

CSAM's Forum for Dialogues in Addiction Medicine

Revisiting the Legalization/Decriminalization Debate



James P. Gray, Judge of the Superior Court in California, delivered an impassioned and evocative dessert talk at CSAM's recent State of the Art Conference. This issue's Forum consists of a summary of his thoughts, a compilation of the best counter arguments some of those in attendance offered, a brief reply by Judge Gray, and a final commentary by the Forum editor. First, Judge Gray's perspective:



Decriminalize Drug Use

BY JAMES P. GRAY, Judge of the Superior Court in California and Author of *Why Our Drug Laws Have Failed and What We Can Do About It – A Judicial Indictment of the War on Drugs* (Temple University Press, 2001)

Our nation's policy of Drug Prohibition is not working and will never work because we cannot repeal the Law of Supply and Demand, and illicit drug dealers make money – big money – by producing the supply that meets that demand.

Prohibition causes more harm than the drugs themselves. In order to understand this point, we need to make a distinction between drug crime on the one hand, and drug money crime on the other. In order for the scourge of increasingly violent drug money crime to exist, drug use must be illegal – and prosecuted vigorously. Remember, without alcohol prohibition, Al Capone would have been just another thug. Instead, he helped organize crime.

Evidence of the complete failure of the War on Drugs is all around us. Today marijuana is the number one crop in California. Even though our government has spent about \$470 billion on "Plan Colombia", the cost of Colombian cocaine today is about one-third what it was in the 1980s. We are seeing the same results in Afghanistan with heroin. And the violence caused by drug money in Mexico along our border has literally begun to spill over into the Southwest United States.

Even when the police are successful in seizing a large quantity of drugs, this only temporarily reduces the supply, which increases the price and in turn increases the incentives for people to sell them. The end result of this economic reality is that the policy of Drug Prohibition is doomed to failure, and "victory" increasingly is defined simply as slowing down the pace of defeat.

When we make drugs illegal, we give up all of our ability to regulate and control them. The strength, quantities and purity levels of drugs that are being sold and the age restrictions for the buyers are thus controlled exclusively by the illicit drug dealers, and they don't ask for i.d.!

I believe we should return to using the Criminal Justice System to hold people accountable for what they do, instead of what they put into their bodies. It makes as much sense to me to put Robert Downey, Jr. in jail for his cocaine addiction as it would to have put Betty Ford in jail for her alcohol addiction. It is the same thing; it is a medical problem. But if anyone drives a motor vehicle while under the influence, that would still be an offense because it puts the safety of other people at risk.

There are simply better ways of reducing drug abuse and all of the crime and misery that accompany it than our current War on Drugs. But we can change course only if we take off our muzzles and give ourselves permission to discuss alternative drug policies openly, fully and honestly.

There are good examples of a more effective approach to reducing drug abuse and suffering caused by misled drug policy.

Needle Exchange Programs work. All of the research studies show that programs of this kind do not increase drug usage, and they do not decrease it either. They are neutral in that regard. But they reduce the incidence of the HIV virus that leads to AIDS as well as Hepatitis C and other blood-borne diseases by about 50 percent!

Much hope can also be gained from a Heroin Maintenance Program that has been in operation in Switzerland since the mid 1990s. This program, run by licensed medical doctors, furnishes heroin prescriptions to addicts that are filled at local pharmacies. To qualify for the program, people must be at least 22 years old, addicted to heroin for at least two years, present signs of poor health, had two or more failed attempts at treatment, and must surrender their drivers' licenses.



Holland now recognizes that even though these drugs can be dangerous and cause harm to society, they are here to stay. This realization has led Holland to adopt a national program that includes not only honest education, needle exchange programs and drug treatment on demand, but also the decriminalization of drugs. Although it is still illegal in Holland to buy, use or possess these drugs, the police are instructed in writing to look the other way. Of course, if a person drives a motor vehicle under the influence of any of these drugs, that person is prosecuted heavily.

The big prize for libertarians, however, is legalization – or, at a minimum, decriminalization. Nothing else would be as effective at eliminating drug money and the host of virulent problems it engenders. Nothing else would protect drug users from impure products of unknown strength

better than fully medicalizing the maintenance of addicts on safe regimens. Nothing would reduce the pool of people harboring HIV, Hepatitis C and other infections more. Nothing else could stop the overcrowding of our prisons faster, or eliminate the severe ethnic imbalances among those who are incarcerated for drug possession. Nothing else could remove the incentive for drug dealers to initiate children into the dealing and using culture any faster than ending the profit motive created by prohibition.

Until enough sanity can be mustered by our political representatives to end prohibition, let us at least work to convince our city councils, mayors and chiefs of police to make the arrest and prosecution of non-violent offenders for the possession and use of drugs their lowest priority. ■



The Counter Arguments

[NOTE: The following is a compilation of comments elicited from Steven Ey, MD, William Brostoff, MD, Steve Eikelberg, MD, Monika Koch, MD, and Gail Jara, consultant to CSAM.]

To be fair, it should be noted that the group actually registered more sympathy than antipathy with Judge Gray's positions. However, each took seriously the task of helping to present the most cogent objections they think exist to his proposals. A summary of these objections is presented.

Before beginning, several expressed a need for more precise definitions to facilitate the debate. What policies fall under the umbrella of "prohibition"? Does "decriminalization" simply mean "depenalization," or does it also imply some form of "legalization"? And when does "legalization" mean medically supervised availability of a currently illicit drug versus full commercialization within parameters similar to those in place currently for alcohol or tobacco? The following objections attempt to be clear about these distinctions:

1: Arguing from analogy is problematic. Few of us have more than a passing familiarity with the genesis or effect of European drug policies. Furthermore, there is no reliable way to predict how experience in England, Holland, Germany, Switzerland, or even within the U.S. when the Volstead Act was passed (1919) or repealed (1933) relates to our country's current situation.

2: It is hard to ignore the likelihood that increasing the availability of addictive drugs, whether through outright legalization or medically supervised accessibility, would not eventuate in their greater availability throughout society, and especially for youth. As a general rule the more drugs are available, the more drug problems and complications there will be. Making drugs more legally available will result in more abuse, addiction, and medical and psychiatric problems, no matter the social benefits arising from diminishing the rate of incarceration for mere possession.

3: The idea of legalization, to the point of commercialization, is universally rejected, particularly for the sake of youth. The idea of a marijuana dispensary on the same street corner as a liquor store, promoted with all the skill possessed by corporate America's advertising machinery, is almost guaranteed to provide no better means of keeping its product from teenagers than currently achieved by tobacco and alcohol restrictions. By fully legalizing marijuana, availability to youth will inevitably increase, with a resultant increase in abuse.

4: The idea of full legalization is an illusion. There is no chance that restrictions on use by under aged youth will ever be deemed desirable. Legalization, at best, is strictly an adult goal.

5: Increased availability of stimulants (e.g., amphetamines, cocaine, crack), even when medically monitored, is likely to present too great a public health risk to be tolerated. Fueling paranoia, psychosis and the potential for violence via free access to stimulants differs substantially in its consequences from the effects of marijuana, opiates and even psychedelics (although not necessarily alcohol). As a result, decriminalization and legalization should not be seen as totally eliminating Black Market activity.

6: Whatever public policy eventually replaces the current failed strategy of incarceration perpetrated by the War on Drugs, the goal should be to funnel as many addicts into treatment as possible, whether by coercion (i.e., Prop 36) or honey (heroin clinics providing ready access to treatment). Maintaining sanctions against a Black Market in drugs, but with medically monitored availability of select drugs and providing intervention and treatment instead of incarceration whenever warranted, strikes most as the sanest guiding principle.

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.

7: Finally, we must face the practical reality that we currently lack the financial resources to create the health care and treatment facility infrastructure required by a depenalization policy. Whether we could find the resolve to answer the complex questions required to implement de-penalization is far from guaranteed. For example, where will the resources come from to find the needed infrastructure? Who controls the ground rules regarding what drugs would be available, to whom, in what quantity – the federal government, states or local? Could welfare checks or food stamps be used to purchase drugs? Would driving while intoxicated be monitored by mandatory blood tests? To list but a few. ■

A BRIEF REBUTTAL BY JUDGE GRAY

First Point: We are not a European country, but we can learn from their experiences. The Swiss Heroin Maintenance Program has achieved a notable reduction in crime and drug usage, as well as an increase in addicts requesting treatment.

Second Point: If drugs like marijuana were to be available for adults through a strictly-controlled government package store, and taxed, a large part of those taxes would be used expressly for drug treatment and honest drug education, which would noticeably reduce drug usage. And even if it didn't, other benefits that would accrue to us all would be enormous.

Third Point: My proposal of strictly-regulated distribution for adults would not allow any advertising and would have good quality but generic drugs.

Fourth Point: I would still make it a fully-prosecutable offense for anyone to sell, furnish, or in any way transfer any of these drugs to children.

Fifth Point: All approaches have problems because there is no perfect system. So we should adopt an approach that best reduces those harms. In other words, we should adopt a program of "harm reduction." And drug usage is not the only harm. We also have the problems from incarcerating hundreds of thousands of non-violent drug users and the increased crime associated with a Black Market.

Sixth Point: Drugs do not have to be illegal for us to hold people accountable for their actions, and we can still coerce the problem users into treatment!

Seventh Point: Nonsense! Our government has plenty of money, we are simply misspending it. Incarceration is the most expensive option.

Finally, our country needs its medical professionals to take a few steps forward. Today your function is being usurped by police officers. Who is in a better position to decide which drug should be in which federal schedule, a medical doctor or a police officer? Similarly, who is better able to address the medical needs of drug-addicted people? It is easy to pick on and punish most drug-addicted people because they do not have the political power to fight back. But not only do you have the power, you also have the expertise and the stature to do so effectively. And then we can leave the criminal justice system to do what it is best able to do, which is to hold people accountable for their actions, instead of for what they put into their bodies. ■

COMMENTARY

By TIMMEN CERMAK, MD

PRESIDENT-ELECT AND NEWSLETTER EDITOR

It is easy to think that this debate has been around a few too many times to be very interesting. Rigorous honesty requires an admission, however, that a true debate, with all sides coming to the table in good faith, has not ever occurred in our lifetime. In debating this issue, a few facts are worth keeping in mind.

1. Monitoring the future has consistently shown that marijuana use among American high school students is inversely related to their perception of its harmfulness, from a high of over 50% use 1979 to a low of slightly over 20% in 1991, even as the availability remained constant.
2. Dutch policy regarding marijuana has exhibited two phases. De-penalization (1976) had no effect on lifetime prevalence for youth for the first 7 years. A gradual progression to legalization (and commercialization in "coffee houses") between 1984 – 1996 saw the lifetime prevalence for 18-20 year olds rise from 15% to 44%.
3. Parental drug use is an important influence on adolescents' drug use. Easy household access is associated with greater risk of marijuana use among both younger and older adolescents.
4. The California Medical Association opposes the legalization of the use of illicit drugs, but does not oppose the decriminalization of drug use.

Two questions face CSAM: (1) Does a substantial consensus exist among the membership, either regarding the principles that should lead our way out from the failures of the War on Drugs or the policies that should be pursued to improve the public's health vis a vis drugs of addiction? (2) Should CSAM, as the voice of addiction medicine in California, take a more active role in promoting policy change?

Gail Jara has long guided our society; so I will end by quoting her directly when she wrote, "I personally believe that medicine should be a vocal and visible advocate for decriminalization."

The following two articles provided perspective for the above comments:

"Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate," Robert MacCoun and Peter Reuter, *Science*, October 3, 1997, Vol. 278, Issue 533

"Legalization of Marijuana: Potential Impact on Youth," Alain Joffe and Samuel Yancy, *Pediatrics*, Vol. 113, No. 6, June, 2004, pp e632-638 (Technical Report by the Committee on Substance Abuse and Committee on Adolescence) ■

CSAM offers an on-line BLOG to allow exchange of ideas beyond the newsletter. In each newsletter, we have a topic/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.

To post your own comments to the blog discussion go to: www.csam-asam.org and click on "CSAM BLOGS."

President's Column

BY JUDITH MARTIN, MD, CSAM PRESIDENT



C SAM has many interesting conversations going on, and as president I'm in the middle of some of them. Here are a few items to share with the membership. My predecessor, superman **David Pating, MD**, organized the content areas of these many interactions in the CSAM 10-point *Blueprint*. The

anchoring first statement in this *Blueprint* reads "Addiction is a Brain Disease." CSAM members know that a caring, evidence-based approach to treatment of addiction is our job. (If you want to see the other nine CSAM *Blueprint* points, they are on the last page of your previous newsletter, and on our CSAM website, www.csam-asam.org, under the Public Policy section.

The Latest from AATOD

The American Association for the Treatment of Opiate Dependence (AATOD) held its national conference in San Diego this year, as the hills around us burned. The theme of the conference was "Evidence-Based Principles and Practices: Improving Medication-Assisted Treatment". The conference chair was **Joan Zweben, PhD**, a well-known friend and contributor to CSAM, and prior Vernelle Fox awardee. Joan is also the person who hired me in 1986 to work at The 14th Street Clinic in Oakland, starting me on my addiction medicine path. It's always interesting to hear how CSAM members were guided into, were seduced into, or stumbled into the field in various ways. Serendipity, or as executive council member **Steve Eickelberg, MD** says "the unseen hand". Steve himself is quite visible in guiding young physicians into our field. You may have noticed the specially designated "MERF tables" at our conference every October. MERF is the foundation that subsidizes residency participants who attend the annual conference.

By the way, the phrase "medication assisted treatment" or MAT is the phrase used by the Center for Substance Abuse Treatment (CSAT) to describe methadone and buprenorphine maintenance pharmacotherapies, and the phrase is featured in the title of CSAT's TIP 43. These medications are offered in the context of integrated psychosocial interventions, hence the phrase. CSAM has a very active Committee on the Treatment of Opioid Dependence, now led by executive council member **Karen Miotto, MD**. This committee sponsors and organizes trainings for physicians who work in California's Opioid Treatment Programs, known as OTPs or methadone clinics. These trainings are based on a set of guidelines written by the committee and edited by **Deb Stephenson**. The guidelines are available free on the CSAM website. At the November meeting of the committee we worked on various updates, including new

information about methadone induction, cardiac risk, and medication interactions.

Cardiac Risk with Methadone

One developing area in evidence-based practice related to opioid dependence is cardiac risk in patients treated with methadone. You may have heard that the FDA added a black box warning to the methadone label in 2006.

(<http://www.fda.gov/cder/foi/label/2006/006134s028lbl.pdf>.)

The warning was aimed at physicians who use methadone for pain treatment, but addiction physicians who work with methadone are also taking the warning seriously. Cardiologist Mori Krantz has presented his case series of methadone-related cardiac risk at AATOD conferences for several years.^{1, 2} CSAM members may have heard a discussion on this topic led by Ed Salsitz, MD at ASAM's conference in Miami last spring. Since 2005, some prospective data are appearing about QT interval changes in methadone maintenance patients. Martell et al.³ prospectively measured QTc before and after admission to methadone maintenance. She found modest increases averaging slightly over 10 msec. Peles et al.⁴ sampled patients in Tel Aviv who were already stabilized in methadone maintenance, and found 3 out of 138 MMT patients with QTc of 500 msec or longer. After following these patients over two years, two of those three patients had died, although the deaths were not attributed to cardiac problems. Fanoie⁵ interviewed patients in Copenhagen about syncopal episodes. These patients were in maintenance treatment either with buprenorphine or with methadone. Higher methadone doses were found to be associated both with longer QTc and with self-report of syncopal episodes. In comparison, several reports indicate that sublingual buprenorphine treatment is not associated with QT prolongation at therapeutic doses.⁶⁻⁹ Another interesting bit of information is that the stereoisomer R-methadone – the one that is therapeutically useful at the mu receptor – is not the one that is associated with most QT prolongation.¹⁰ So, how to use all this evidence? Some OTP physicians have developed protocols for a risk-benefit discussion with patients, and for doing ECGs for those with cardiac risk, or above certain methadone doses. Obviously, in most cases the risk of certain relapse to injection drug use would be greater than the risk of a rare arrhythmia, and withholding a life-saving treatment is not a helpful intervention. (CSAM *Blueprint* point number 2: "Treatment Saves Lives.") For some patients at risk, transfer to sublingual buprenorphine may be an option, although in California cost is still a significant barrier to this treatment within the OTP. We can speculate that asking patients about

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CSAM Members in the News



National Council on Alcoholism and other Drug Addictions-Bay Area (NCA-DA-BA) presented the 2007 Bronze Key Award to **Barry Rosen, MD** for having made a significant contribution to the field of addiction treatment. The Bronze Key is a National Award that is presented by the local NCADD. Rosen can be reached at: barryr108@aol.com



Garrett O'Connor, MD has been named CEO of the Betty Ford Institute. O'Connor can be reached at: goconnor@bettyfordcenter.org



Denise Greene, MD has been named Chief of Addiction Medicine at Kaiser, Carson, CA to succeed **Gary Jaeger, MD** who is retiring this year. Jaeger can be reached at: gary.a.jaeger@kp.org and Greene can be reached at: denise.e.greene@kp.org



Peter Banys, MD represented CSAM in working with the Drug Policy Alliance in drafting a ballot initiative that will go before CA voters in November 2008 called the "Nonviolent Offender Rehabilitation Act" (NORA). The measure addresses drug treatment for youth and nonviolent offenders and makes a series of reforms to the parole process and the correctional system. The

initiative calls for \$65million per year to invest in building a system of care for youth. Banys can be reached at: peter.banys@ucsf.edu



David Pating, MD completed two years service as CSAM's President in October. He was recognized for his contributions in furthering CSAM's public policy work, in creating a *Blueprint* for California to address treatment needs, and for his outstanding contributions in furthering CSAM's work in educating physicians and the public on evidence-based treatment. Last year, Pating was named by Governor Schwarzenegger to a seat on the Mental Health Services Commission responsible for implementing Proposition 63. He was presented with the CSAM President's Plaque by incoming CSAM President, Judith Martin, MD, and ASAM President, Mike Miller, MD. Pating can be reached at: david.pating@kp.org



New CSAM member **Elinore McCance-Katz, MD** recently was named president of the American Academy of Addiction Psychiatry (AAAP). Having recently relocated to San Francisco from Virginia, she is shown here meeting with CSAM President, Judith Martin, MD. McCance-Katz can be contacted at: elinore.mccance-katz@ucsf.edu



SBIRT - Understanding its Significance to Addiction Medicine

BY TIMMEN CERMAK, MD, EDITOR, CSAM PRESIDENT-ELECT



Screening, Brief Intervention, Referral and Treatment (SBIRT) is a technology for approaching substance abuse that has a strong evidence base and is poised to have a major impact on the field of addiction medicine. Understanding its history, application and implications is important to CSAM members.

The traditional approach to substance abuse has emphasized universal prevention strategies aimed at those who have never initiated use or specialist treatment for those who have become dependent. Little attention has been paid to those who use without dependence but intermittently engage in high-risk behaviors.

SBIRT received a major boost from a 5-year initiative funded by the Substance Abuse Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT). The SBIRT Initiative targets those with nondependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. For further information, visit <http://sbirt.samhsa.gov>.

Programs funded by SAMHSA/CSAT include university/college programs and state cooperative agreements. In 2003 California received funding for CASBIRT, a demonstration project based in San Diego, which has screened 190,000 patients in various primary care settings.

The core components of SBIRT begin with Screening: Incorporated into the normal routine in medical and other community settings, screening provides identification of individuals with problems related to alcohol/or substance use. Screening can be through interview and self-report. Four of the most widely used screening instruments are AUDIT, ASSIST, DAST and CRAFFT (for adolescents).

Brief Intervention is provided for individuals with screening results that indicate moderate risk. This involves motivational discussion focused on raising individuals' awareness of their substance use and its consequences, and motivating them toward behavioral change. Successful brief intervention encompasses support of the client's empowerment to make behavioral changes.

Following a screening result of moderate to high risk, *Brief Treatment* is provided. In addition to motivational interviewing and empowerment, brief treatment includes more comprehensive assessment, education, problem solving, coping mechanisms and building a supporting social environment.

In the face of a screening result of severe risk or dependence, a *Referral to Treatment* is provided. This imperative component is a proactive process that facilitates access to care for those individuals requiring more extensive treatment than SBIRT provides.

The data from SBIRT is not merely impressive; within the framework of most medical interventions, the impact of SBIRT is astounding, knock-your-socks-off, nearly too good to be true, especially when SBIRT is provided in emergency departments and trauma centers. For example, Gentilelo found among trauma patients that 46% tested positive for alcohol, only 1.6% refused brief intervention, and SBIRT resulted in a 47% reduction in new injuries requiring treatment over the following 3 years ("Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence," *Annals of Surgery*, Vol 230, No. 4, 473-483, 1999).

Washington State's CSAT-funded SBIRT project in emergency departments produced a 46% reduction in binge drinking with brief intervention alone, and an 88% reduction with brief or CD treatment 6 months after the SBIRT event. And brief intervention alone increased abstinence from both alcohol and other drugs 6 months later by 96%, while brief therapy or CD treatment increased abstinence from both by 3,200%.

The CASBIRT model, which includes primary care clinics, produced a six-month impact of reducing hazardous alcohol use by 44% and illegal drug use by 50.8%. All of these figures represent astounding benefit for a very low investment in money and time required to conduct SBIRT.

The only caveat to date stems from the fact that surveys of long-term financial savings from SBIRT have been mixed, with half documenting significant savings and half noting no financial benefit despite the decrease in incidence of high-risk drinking (Wutzke, "The long-term effectiveness of brief interventions for unsafe alcohol consumption: a 10-year follow-up," *Addiction*, Vol 97, Issue 6, 665-675-2002).

Within California, the impetus for expanding SBIRT is largely in the hands of the Governor's Prevention Advisory Council (GPAC) Subcommittee on SBIRT. Two CSAM members, **Maureen Strohm** (Director, USC/California Hospital Family Medicine Residency) and myself currently serve on the SBIRT Subcommittee.

The CASBIRT Subcommittee's goal is to provide strategic input for including SBIRT in the standard continuum of healthcare in California, and to expand and sustain SBIRT practices in general medical and community settings, including all levels of healthcare, school-based health clinics, student assistance programs, occupational health clinics and EAPs. This goal represents a major expansion of a public health approach to protecting against the huge cost to society of high-risk behaviors stemming from alcohol and other drug use.

What will be the effect on addiction medicine if SBIRT becomes widely used? The initial role might well be educating our colleagues to increase acceptance of SBIRT into

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Don Wesson Tribute

CONTRIBUTED BY PETER WASHBURN, MD

When Don Wesson, MD stepped down as editor of *CSAM News* last year, he had served the membership in this capacity for 26 years. In lesser hands, our newsletter might have gradually become the voice of its editor instead of the Society. But Don's goal was to preserve the voice of each individual writer while remaining behind the scenes. He points to *Scientific American* as a journal that is so heavily edited that all the articles sound like they have the same author. Nothing wrong there, but Don wanted to avoid that sameness. He saw his task as helping authors highlight their points, fix their grammar and smooth awkward sentences while leaving their style alone. He strove to be the agent of the reader. Determine what message was being made. Eliminate ambiguity. Cut through impenetrable prose. Like theater lighting, when it's done well, the spectator doesn't notice.

It only seems like Don has always been the editor. David Smith and Forrest Tennant, MD filled that role for the first six years, with Gail Jara ghosting most of the unsigned articles. Gail, who had been editing, typing, formatting the *News* since its inception in 1974, was first credited for her work in the July/August 1980 issue — Don's first as editor. Don graciously notes it was Gail who taught him the essence of being a good editor. She had been cutting her teeth at the *CMA* as a writer/editor, and I know from personal experience that Gail could be the editor from hell. When I co-authored an article for the *News* in 1987, an early draft came back so heavily marked up I doubted I would ever write another article.

The first issue Don edited opens with an article written by Don himself entitled "Current Diagnosis or History of Alcoholism Grounds Commercial Pilot" (1980). Twenty-seven years later pilots and alcohol are still in the news. Leafing through old copies of Don's *CSAM News* is a rewarding experience. An anthology of the "best" illustrates the timeliness of his influence: "Persian Heroin in the SF Bay Area, 1977-1980: The New Wave?" (1980), "Methadone in the



DON WESSON, MD WITH HIS WIFE, EILEEN, AT HIS 65TH BIRTHDAY PARTY LAST YEAR WHERE MANY CSAM MEMBERS AND FRIENDS JOINED HIM TO CELEBRATE.

Relief of Pain" (1984), "A Commentary on Urine Testing of Some Workers Employed as Athletes" (1989), and three articles on nicotine and smoking cessation in 1990-1991 — to mention just a few. Don is particularly proud of articles that introduced ideas for the first time. An article describing the use of Catapress R patches for opiate detox was the first to describe the use of transdermal clonidine for opiate withdrawal (1986). His article, in collaboration with David Smith, MD on "Low Dose Benzodiazepine Withdrawal Syndrome - Receptor Site Mediated" was a theory at the time (1982) that was eventually shown to be correct. Timmen Cermak's first article on Cannabis in 1997 elicited the most number of requests for copies.

The California Society of Addiction Medicine is enormously grateful to Don for his years of effort and service to the *CSAM News*. His commitment to maintaining high standards is a legacy that will continue to guide *CSAM's* newsletter. We were extremely lucky to have someone who could teach us over the years to write clearly and succinctly. And we feel graced by the warm and easy manner with which he treated us all.

Thank you, Don.

SBIRT

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the standard of good medical practice. There is no data to indicate that SBIRT will eventually be able to intervene early enough in the disease progression to decrease the number of people eventually requiring intensive treatment for chemical dependence, although this would be the ultimate hope. The more likely outcome would be an initial increase in referrals for treatment, an ongoing need for expert assessment of those who are found to be at severe risk or dependence and training/support of special workers administering SBIRT.

CSAM has already taken a role in promoting the use of SBIRT. In our *Recommendations for Improving California's Response to Methamphetamine*, CSAM proposed requiring SBIRT in emergency rooms for designated diagnoses. This recommendation was then written into Assemblyman Paul Krekorian's AB1461, which is designed to set up a two county demonstration project.

Early diagnosis is the key to reducing the harm produced by any disease. SBIRT may well provide the key long needed by the field of addiction medicine. ■

Announcing the CSAM Executive Council

At the CSAM Annual Business Meeting held on October 19, 2007 at the Sheraton Universal Hotel in Los Angeles, the following slate was approved by the membership for the CSAM Executive Council:

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President's Column

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syncopal episodes, or paying attention to other medications that could add QT risk might be important, and clinicians include these questions in their risk assessment. Perhaps in the distant future we will be offering treatment with R-methadone, or screening patients for genetic variants of cytochrome activity. But that is speculation at this point, and as experts point out, we really don't have the evidence to show us what to do about QT risk in general.¹¹ CSAT is convening a consensus workgroup to come up with clinically useful guidance pending such evidence. Stay tuned for those updates. For those of you who work in OTPs, the CSAM's next physician training is planned for April. ■

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3. Martell B, Arnsten J, Krantz M, Gourevitch M. Impact of Methadone Treatment on Cardiac Repolarization and Conduction in Opioid Users. *American Journal of Cardiology*. April 1 2005;95:915-918.
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Public Protection and Physician Health Program

By STEPHANIE SHANER, MD, CHAIR, CSAM COMMITTEE ON PHYSICIAN WELL-BEING



On July 26, 2007, the Medical Board of California voted to close the Physician Diversion Program on June 30, 2008. The following represents joint preliminary recommendations on the goals and parameters of a new Public Protection and Physician Health Program in California that will

serve to protect California patients.

CSAM stands ready to work with the Legislature, the Medical Board and the larger community of interested parties to fashion a state-of-the-art public protection/physician health program for California. We believe that the citizens of the state deserve the protection such a program offers. Only by having the ability to identify and monitor impaired physicians until they regain the ability to practice safely is the public interest protected.

The California Medical Association, California Psychiatric Association and the California Society of Addiction Medicine recommend that the California Public Protection and Physician Health Program entity be established expeditiously with the following goals:

- To ensure the safety and protection of patients.
- To focus on early intervention, assessment and monitoring for physicians with significant health impairments that may impact their ability to practice.

The following are specific operational recommendations. A California Public Protection and Physician Health Program should be:

1. Established as a formal, legislatively sanctioned, not-for-profit, independent, but publicly accountable entity.
2. Regularly audited for clinical quality and fiscal integrity.
3. Supported by a stable and continuing source of funds from professional licensing fees.
4. Structured to provide a continuum of medically based services including comprehensive assessment, triage and monitoring services for behavioral disorders, including psychiatric, substance abuse and possibly other medical conditions.
5. Open to voluntary, and Board-referred participants.
6. Confidential for compliant participants.
7. Coordinator of a statewide system for drug testing with a Medical Review Officer (MRO) employed to assure the oversight of procedures and toxicology reporting and standards.
8. Actively engaged with physician well-being committees in all phases of the assessment, triage and monitoring of physicians.

9. Providing training of well-being committees, evaluators and other contract or volunteer personnel associated with the program.
10. Governed by a Board composed of both physicians and non-physicians with expertise in physician health and impairment; managed by a Medical Director who is knowledgeable and responsive to the Board; and staffed by individuals with strong clinical training where participant contact is required.

What the CSAM, CPA and CMA Workgroup is Doing

With the imminent demise of the Medical Board's Diversion Program, CMA, CSAM, CPA and Kaiser Permanente have been working together to define what we believe would be an ideal program to replace it. We believe that an independent not-for-profit entity would best serve California, and we are working to define what the best structure and elements would be.

Our intention is to seek legislative authorization for a new entity.

We hope to forge a unified voice in the medical community in support of our efforts. We need to move quickly to fill any gap that occurs with the closing of the Diversion Program.

Our preliminary framework includes: referrals from the Medical Board; a confidential program for compliant participants; engagement with well-being committees; governed by experts.

The Gap

There is much concern about where physicians can be referred for monitoring because hospitals, medical groups and many individuals relied significantly on the Diversion Program.

In the likely event that the Diversion Program will close before an alternative is in place, we are also looking for interim solutions.

The California Landscape

There are many individuals, groups and institutions who have worked in various capacities in concert with California's Diversion Program for more than 25 years or physician health programs in other states.

Some of the original founders of the program and others who have developed knowledge and experience in relation to the Diversion Program are actively engaged in various aspects of monitoring and treatment now.

We are interested in reaching out and learning from all these resources to support a new program as soon as possible. In the best of all possible worlds, we would be able to bring all this experience to bear in the creation of a program for California. ■

2007 State of the Art Conference in Los Angeles



The CSAM State of the Art Conference was held October 17-20 with over 300 attendees. Lori Karan, MD was chair of the Planning Committee for the conference. Other members of the Planning Committee were: Stephanie Shaner, MD (Vice-Chair); James Barger, MD; Murtuza Ghiadali, MD; Robert Martin, MD; Jean Marsters, MD; Karen Miotto, MD; Garrett O'Connor, MD and Barry Rosen, MD.

The conference featured keynote addresses by NIDA Deputy Director Timothy Condon, PhD and CSAT Director H. Westley Clark, MD, JD, MPH. Other highlights included A. Thomas McLellan, PhD on Defining and Measuring Recovery, Leslie Morrow, PhD on GABA and Neurosteroids, Alan Marlatt, PhD on Mindfulness-Based Therapies, Paula Riggs, MD on Adolescent Treatment, and a section on steroids with Harrison Pope, MD, Don Caitlin, MD, Ruth Wood, PhD as well as Lance Williams and Mark Fainaru-Wada (authors of a popular book on Barry Bonds and the steroids scandal in professional sports).

A number of special evening events provided a break from the rigorous schedule: Howard Richmond, MD, a CSAM member, performed stand-up comedy, the Honorable James Gray, presiding judge of the Superior Court of Orange County, gave an evening talk on "Why Our Drug Laws Have Failed," (see his article on page 1 of this newsletter), and a dinner meeting gave attendees a chance to meet and ask questions of Lance Williams and Mark Fainaru-Wada.



The CSAM Community Service Award was presented to **Kristen Ochoa, MD** in recognition of her ambitious efforts to advance a public policy agenda in support of substance abuse treatment. Notably, she was honored for her work as Director of the Los Angeles Overdose Prevention Task Force and her efforts to bring policy makers, public health officials, law enforcement, service providers and researchers together to create an overdose prevention and

evaluation plan for Los Angeles County. Ochoa was also the recipient of ASAM's Young Investigator Award in 2003 for the best abstract submitted by an author who is within five years of receipt of a doctoral degree. Ochoa can be contacted at: kochoa@ucla.edu.



Rick Rawson, PhD, received the 2007 Vernelle Fox Award in acknowledgement of almost three decades of scientific leadership, treatment development, and education in the field of addiction. The award was presented by Karen Miotto, MD who thanked Dr. Rawson for his tireless dedication, direction, and vision of the UCLA Integrated Substance Abuse Programs research and training projects. Rawson can be contacted at: rrowson@mednet.ucla.edu.



Lance Williams and Mark Fainaru-Wada, *San Francisco Chronicle* reporters and authors of a *Game of Shadows: Barry Bonds, BALCO, and the Steroids Scandal that Rocked Professional Sports*, spoke at the State of the Art Conference and at a more informal dinner meeting.



CSAM Member **Howard Richmond, MD** performed to rave reviews as "The Comic Shrink". Richmond proved that laughter really is the best medicine! He can be reached at: drhowardrichmond@sbcglobal.net.

CSAM Workshop for Medical Personnel Working in Methadone Maintenance Treatment Programs

CSAM's ground-breaking "Guideline for Physicians Working in California's Opioid Treatment Programs" is the basis for the 4th in a series of workshops organized by the Committee on the Treatment of Opioid Dependence. The third edition of the guideline (2008) incorporates new clinical information as well as changes in California's regulations.

The next workshop, "Medical Management of Patients on Methadone: The Current Standard of Care", to be held in Oakland on April 2, will include discussions of the growing incidence of prescription drug dependence as it presents in methadone-treatment programs, inducting patients onto methadone, the challenge of prolonged QT intervals, drug interactions commonly seen in methadone treated patients, co-occurring medical disorders, interpreting urine toxicology and new methods of drug screening such as hair and saliva testing, risk management in the OTP, and transitioning methadone patients to buprenorphine.

Planners are Karen Miotto, MD, Medical Director, Drug Dependency Treatment Program, Veterans Affairs Greater Los Angeles Healthcare System; David Kan, MD, Head of the Opioid Replacement Team (ORT) at the San Francisco VA; Carolyn Schuman, MD, Medical Director of BAART's 14th Street Clinic in Oakland and the San Mateo Medical Center Methadone Treatment Program; and Brad Shapiro, MD, Medical Director of the San Francisco Department of Public Health Opiate Treatment Outpatient Program (OTOP) and Office Based Opiate Treatment Program (OBOT).

"Medical Management of Patients on Methadone: The Current Standard of Care" Wednesday, April 2, 2008, 8:30 am to 4:45 pm, Offices of Alameda County Behavioral Sciences, 2000 Embarcadero Cove, Oakland. For information, contact CSAM 415/927-5730. For a copy of the guideline and full details about the April 2 workshops, see www.csam-asam.org. ■

Welcome New Members!

Ian Carroll, MD - Palo Alto

Gary Chase, MD - Santa Monica

Todd Clements, MD - Newport Beach

Parvez Fatteh, MD - Hayward

Timothy Fong, MD - Los Angeles

Gregory Freed, MD - Orange

Thomas Gonda, MD - Oakland

Victoria Greenberg, NP - Irvine

Stephen Groth, MD - San Juan Capistrano

Pa Heu, MD - Fresno

Dexter Jensen, MD - San Diego

Sheldon Jordan, MD - Santa Monica

Max Lebow, MD - Manhattan Beach

Philip Martin, MD - Tustin

Elinore McCance-Katz, MD, PhD - San Francisco

Bruce Stark, MD - Hollywood

Lucille Thomas, MD - Simi Valley

Lilit Yegiazaryan, MD - Burbank

California Society of Addiction Medicine Presents an Evening of Addiction Medicine ASSISTING THE IMPAIRED PHYSICIAN

Speaker: *Elinore F. McCance-Katz, MD, PhD, Professor of Psychiatry, University of California San Francisco; former medical director of the Virginia Health Practitioner's Intervention Program; President, American Academy of Addiction Society.*

Friday, March 7, 2008

Delancey Street Restaurant

600 Embarcadero (at Brannan)

San Francisco • Fee \$25/person.

No pharmaceutical company funds are being used for this event. **1 hour of Category 1 CME**

Register online at csam-asam.org

California is currently struggling with how to manage its physicians with impairing illnesses — principally substance use disorders. This talk will:

- review impairment in physicians and other health professionals;
- provide an overview of types of monitoring programs and the components of those programs;
- discuss pharmacotherapy for addiction in healthcare professionals;
- provide physicians with knowledge of how to manage impaired healthcare providers, and will provide the basis for a discussion of issues in the management of impaired health professionals.

SAVE THE DATE!

Addiction Medicine Review Course 2008

October 22-25, 2008

Newport Beach Marriott Resort and Spa, *Newport Beach, CA*



Four-day overview of the principles of addiction medicine. An excellent review for those preparing to take the ASAM certification exam. Conference will feature a special "Certification Exam Review Track" with extra sessions to prepare those taking the exam.

Conference Chair: *Jean Marsters, MD*

CSAM

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THE CLINICAL INSTITUTE NARCOTIC ASSESSMENT (CINA) SCALE FOR WITHDRAWAL SYMPTOMS

Source: Adapted from Peachey, J.E., and Lei, H. Assessment of opioid dependence with naloxone.

British Journal of Addiction 83(2):193-201, 1988.

PARAMETERS	POINTS	FINDINGS
Parameters Based on Questions and Observation:		
(1) Abdominal Changes: <i>Do you have any pains in your abdomen?</i>	0 1 2	No abdominal complaints; normal bowel sounds Reports waves of crampy abdominal pain Crampy abdominal pain; diarrhea; active bowel sounds
(2) Changes In Temperature: <i>Do you feel hot or cold?</i>	0 1 2	None reported Reports feeling cold; hands cold and clammy to touch Uncontrolled shivering
(3) Nausea And Vomiting: <i>Do you feel sick in your stomach?</i> <i>Have you vomited?</i>	0 2 4 6	No nausea or vomiting Mild nausea; no retching or vomiting Intermittent nausea with dry heaves Constant nausea; frequent dry heaves and/or vomiting
(4) Muscle Aches: <i>Do you have any muscle cramps?</i>	0 1 3	No muscle aching reported; arm and neck muscles soft at rest Mild muscle pains Reports severe muscle pains; muscles in legs arms or neck in constant state of contraction
Parameters Based on Observation Alone:		
(5) Goose Flesh	0 1 2 3	None visible Occasional goose flesh but not elicited by touch; not permanent Prominent goose flesh in waves and elicited by touch Constant goose flesh over face and arms
(6) Nasal Congestion	0 1 2	No nasal congestion or sniffing Frequent sniffing Constant sniffing watery discharge
(7) Restlessness	0 1 2 3	Normal activity Somewhat more than normal activity; moves legs up and down; shifts position occasionally Moderately fidgety and restless; shifting position frequently Gross movement most of the time or constantly thrashes about
(8) Tremor	0 1 2 3	None Not visible but can be felt fingertip to fingertip Moderate with patient's arm extended Severe even if arms not extended
(9) Lacrimation	0 1 2	None Eyes watering; tears at corners of eyes Profuse tearing from eyes over face
(10) Sweating	0 1 2 3	No sweat visible Barely perceptible sweating; palms moist Beads of sweat obvious on forehead Drenching sweats over face and chest
(11) Yawning	0 1 2	None Frequent yawning Constant uncontrolled yawning
TOTAL SCORE:	SUMMARY	Percent of maximal withdrawal symptoms: = (total score/31) x 100% = ____/31 x 100% = ____%
Date: _____		Number of Absent Signs and Symptoms: ____ out of 11
Time: _____		Number of Maximal Signs and Symptoms ____ out of 11
Patient Name:		Minimum score = 0, Maximum score = 31. The higher the score, the more severe the withdrawal syndrome.



Provided by:
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