CSAM NEWS

Newsletter of the California Society of Addiction Medicine Spring 2000 Vol. 27, No. 1

CALIFORNIA LEGISLATION

Parity for Substance Abuse Treatment

BY GARY JAEGER, MD, CHAIR
CSAM COMMITTEE ON PUBLIC POLICY

Thanks to the efforts of the County Health Officers, a "parity" bill was introduced into California's legislature at the beginning of this year. As introduced, SB 1764 (Chesbro) would have required that every health care service plan provide coverage for the treatment of alcohol and other drug abuse. "Coverage for alcohol and other drug abuse pursuant to this section shall be subject to all other terms and conditions of the plan that apply generally to other benefits."

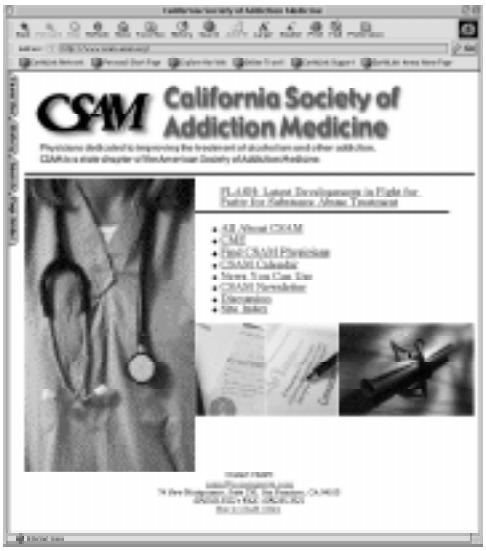
As opposition emerged, all the requirements for coverage were dropped and replaced with a requirement for the Legislative Analyst to make a study of the cost effectiveness of substance abuse treatment parity and the cost impact to employers and employees. The study is to be restricted to review of existing data and "a survey of a sampling of health plans," according to the notes from a Senate Staff Consultant. The wording in the bill calls for review of "information on private resources and organizations statewide that provide alcohol and drug treatment services ... ".

Opposition to the original bill was recorded from the Association of California Life and Health Insurance Companies, Blue Cross of California, the California Association of Health Plans, the California Chamber of Commerce, and Employers Health Care Coalition of Los Angeles.

Continued on page two

NEW CSAM WEBSITE

www.csam-asam.org



Home page for CSAM's website. From this page, a click on any of the listings takes you directly to that "page" or that section of the website.

The California Society of Addiction Medicine is on line! At **www.csam-asam.org**, you'll find eight different sections or "pages" filled with current CSAM information as well as links to internet sites of interest to addiction medicine.

All About CSAM
This page lists all CSAM committees, their charges, and a roster of their members. For many of the committees, you will find the minutes of a recent meeting.

There is also a description of CSAM publications and an order form. You can place your order on line, if you want.

To help your communication with potential new members, there is an informative history of CSAM, a listing of the benefits of membership in CSAM and ASAM, and an on-line membership application.

Continuing Medical Education (CME) Calendar
This page gives details about all the CME programs related to Addiction Medicine that we know about. It includes every CME program which CSAM offers plus all the others we know about. It tells what, where, when, the number of hours of credit, speakers and sponsors. It gives contact phone numbers for other information.

The program outline for CSAM's Addiction Medicine Review Course in October, 2000, and a form to register on line, will soon be on the site.

Membership Directory
The full directory of members is on line, listing all CSAM members with information about their specialties, positions, ASAM certification/recertification, CAQ in addiction psychiatry, Medical Review Officer (MRO) certification, and whether they take private patients.

To make navigation through this long list easier, the directory is indexed both by last name and by county (within California) or State (outside California). Soon there will be a third index by specialty.

As address changes, new phone numbers and e-mail addresses are received in the CSAM office, they are entered into the membership directory which appears on line,

Continued on page three

The full text of the amended bill is available from **www.info.sen.ca.gov**. For a copy of the original bill, before it was reduced to a study, contact the CSAM office.

Office-based use of methadone and LAAM for treatment of opioid dependence is almost certain to become a reality in the near future. The Federal initiative to revamp the methadone maintenance treatment system includes a provision for physicians to treat patients in regular office or clinic settings. SB1807 (Vasconcellos) would require California's Department of Alcohol and Drug Programs (ADP) to have a such a program. The bill requires a link between an established narcotic treatment program (NTP) licensed by ADP and the physician providing the office-based care. CSAM supports the bill and is on record advocating for office-based treatment of opioid addiction.

Triplicate prescriptions would be eliminated on January 1, 2003 if AB2018 (Thomson) passes. The bill would shift the record keeping from the paper system to an electronic system currently being tested: the Controlled Substance Utilization Review and Evaluation Systems (CURES). The pilot test of CURES began in 1998. A report to the legislature in 1999 showed that in the first 7 months, CURES recorded data from 892,985 Schedule II prescriptions. Compare that to the number of paper prescriptions recorded during the full year 1995 by Department of Justice – 256,303. According to the report, the ability of the Department of Justice to stay breast of data entry from triplicate forms has declined. In 1998, only 39,945 forms, or 1.7% of the total, were manually entered into the system.

Committee on Public Policy Is Speaking Out for You
Parity for treatment of chemical dependency and increasing access to treatment for opioid dependence are the two main areas of activity, but we try to keep members informed of other areas relevant to our field. As chairman, and speaking for the members of the committee, David Breithaupt, Ihor Galarnyk, Donald Kurth, Jack McCarthy and Lee Snook, I welcome your comments and suggestions.

Doctor Jaeger can be reached via e-mail at jaegerga@aol.com.

Addiction Education — A Call to Arms!

By David Pating, MD, Chair, CSAM Committee on Education

At their last meeting, the members of the CSAM Committee on Education noted that addiction medicine continues evolving at a blistered pace. This year, office-based opiate treatment, including buprenorphine, as well as new mental health parity legislation has taken center stage. With the annual conference (Addiction Medicine Review Course, October 11-14) still months away, the need for timely and relevant addiction education is more important than ever.

Taking the lead, several CSAM committees are now planning comprehensive updates on 1) substance abuse parity and the role of addictionists in legislation, 2) office-based opiate treatment, and 3) treatment of the impaired physician. Look for these events within the year.

Call to Arms! ...You Can Help
The CSAM Committee on Education now actively seeks members to participate on educational planning groups for the following topics:

- Primary Care Treatment of Addiction
- Harm Reduction/Treating Difficult Patients
- Addiction Medicine for Physicians-in-Training
- Office-Based Research
- Special Populations: Women, Adolescents, Elderly and Minorities
- Trends in Drug Use: Club Drugs, Heroin, Amphetamine
- Integrating Components of Addiction Treatment
- Wellness & Self-Help Recovery

The committee is also looking for members interested in coordinating regional CME lecture-dinners or half-day seminars. These events are great ways to meet colleagues while hearing the latest trends in addiction medicine. Our CSAM Executive Director (Kerry Parker) can help you focus your topic and identify speakers. She will also discuss how you can find accessible sites and sponsorship.

Please call CSAM today at 415/243-3322 to make it happen!

CMA Resolution on Parity

One of the first activities of the new CSAM Committee on Public Policy was to sponsor a resolution to the CMA House of Delegates in March, 2000, calling on CMA to advocate for parity. David Breithaupt, working with the CMA Delegation from Santa Clara County Medical Association, along with Gary Jaeger's efforts with the Los Angeles County Medical Association, succeeded in getting the resolution introduced. Doctor Breithaupt, Lee Snook and Peter Banys testifed before the CMA Reference Committee, and the House of Delegates adopted the resolution.

The full text of the new CMA policy statement is "that CMA advocate health care benefits for the entire continuum of clinically effective and appropriate research-based treatment services for substance abuse disorders; and further that CMA advocate that all health care benefit plans provide benefits for substance abuse disorders."

so you'll always have the most current information that the CSAM office has. *(Do you have a correction in your address or any part of your listing in the directory? Send it in from the web site. Click on the e-mail link to csam@compuserve.com wherever you see it. It appears in several places.)*

CSAM Calendar
The Calendar lists activities other than the CME programs noted above. Examples are the meetings of CSAM Committees as well as meetings of other organizations such as the California Medical Association and the Medical Board of California. *(Is there an activity in your region you want to highlight? Send the information for posting in this section of the website.)*

News You Can Use
The most frequently updated section gives you brief bulletins on public policy issues as well as scientific and clinical topics. Current topics include pending California legislation, the French experience with buprenorphine, a review of the new NIDA booklet, *Principles of Addiction Treatment*, a review of a recent issue of the journal *CNS Spectrums* on Novel Pharmacotherapies for Alcoholism, a press release from NIDA on a new study which underscores the efficacy of methadone as a treatment for heroin addiction, studies on nicotine dependence, medical marijuana and more.

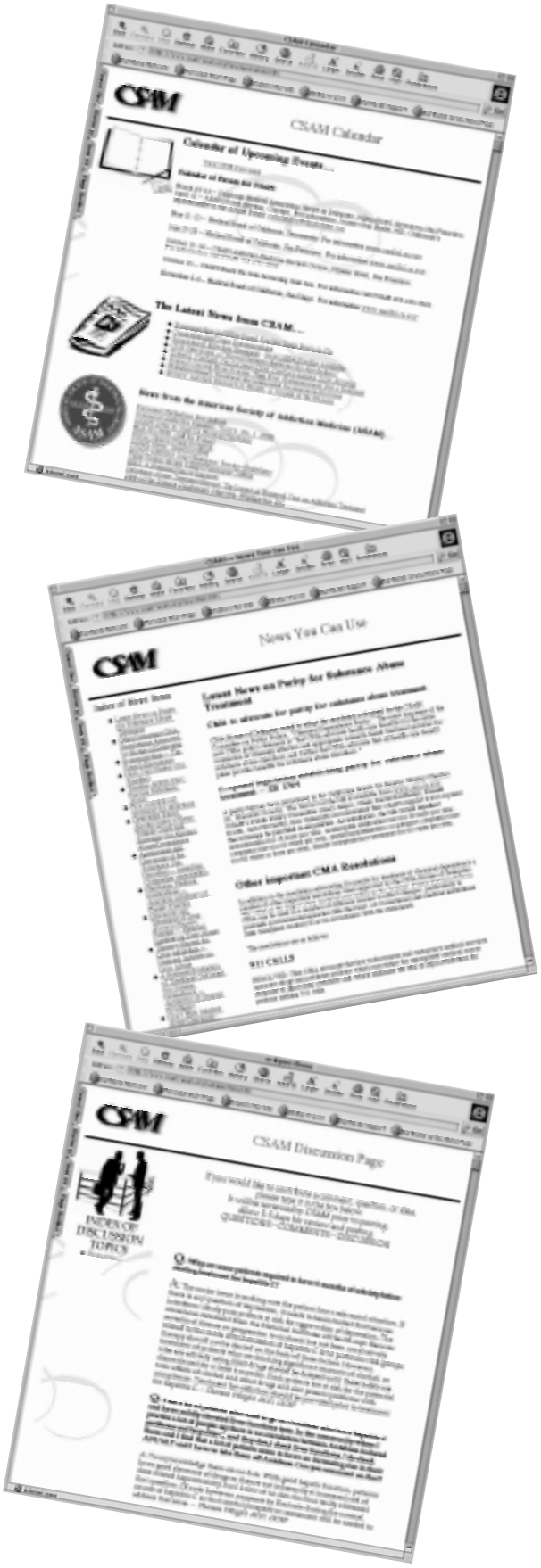
CSAM Newsletter
Issues of *CSAM News* from the last two years can be viewed here and downloaded. Also available on this page are a subject index (listing key articles by topic) and a chronological index listing the articles in each issue. You can order copies of past issues.

Site Index
This list lets you click on topic names or section names and get to different sections of the site quickly.

Future Plans
CSAM plans to add several additional sections to the site, including a "press room" where journalists and others can browse CSAM statements and add their names to CSAM's press contact list.

A Discussion Page is in the works
CSAM plans to make a section of the web site into a site for questions and answers, comments, recommendations and dialogue. Do you have a question you would like answered, an idea you'd like others to know about, an announcement, or something else? Submit it on the form at the bottom of this page on the web site, and your message will be automatically forwarded for posting on the Discussion Page. *(Try it.)*

Who is responsible for all of this?
CSAM's Executive Director, Kerry Parker, designed the site and oversees it along with CSAM's Publications Committee; updating is by Michael Barack, CSAM's Administrative Manager. News and comments coming from the CSAM members will make the site more lively and interesting. Send your comments to csam@compuserve.com.



Watch for this symbol:

www.csam-asam.org

It means there is more information available on CSAM's website.

My Wish List For Addiction Treatment in California

By John J. McCarthy, M.D.

The most important issue for this next year is passage of the Drug Abuse and Crime Prevention Initiative on Caifornia's November ballot. (For the full text of the initiative, **www.drugreform.org**) This initiative will direct all people arrested for nonviolent, petty drug charges (excluding drug sales) into the drug treatment system. It will create a special form of probation where the requirement will be to engage in treatment. It will move far more people into treatment than the handful of people who currently manage to qualify for drug courts. If passed, it will be a signal of the end of the cycle of wasteful and cruel incarcerations that have characterized public policy toward addicts for the past 86 years.

The money for the expansion of treatment will come from the $200 million the Legislative Analysts predict will be saved in criminal justice costs.

After the public passes this initiative by an overwhelming majority, we will need an expanded treatment system for the thousands who will finally have access to treatment. Then we will need doctors, especially in the area of narcotic addiction treatment. The money for the expansion will come from the $200 million/year that the State's Legislative Analysts expects will be saved in criminal justice costs. We have tens of thousands of untreated opiate addicts in California alone. We need physicians to manage their addiction and these physicians have to be able to use methadone, the standard of care for the chronic addict.

So my next wish is passage of AB 1807. Senator John Vasconcellos has introduced a bill to allow physicians in private practice who wish to do so to manage up to 20 patients on methadone or LAAM. This bill would allow the existing methadone treatment system to contract with rural physicians to manage opiate addicts in their private practices. Potentially, any physician could treat one of their patients with methadone or LAAM, in addition to whatever other condition they are managing. The existing treatment system will provide the mechanism to get treatment to rural areas. CSAM should have the role of providing resources and training to interested physicians.

However, even if I got my first two wishes, we still would not have enough treatment. The existing methadone treatment system is bound and gagged with laws and regulations. It can never answer the true need. Therefore, we need buprenorphine approved for the management of opiate addiction in the private practice setting, administered by physicians trained in addiction medicine. This opiate treatment mechanism will exist independent of the methadone clinic system. Buprenorphine may not be as effective as methadone for chronic addicts, but may have a role in special populations, such as younger individuals with shorter histories. We are waiting for Federal approval of buprenorphine, and we are told that it is just a matter of time.

If I get all my wishes, doctors around the state will start treating opiate addicts with drugs that actually work.

If I get all my wishes, the real change will occur. Doctors around the entire State of California will start treating heroin addicts, opium addicts, and all the other varieties of opiate addicts. They will feel more helpful, since they will be able to use medicines that actually work. Then they will recognize their addict patients as human beings like the rest of us, with a manageable illness. They will come to know them, and to understand them, and to appreciate them. And they will see beyond the myths of criminality and the distortions of our propaganda and find that they really are very interesting people.

Now my next wish is ...

Doctor McCarthy is Executive and Medical Director of the Bi-Valley Medical Clinic in Sacramento. He is a member of CSAM's Committee on the Treatment of Opiate Dependence and Committee on Public Policy.

EDITORS
Donald R. Wesson, MD
Gail Jara
Kerry Parker, CAE

PRODUCTION
Michael Barack

CSAM NEWS is published three times a year by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at 74 New Montgomery Street , Suite 230, San Francisco, CA 94105; Phone: 415/243-3322; Fax: 415/243-3321; E-mail: csam@compuserve.com

The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

Buprenorphine Status Report

The Center for Substance Abuse Treatment (CSAT) announced its intent to issue regulations governing the use of approved partial agonists in the office-based treatment of opiate addiction. The notice appeared in the Federal Register of May 4, 2000.

The notice explains that partial or mixed agonist medications [such as buprenorphine] are different from full agonists such as methadone and LAAM and therefore warrant a treatment model different from the system of licensed narcotic treatment programs. "Indeed, partial agonist medications' pharmacological properties and safety profiles warrant a new paradigm in narcotic addiction treatment, office-based treatment."

CSAT, for the Department of Health and Human Services, will issue proposed regulations for determining the training and experience necessary to safely and effectively treat opiate addicts with partial agonists. They may include:

- limits on the number of patients that may be treated by any one office-based physician
- standards re: the medical and psychosocial services, including counseling, that should be available to patients that are determined to need them
- standards re: the quantities of medications that may be prescribed for unsupervised use

The Drug Enforcement Administration (DEA) is preparing separate proposed regulations to allow the office-based physician to *prescribe* the medication, rather than be required to dispense directly to the patient.

The Food and Drug Administration (FDA) is reviewing two New Drug Applications—one for buprenorhine alone to add treatment of opioid addiction to the list of approved indications, and another for buprenorphine combined with naloxone, also for the indication of treatment of opioid addiction.

FDA approval of the new indication for buprenorphine and approval of the new buprenorphine/naloxone combination, with the action of DEA to remove the restrictions against office-based practice, together with authorizing legislation and/or regulation, will make the new treatment approach a reality. Although there is no announced schedule for when these factors might be in place, the May 4 notice says the proposed regulations will be published "in the near future."

The full text of the two-page notice is available from the Government Priting Office website **http://frwebgate.access.gop.gov**. The full text of the CSAT National Advisory Council Subcommittee report on buprenorphine is available at the SAMHSA website **www.samhsa.gov**.

Brief Reviews

CNS Spectrums

The February issue of *CNS Spectrums* (vol. 5, no. 2) is devoted to "Novel Pharmacotherapies for Alcoholism." Noted clinical researchers in the field cover management of alcohol withdrawal, the role of SSRI's in the treatment of alcohol dependence, opioid antagonists in alcohol treatment, a review of double-blind, placebo-controlled trials of Acamprosate (a glutamate and GABA-active medication available in Europe) for the prevention of alcohol relapse, and the use of combined medication strategies in alcoholism. This journal putatively has a subscription rate of $90/year but is mailed free to many physicians. The journal's e-mail address is **cns@mblcommunications.com**.

Reviewed by Peter Banys, MD

Alcohol: Research & Health (a journal of the NIAAA)

Alcohol: Research & Health may well be the single best investment you'll ever make for your continuing medical education dollar. This journal is inexpensive, but of unusually high relevance for practitioners. It is organized by theme issues. Articles are generally written by top experts in the field or by professional science writers which means well written articles that will keep you up to date in this rapidly evolving field. A recent issue (vol. 23, no. 2, 1999) has 12 articles on evidence-based treatment strategies for the treatment of alcoholism. Approaches reviewed included states of change theory, cognitive-behavioral treatment, medications, and relapse prevention. Authors include Richard K. Fuller, Carlo C. DiClemente, William R. Miller, Steven T. Higgins, G Alan Marlatt. Subscriptions at $22 per year and single copies at $9.75 are available from PO Box 371954, Pittsburgh, PA 15250 or you can fax a credit card order to 202/512-2250 code #5746.

Reviewed by Peter Banys, MD

Methadone Levels in Human Milk

Pregnant women on methadone maintenance treatment frequently want to nurse but are often discouraged from doing so because of concerns about the amount of methadone that may be in the breast milk. A study conducted on 14 samples of breast milk from eight women on methadone doses ranging from 25 to 180/mg per day showed that the mean daily methadone ingestion of the baby was 0.05 mg per day. The range of the mother's methadone dose in this study was higher than in the previous studies: 25-180 mg/day compared to ranges in previous reports of 10-80 mg/day. Yet the level of methadone in the milk was low and was consistent with the level reported in the previous studies. No adverse events were associated with breastfeeding or weaning in any of the studies. The findings in this study were consistent with the findings of previously-reported studies, conducted between 1974 and 1997. The conclusions of all the studies supported the compatibility of breastfeeding and methadone maintenance therapy. *Journal of Human Lactation 2000 Vol 16, No. 2, pages 115-120.*

Reviewed by John McCarthy, MD

PRESIDENT'S COLUMN

Paradigm Shifts in Substance Abuse Treatment

BY PETER BANYS, MD

PETER BANYS, MD

Thomas Kuhn [1], a historian of science, writes in the *Structure of Scientific Revolutions* that the march of science proceeds very slowly; and, that as evidence gathers little by little, previously held conceptions suddenly give way to new paradigms of thought. One illustrative example is, of course, the shift from Newtonian physics to quantum mechanics. In this millennial year, I offer these reflections on some important paradigm shifts from the century just ended.

Moral to Medical Model

Alcoholism is the oldest and most prototypical addiction known to man. We are able to read about alcohol and its regulation from the earliest writings, such as the Code of Hammurabi. When over 90% of drinkers do so in control, this makes it look easy. Surely, people tend to think, alcoholic drinkers are making choices. For centuries, will and sin have been inextricably entwined in Judeo-Christian thinking, making failure of (good) will a kind of sin (or a human weakness).

Research distinguishes between brief slips and extended relapses — a violation of former dogma — and clinicians find this helpful in working with patients

One of the greatest contributions of the shift to the medical model [2] of addiction in the early 20th century is its quality of forgiveness. Doctors do not blame patients for having illnesses. They do, however, expect significant cooperation with treatment. This makes the medical model especially useful in the *early* stages of treatment for an illness that patients themselves attribute to "weakness" and "badness." It is arguably somewhat less useful for patients in more advanced phases of recovery. Alcoholics Anonymous continues to represent a nonmedical program focused on issues of integrity, self-knowledge, and altruism

Behavioral to Brain Disease

One may have a bona fide disease without necessarily understanding root causes. At such stages in medical history empirical interventions have predominated. In ancient times, the amethyst was thought to have protective powers over wine and drunkenness. Today, modern molecular chemistry has opened the door to true amethystic, or "normalizing," medications. It is beginning to look as if pretreatment of an alcoholic with an opioid blocker such as naltrexone makes alcohol relatively more ordinary and less rewarding as a beverage for his vulnerable brain. The genetic basis for alcoholism is now well-established and probably accounts for around half of the vulnerability to this disease.

In regard to other addictions, we now know that the brain produces endorphins for opioid receptors, cannabinoids for anandaminde receptors, and a host of other regulatory peptides. Dopamine reward pathways are increasingly well-understood (without, however, dopaminergic medications proving to be very efficacious in treating stimulant addiction). In the next few years we will probably be able to do sophisticated blood test-based genetic counseling, we are likely to have increasingly more precise medications for craving, and for neuro-protection in detoxification. The holy grail at this point is to discover underlying biochemical mechanisms of some of our most perplexing maladaptive behaviors.

Detox to Recovery

Physicians once assumed that withdrawal symptoms were a major reason that addicts continued to use. Yet, there is no evidence that a comfortable detox either improves or lessens chances for sustained sobriety. Conversely, nor is there evidence that a painful or uncomfortable detox is "motivating" to give up addiction. It appears, then, that short-term withdrawal syndromes are mediated by one set of chemical and physiological events and long-term reward and relapse pathways through different ones. Detox remains important to do for humanitarian reasons and perhaps to reduce "kindling" effects such as seizure disorders and hallucinations later in the natural history of drinking, but it may have little to do with recovery apart from the initiation of it.

Today, we know that detox (getting sober) is relatively easy and recovery (staying that way) is hard. This recognition means that physicians do not merely intervene surgically at the beginning of treatment; they support the patient over the long haul.

Relapse to Slip

As recently as a decade ago, American substance abuse treatment and research thought in binary terms. Patients were either sober or relapsed. The dogmatic idea of "one drink, one drunk" prevailed. Modern alcohol research, however, increasingly distinguishes between brief slips and extended relapses. In part to tease apart the discouraging data about high relapse rates for most drug treatments, researchers began to measure many kinds of outcomes besides abstinence. This eventually led to the development of the Addiction Severity Index (ASI) which measures seven separate domains of psychosocial function.

Clinicians increasingly find this violation of prior dogma helpful; they are better able to find patient-learning in some slips. Modern research, such as Project Match, goes even further by measuring drinking days, days to relapse, and a variety of related factors [3]. Although still not much interested in controlled drinking trials, American physicians have joined the British and Europeans in making finer distinctions about alcohol and drug use and the varieties of possible outcomes. Alcohol and drug use are now conceptualized as occurring on a gradient. This increase in flexible thinking has assisted American practitioners in embracing the initially European concept of "harm-reduction," a conceptual model that derives more from public health thinking than from moralizing.

Just because physicians have made a paradigm shift from a moral model does not mean that the public, legislators, or funding agencies have.

Cure to Chronicity

"Taking the cure" is a very old idea, applied in earlier times to treatments in TB sanitariums, or to taking the waters in spas for arthritic or other mysterious ailments, and applied in more modern times to the asylums for inebriety, and 28-day substance abuse treatment programs. (Why this latter cure was on a lunar/menstrual cycle has never been satisfactorily explained to me.) In any case, this most recent heroic approach — thinking that a definitive initial period of treatment would produce better outcomes — died down from the combined efforts of Miller and Hester's masterful review of outcome evidence [4] and insurance companies' less than masterful refusal to pay. More to the point, the evidence would not support it.

Despite the indisputable facts that addictions are chronic relapsing disorders and that cures remain illusory, it is essential to remember that, with the exception of some surgeries and many antibiotic treatments, most of medicine remains the delivery of chronic care for refractory disorders. O'Brien and McLellan [5] recently compared substance abuse outcomes to those of other medical disorders such as arthritis, hypertension, asthma, and diabetes. They remind us that noncompliance, behavioral dyscontrol, and dietary misadventures are common to all. They marshal the evidence that outcomes for addiction treatments are on a par with the outcomes for other common chronic medical disorders. From some perspectives, they are even better.

Punishment to Parity

The present-day struggle for parity in a managed-care environment ties many of the above paradigms together. If addictions are indeed illnesses, if they are brain and neurochemical diseases, if reward pathways remain active long after detoxification, if addicts are determined to "do research" by relapsing, and if these disorders are truly forms of chronic disease, then why shouldn't insurance and managed care pay for demonstrably effective treatments?

Well, there are many answers. First, it does cost providers money in the narrow sense, even if there is a cost-offset in the larger social context. Second, just because physicians have made a paradigm shift from a moral model does not mean that the public, legislators, or funding agencies have. Those groups have shown themselves only a little more ready to pay for the treatment of other "behavioral" diseases such as depression, but they continue to demonstrate a certain rigidity and a desire to "hold the line" at paying for substance abuse treatment.

However, in my opinion there is another paradigm shift in progress. Medical care is increasingly conceptualized as a basic human right, and as this takes place, the struggle for substance abuse parity inevitably becomes a form of a civil rights struggle.

References

1. Kuhn, T.S., ***The Structure of Scientific Revolutions.*** 1962, Chicago: University of Chicago Press. xv, 172.

2. Siegler, M. and H. Osmond, ***Models of Madness, Models of Medicine.*** 1974, New York,: Macmillan. xxi, 287.

3. ***Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Posttreatment Drinking Outcomes*** [see comments]**.** J Stud Alcohol, 1997. 58(1): p. 7-29.

4. Miller, W.R. and R.K. Hester, ***Inpatient Alcoholism Treatment. Who Benefits?*** Am Psychol, 1986. 41(7): p. 794-805.

5. O'Brien, C.P. and A.T. McLellan, ***Myths About the Treatment of Addiction.*** Lancet, 1996. 347(8996): p. 237-40.

ANNOUNCING ...

Addiction Medicine Review Course 2000

OCTOBER 11-14, RADISSON MIYAKO HOTEL SAN FRANCISCO

Wednesday, OCTOBER 11

Master Classes *(with limited enrollment)*

- **The Evidence for 12-Step Programs** / John Chappel, MD
- **Changing Addictive Behavior** / Alan Marlatt, PhD
- **Impaired Physicians and the Evolving Role of the Diversion Program** / Norman Reynolds, MD; Janis Thibault, MFT; Kimberly Davenport-Ware, JD
- **Office-Based Treatment for Opioid Dependence Using Methadone and LAAM** / John McCarthy, MD
- **Managing Chronic Pain in Addicted Patients** / Howard Heit, MD
- **Anger Management in Addicted Patients** / Patrick Reilly, PhD; Monika Koch, MD
- **Role of the Medical Review Officer** / William Glatt, MD; David Smith, MD
- **Neurobiology of Addiction** / George Koob, PhD

Alan Leshner, PhD
"What is Addiction?"

Thursday, OCTOBER 12

Keynote Address: What is Addiction? / Alan Leshner, PhD
Addiction in Flies, Mice and Men / Ivan Diamond, MD, PhD
Behavioral Components of Addiction / Alan Marlatt, PhD
Evidence for 12-Step Programs / John Chappel, MD
Psychostimulants, Cocaine, Methamphetamine / Michael Scott, MD
Opioid Pharmacology / Donald Wesson, MD
Management of Opioid Dependence / Ernest Vasti, MD
Benzodiazepines / Dan Lewis, MD
Workshop on Preparing for and Taking the ASAM Certification Examination / Lori Karan, MD

Alan Marlatt, PhD
"Behavioral Components of Addiction"

Friday, OCTOBER 13

Treating Alcohol Dependence / Steven Ey, MD
Genetics of Alcoholism / Kirk Wilhelmsen, MD, PhD
Epidemiology for the Addiction Medicine Practitioner: Real Numbers for Clinically Important Co-morbidities, Gender Specifics and Current Trends / Constance Weisner, DrPH, LCSW
Medical Consequences of Chronic Alcoholism / William Brostoff, MD
Psychiatric Co-Morbidities / David Pating, MD
Alcohol and Drug Dependence During Pregnancy / Marty Jessup, RN, MS
Infectious Diseases, including HIV / Peter Jensen, MD
Hepatitis C / Steven Rossi, PharmD
Treatment of Adolescents / Ihor Galarnyk, MD

Saturday, OCTOBER 14

Nicotine / Richard Hurt, MD
Marijuana / Timmen Cermak, MD
Hallucinogens, Ecstacy, Inhalants / David Smith, MD
Role of the Medical Review Officer / David Smith, MD
Development and Use of ASAM's Patient Placement Criteria and Dealing with Managed Care / David Mee-Lee, MD
NIDA's Principles of Treatment / Peter Banys, MD; Barry Rosen, MD

This is an activity sponsored by the California Society of Addiction Medicine (CSAM), a CMA-accredited provider. Physicians attending this course may report up to 21 hours of Category 1 credit toward the California Medical Association Certificate in Continuing Medical Education and the AMA Physician Recognition Award. Up to 6 additional hours of Category 1 credit is available for those attending the master classes on Wednesday, October 11.

THE CONFERENCE BROCHURE with complete curriculum and registration form will be mailed to all CSAM members and CSAM News subscribers in June.

Complete conference information is also available on-line at the CSAM web site: www.csam-asam.org or call 415.243.3322 to request a conference brochure.

"We have assembled an excellent group of speakers that will provide a comprehensive overview of Addiction Medicine, while bringing in some new presenters that will give this review course a 'State-of-the-Art' feel. The course is current and relevant. It brings together the best minds in addiction medicine with physicians who care about providing the highest level of care for their patients."

Steven R. Ey, MD, Chair, CSAM Review Course 2000

Special Events During CSAM's *Addiction Medicine Review Course 2000*

TOOLS FOR THE PRACTICING PHYSICIAN
CSAM 2000
WWW.CSAM-ASAM.ORG

THURSDAY, OCTOBER 12 7:30 PM
H. Westley Clark, MD, JD, MPH
Director, Center for Substance Abuse Treatment (CSAT) will give the
First Annual Jess W. Bromley Memorial Lecture
Moderated by David E. Smith, MD

FRIDAY, OCTOBER 13 6:30 PM
CSAM Black Tie Gala
honoring
Gail B. Jara
Founding Executive Director of CSAM

CSAM and the California Diversion Program for Physicians

By William S. Brostoff, MD, Chair, CSAM Committee on Physician Impairment

William S. Brostoff, MD

An important new direction for CSAM and its newly-reactivated Committee on Physician Impairment is the decision to send a representative to each meeting of the Division of Medical Quality (DMQ) of the Medical Board California (MBC) to speak for CSAM on matters related to the Diversion Program. The DMQ meetings are rotated throughout the state and held five times yearly. Dr. Norman Reynolds, a member of the Committee, attended the most recent DMQ meeting in February on behalf of CSAM and reported that the presence of a CSAM representative was very favorably noted by DMQ members.

The Medical Board of California's Diversion Program for physicians is administered by the Enforcement Branch of the MBC staff and policy is set by the Medical Board's Division of Medical Quality.

The Diversion Program is in full compliance with proposed national guidelines and on some points exceeds them.

A special Medical Board Task Force, appointed in 1997 and chaired by DMQ Public Member Karen McElliott, is conducting an evaluation of the Diversion Program. The Diversion Program has been under criticism for being too expensive ($800,000 per year in 1999), for being too easy on physicians, and for not reaching more physicians with alcohol and drug problems. Criticisms have come from the Center for Public Interest Law (CPIL), a watch dog group based in San Diego. CPIL representatives attend all meetings of the MBC and monitor all the Board's activities, not only those related to the Diversion Program. CPIL has long been a strong and vocal critic of the Diversion Program and even of the principle of the Medical Board sponsoring rehabilitation for physician licensees.

Janice Thibault, Diversion Program Manger, made a presentation to the Diversion Task Force, at its fourth meeting in February, 2000, in which she compared the functioning of the California Diversion Program to guidelines soon to be published by the Citizens Advocacy Center, a network for public members of health care regulatory and governing boards. The comparison showed that the California program was in full accordance with the proposed guidelines, and on some points exceeded them. For the full text of report comparing California's program to the national guidelines, see the CSAM web site, **www.csam-asam.org** or contact the CSAM office.

www.csam-asam.org

At the close of the meeting, the Task Force indicated its support for Diversion, and made several recommendations, including increased accountability to the Medical Board, better data collection for continuous quality improvement and continued assurance that impaired physicians are adequately monitored and not allowed to practice when impairment endangers patients.

The MBC Task Force on Diversion made several recommendations.

Doctor Reynolds' report of the Task Force meeting includes this summary of recommendations made by the Task Force:

- There is a need for greater accountability to the MBC demonstrating that the program does what it says it does.
- Without compromising the confidentiality of physician participants, better data is needed for continuous quality improvement. Given its mission to protect the public, the MBC wants assurance that impaired physicians are adequately monitored by Diversion and not allowed to continue to practice when they are in states of impairment that could endanger patients.
- Instead of relying on the Program's current policy manual, regulations need to be enacted to implement and carry out the intent of the law which created the Diversion Program.
- Consideration should be given to making the Liaison Committee to Diversion a standing committee within the MBC's DMQ. The membership should continue to include representatives of CSAM, CMA, Diversion, and Diversion Evaluation Committee Chairs.
- An opinion should be obtained from the Attorney General's office as to whether the DECs have the authority to remove physician participants from practice.

His report included several of his own observations:

- The Board acknowledged that the Diversion Program is probably under-funded and that case manager loads (currently at 1:50) are too high.
- Although there is no budget for such a position, ideally, there would be medical input into the operations of the Diversion Program. (The position of Chief Medical Consultant to the MBC was eliminated over four years ago. A physician is currently volunteering to serve as an MRO to assist the DECs if asked.)

• There should be greater outreach efforts to increase the visibility of the Diversion Program and promote better understanding of the important role it plays within organized medicine, physician well-being committees, and the medical community at large. Currently, MBC has no budget for outreach for the Diversion Program.

The Diversion Program is under very close scrutiny, and sometimes under attack. The "law and order" mentality of the last several years in California government continues to influence the way in which the Program is viewed.

Physicians who suffer from chemical dependence receive little sympathy, or even clinical understanding, in some quarters because the focus on their potential to jeopardize patient safety if they are under the influence of drugs or alcohol can override considerations of how to give them the best chance for treatment and full rehabilitation.

What is a concerned physician to do?

What is a concerned physician to do? First, stay informed. The battle to achieve legitimacy for the treatment and full rehabilitation of physicians impaired by chemical dependency is far from over, and there are strong opposing forces, political, societal and cultural. Pay close attention to the issues involved. Consider attending meetings of the Medical Board (or its Division of Medical Quality) when they occur in your area.

www.csam-asam.org

The dates and places of MBC meetings are posted on the CSAM web site or available from the CSAM office. Second, continue to contribute to this cause by your interest, by your feedback and by your support of your hospital physician well-being committees. Let those who are working directly with impaired and recovering physicians know of your interest and support. Third, consider a letter to your legislative representatives in Sacramento, letting them know your opinions, suggestions and concerns about this important issue that directly or indirectly affects all citizens.

MBC Suffers from a Manpower Shortage

CSAM Endorses Norman Reynolds for Medical Board

Governor Gray Davis is overdue to appoint members to fill the vacant seats on the MBC. The roster of the MBC has been reduced as members complete their terms and become ineligible for reappointment. On the 19-member Board, there are currently 6 vacancies, 4 for physicians and 2 for public members. In June, 5 more seats will open.

CSAM member Norman Reynolds, MD, of Santa Clara has applied for one of the open seat on the Medical Board. CSAM has written to Governor Davis formally endorsing Doctor Reynolds. The California Psychiatric Association has also endorsed Doctor Reynolds.

Report from May 11 Meeting

MBC Task Force on Diversion

CSAM President, Peter Banys, MD, attended the meeting of the Task Force on Diversion on May 11, 2000 to speak for CSAM and for the Liaison Committee to Diversion. This is his report.

The Medical Board of California's Task Force on the Diversion Program met on May 11, for the fifth time in the two years since it was created. The Task Force is chaired by Public Member Karen McElliott; members attending at this meeting were James Bolton, Ph.D., and Alan Shumacher, M.D. Most of the time was spent grilling Janis Thibault, Diversion Program Manager.

In the audience were several attorneys representing the Center for Public Interest Law (CPIL) from San Diego. The CPIL has been submitting briefs to the Medical Board for the past several years, lobbying for (a) stricter controls on Diversion Evaluation Committees (DEC's), saying they are unauthorized by state law and remain essentially unaccountable, (b) tougher sanctions on relapsing doctors, and (c) more public release of physician-specific information.

Again and again, the themes were "public safety," "accountability," and "unequivocal standards" for termination of a physician from Diversion related to severity/frequency of relapse and failure to comply with the requirements of the Diversion Program. The Task Force spent much of the afternoon agreeing in principle with several of the points made by CPIL, although I sensed a resistance to joining them in their proposed remedies.

She stood her ground on clinical issues, refusing to agree to overly simple rules.

Dr. Shumacher, in particular, repeatedly articulated his interest in a "Three-Strikes" approach to termination from Diversion and avoiding "empty threats" of termination that take 3-12 months to implement. Toward the end of the day's testimony, however, he acknowledged that clinical judgement is essential.

Janis Thibault, MFT

Program Manager

Janis Thibault was superbly well-prepared for this presentation and she brought good documentation. She was cooperative and yet stood her ground on clinical issues, refusing, for example, to agree to simple rules for termination. She stressed the toughness of the Program and the high degree of supervision. She clearly impressed the Task Force with her knowledge, reasonableness and responsiveness. Impressed me too.

Continued on page 12

SOP Manual
The Diversion staff is working, chapter by chapter, on a standard operating procedures manual. So far they have completed the sections on laboratory monitoring and on DEC's. Good stuff; clarifies just how much oversight there is.

Accountability
The Task Force members repeatedly iterated their intention to make the Program Manager both more clearly in charge of the DEC's and more clearly accountable to the DMQ itself. In other words, they no longer want Diversion to be something of a stealth operation, running quietly somewhere in the background. We can expect to see more demands for aggregated data about doctor relapses, intervals between failed toxicology screens and clinical responses (including interruption of practice). I found this approach to be entirely reasonable and in keeping with a clearly organized system of authority and accountability. This means that the Program Manager will have both more power (over the DEC) and more accountability (to Medical Board) to provide review data. Her problem will be to resist the political pressure to formulate simplistic "three-strikes" rules about termination from Diversion and continue to support the complex clinical deliberations of the DEC's (who will become more explicitly consultative to her office).

The Program Manager will have more control over the DECs which will become more explicitly consultative to her office.

Stop-Practice Algorithms
Task Force members were keenly interested in having a clear understanding of when and how physicians are ordered to stop practice. Public safety, they seemed to say, demands both clarity and prompt response. The problem of course is that this cannot be overly simply tied to dirty urines or missed meetings. Most likely this general issue will continue to be a topic of review for the DEC's and for the Liaison Committee.

Frequency of Urine Testing
Diversion presented the results of a study that showed a significant decline in positive urine test results when the frequency was increased from two per month to four per month. Because this may represent a positive benefit of the very act of monitoring, the Task Force recommended increasing the frequency of testing. They also recommended true randomization and a stop to the predictable practice of asking for urine samples after a Diversion group meeting. In my opinion, this is entirely reasonable — with the following caveat. They may wish to factor in the stages of recovery and do intensive testing (in some cases more than four per month) in the early phases of recovery. In advanced and stable phases of recovery, for example, for participants doing very well in their 3-5th years, lower frequency is fine.

CSAM is interested and is watching! We want to collaborate, offering special expertise in *evidence-based* medicine.

CSAM Role
I had an opportunity to thank the Diversion Task Force and to articulate the following:

- CSAM is interested and watching! We are interested in collaborating and we have special expertise in evidence-based medicine.
- CSAM agrees with some principles articulated by CPIL, but disagrees on many details. I wanted to show that there are over 300 physicians in California who have specialized expertise and who have thoughtful contributions to make. I believe that the DMQ needs to feel the presence of another group besides the lawyerly one.
- CSAM is supporting the reinvigorated Liaison Committee to Diversion. In addition, our level of interest in matters of public policy has increased in the last several years.
- CSAM strongly supports the ***clinical*** approach of the DEC's and supports clarifying both membership and performance criteria for DEC's through the work of the Liaison Committee. We strongly oppose letting simple algorithms such as "three strikes" take the place of the deliberations of groups of experts convened in the DEC's.
- CSAM has no problem with the increase in clarity about lines of authority and accountability.

Summary
A very fine meeting. I believe that everyone got something. DMQ is reassured by the quality of Program Manager and by her capacity to do real oversight. CPIL is clearly having an impact and clarifying lines of authority. CSAM is weighing in from an evidence-based posture. Overall, it was friendly and highly collaborative.

Diversion Liaison Committee Commends Gail Jara

At its January 14 meeting, the Liaison Committee to the Medical Board's Diversion Program presented a plaque to Gail Jara in recognition of the role she has played in the development of the initial design of the Diversion Program and in the establishment and on-going activities of the Liaison Committee. The acknowledgment was made on the occasion of her retirement from the position of Executive Director of the California Society of Addiction Medicine.

The plaque was designed and printed by Leland Whitson, MD, on his press, and signed by Doctor Whitson and all present at the meeting. It was presented to Gail Jara on behalf of the Liaison Committee by William Brostoff, MD and Gary Nye, MD.

Three organizations come together at the Liaison Committee — the California Medical Association (CMA), the California Society of Addiction Medicine (CSAM) and the Medical Board of California (MBC). Each organization can send two representatives. The CMA representative is Gary Nye, MD. The CSAM representatives currently are William Brostoff, MD and Peter Banys, MD. The MBC representative is Ira Lubell, MD. In addition the chair of each of the five Diversion Evaluation Committees is on the Liaison Committee. Staff for each of the three organizations attend all meetings.

Commendation

We, the members of the Diversion Liaison Committee,
representing the Medical Board of California,
California Medical Association, and the
California Society of Addiction Medicine
wish to express our deepest appreciation
and commendation to Gail B. Jara.

Your administrative skills, dedication and leadership
provided essential elements
in the inception, drafting and implementation of the
Diversion Program of the Medical Board of California.

Since the beginning of the Diversion program in 1980,
you continued to participate in guiding
and coordinating the program's evolution.
Your integrity and perseverance have benefitted not only the
hundreds of physicians who have completed the program
but the citizens of California
the program was designed to protect.

Presented on the 14th of January 2000 in San Francisco.

Front Row: Philip Spiegel, Gary Nye, Gail Jara, Glenhall Taylor III, William McCausland, William Brostoff

In Back: Robert Reisfield, Ron Joseph, Peter Banys, Ira Lubell, Maureen Whitmore

You Can Write For

Most physicians miss the opportunity to diagnose substance abuse disorders
The National Center on Addiction and Substance Abuse (CASA) has published data and analysis of a national survey of primary care physicians and patients. The report, titled "Missed Opportunity," highlights the failure of most physicians to address questions of substance use/abuse and failure to diagnose. The study was funded by the Josiah Macy, Jr. Foundation and conducted for CASA by the University of Illinois at Chicago.

Copies of the full 131-page report are available from CASA for $22. Send check payable to CASA to Publications Department, 152 W. 57th Street, New York, NY 10019-3310. For other information, call 212-841-5200. Full copies of the report can be downloaded from the CASA website **www.casacolumbia.org**.

National Drug Control Strategy
The Office of National Drug Control Policy (ONDCP) has defined goals and objectives for the government's efforts to reduce drug use, drug availability and the consequences of drug use. As example, one goal is to increase by 20% the proportion of parents and other adult mentors who attempt to influence youth to reject drugs. To move toward that goal, ONDCP calls for training for health care professionals, who are considered mentors, to include substance abuse prevention in their patient care activities. For a copy of the 219-page report, call the National Drug Clearinghouse, 1-800-666-3332, or see **www.whitehousedrugpolicy.gov**.

News About Members

David Cohn is now Medical Director of Merritt Peralta Institute. He retains his position as Consultant to the Dual Diagnosis and Chemical Dependency Program at Herrick Hospital and as Director of Addiction Treatment Services for Summitt Hospitals East Bay.

Garrett O'Connor is consulting the television show E.R. on issues related to addiction medicine.

Web Sites of Interest

http://arg.org (no www)

Alcohol Research Group in Berkeley, one of 14 national alcohol research centers funded by NIAAA, has been in operation since 1959. Researchers associated with ARG include Constance Weisner, PhD, and Cherryl Cherpitel, PhD. Their web site describes studies and publications.

CSAM Supports Two Court Cases

Ferguson v. City of Charleston
The US Supreme Court agreed to hear a case (Ferguson v. City of Charleston) brought on behalf of pregnant women in South Carolina who were tested for drug use when they came to the hospital to give birth and arrested after giving birth. The appeal was supported by many public health groups, including CSAM and ASAM, on the grounds that the practice will deter women who need prenatal care the most from seeking it. Both CSAM and ASAM signed amicus briefs prepared by legal counsel for The Lindesmith Center.

U.S. Supreme Court to consider the cause of pregnant women

BAART v. City of Antioch
The Federal District Court in San Francisco issued a preliminary injunction against an ordinance passed by the City of Antioch in Contra Costa County (Northern California) preventing a methadone clinic from opening in that city. (Bay Area Addiction Research and Treatment [BAART] v. City of Antioch). CSAM and other groups, including the California Medical Association, had signed an amicus brief prepared by The Lindesmith Center.

A city cannot prevent a methadone treatment program from opening.

CONTINUING MEDICAL EDUCATION

(continued from back cover)

4th Annual Conference
Hepatitis C Global Foundation
August 11-13, 2000
Holiday Inn Golden Gateway, San Francisco
Sponsored by Hepatitis C Global Foundation
Credit: Up to 21 hours of Category 1 Credit
Speakers include: Dr. Daniel Lavanchy (WHO); David Smith, MD; Neal Flynn, MD; Reda Sobky, MD; Teresa Wright, MD
For more information: 415/441-4000

CSAM Review Course in Addiction Medicine
October 11-14, 2000
Radisson-Miyako Hotel, San Francisco
Sponsored by California Society of Addiction Medicine
Credit: Up to 27 hours of Category 1 credit
For information: CSAM, 74 New Montgomery Street, Suite 230, San Francisco, CA 94105. Phone: 415/243-3322. Fax: 415/243-3321.

ASAM Review Course in Addiction Medicine
October 26-28, 2000
Westin O'Hare Hotel, Chicago, IL
Sponsored by American Society of Addiction Medicine
Credit: 21 hours of Category 1 credit
For information: ASAM 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920.

24th Annual National Conference
AMERSA
November 2-4, 2000
Holiday Inn, Old Towne, Alexandria, VA
Sponsored by: Association for Medical Education and Research in Substance Abuse
For more information: Doreen MacLane-Baeder 401/785-8263

Forensic Issues Workshop
November 30, 2000
Westin Fairfax Hotel, Washington, DC
Sponsored by American Society of Addiction Medicine
Credit: 21 hours of Category 1 credit
For information: ASAM 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920.

Pain Management and Chemical Dependency
December 7-9, 2000
The Renaissance Hotel, Washington DC
Sponsored by: Imedex USA, Inc
Credit: 18 hours of Category 1 credit
Organizing Committee: Russell Portenoy, MD; Joyce Lowinson, MD; Myra Glajchen, DSW; Herman Joseph, PhD
For more information call 770/751-7332

New Members

As ASAM notifies us of new members, we ask them for information about their current position. When we receive a response, we include it in the newsletter.

Nicanor K. Bernardino, Stockton

Dennis W. Bleakley, Claremont

Ghassen E. Hadi, LaVerne

David F. Hersh is Director of Substance Abuse and Addiction Medicine at San Francisco General Hospital.

Gary P. Jacobs, San Diego

Monika Koch is a postdoctorate fellow at the Substance Abuse Treatment Clinic in the Department of Psychiatry at the VA Medical Center, San Francisco

Mark Steven Kosins is medical director of Affiliated Psychiatric Medical Group, in San Clemente and Witts Inn in Dana Point

Thomas J. Pendergast, Sausalito

Laurie Anne Richer, San Francisco

C. Lee Sturgeon, Jr., Redwood City

Edward R. Verde is Clinical Director of the Addiction Treatment Program at Loma Linda Veterans Hospital and Assistant Professor of Psychiatry at Loma Linda University School of Medicine.

CONTINUING MEDICAL EDUCATION

Haight Ashbury Free Clinics Annual Conference
From Research to Practice
May 30-31, 2000
UCSF Laurel Heights Conference Center, San Francisco
Sponsored by Haight Ashbury Free Clinics, California Collaborative Center for Substance Abuse Policy Research and Institute on Health and Aging (UCSF)
Credit: 12 hours of Category 1 credit.
Speakers include: David Smith, MD; Ivan Diamond, PhD; Betty Tai, PhD, Walter Ling, MD; Donald Wesson, MD; Richard Rawson, PhD
For more information: Haight Ashbury Training and Education, 612 Clayton Street, San Francisco, CA 94117, 415/565-1904

Cannabis Therapy: Science Medicine and the Law
June 10, 2000
UCSF Laurel Heights Conference Center, San Francisco
Sponsored by Department of Medicine, UCSF School of Medicine
Speakers include: Donald Abrams, MD; Neal Benowitz, MD; Timmen Cermak, MD; Reese Jones, MD; Peter Banys, MD
Credit: Up to 7 hours of Category 1 CME
For more information call 415/476-5208

62nd Annual Scientific Meeting
College on Problems of Drug Dependence
June 17-22, 2000
Caribe Hilton Hotel, Puerto Rico
Sponsored by College on Problems of Drug Dependence
For information: Dr. Martin Adler, Executive Officer, CPDD, Fax: 215/707-1904

ASAM MRO Course
Medical Review Officer Training Course
July 28-30, 2000
Westin Michigan Avenue, Chicago, IL
December 1-3, 2000
West Fairfax Hotel, Washington, DC
Sponsored by American Society of Addiction Medicine
Credit: 19 hours of Category 1 credit
For information: ASAM 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920.

International Doctors in Alcoholics Annonymous
August 9-13, 2000
Hilton Pittsburgh and Towers, Pittsburgh
Sponsored by IDAA
For more information contact Glenn Ponas, Registrar, PO Box 7634, Pittsburgh, PA 15214. Phone 412/939-0646.
Web site: http://idaa2000.org

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