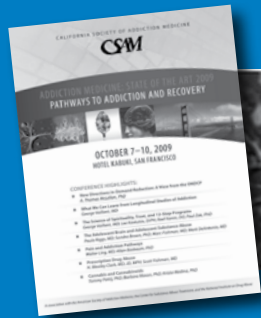
**NOTICE:** It was recently announced that the UCLA Department of Family Medicine was awarded a grant to train a primary care doctor in addiction. The NIDA-funded training program provides resources to physicians and postdoctoral fellows interested in this research direction. They are currently recruiting 1 MD and 1 PhD to commit for two years to conduct intensive research on addiction medicine in primary care. For information, contact Dr. Shoptaw at: [sshoptaw@mednet.ucla.edu](mailto:sshoptaw@mednet.ucla.edu).

# SAVE THE DATE!

## Addiction Medicine: State of the Art Conference

### OCTOBER 7-10, 2009

Hotel Kabuki, San Francisco



*See details inside...*

# CSAM

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