

CSAM's Forum for Dialogues in Addiction Medicine Essential Education & Training

BY ITAI DANOVITCH, MD, CSAM NEWSLETTER EDITOR



For decades educators and researchers have documented the disparity between the impact of addiction and the amount of time spent training physicians to deal with it. The failure of our medical system, and of the physicians at the helm of it, to screen and intervene on substance use disorders has been attributed to inadequate education curricula, negativism, and lack of faculty expertise and modeling. It has also been suggested that the over-exposure to “end-stage” addiction during training imparts in trainees a sense of futility, or demoralization, about the ability to successfully intervene. Advocates for addiction education have pointed

“We wanted to find out what addiction specialists themselves most value when it comes to training future specialists.”

to the importance of initiating addiction training earlier in medical training, increasing formal didactics, expanding access to faculty role models, and facilitating clinical exposure to patients and families in various phases of recovery.

In December of 2008, an expert panel was convened at the Betty Ford Institute to both develop recommendations on improving substance abuse training in primary care, as well as to develop a “model curriculum” for primary care residency training in substance abuse — links to articles reviewing their proposals can be found on-line at: <http://www.merfweb.org/resources.vp.html>.

In this issue of the newsletter, CSAM President-elect Jeff Wilkins, MD discusses a complementary proposal for integrating substance use interventions in pediatric and family practice training. Additionally, Monika Koch, MD, Chair of the CSAM Education Committee, provides an in-depth view of what CSAM is doing to facilitate education.

In addition to training medical students and residents, another question we must grapple with is how to best train ourselves. Perhaps because our numbers are small (at last count 2,032 physicians had ABPN Addiction Psychiatry Board Certification, and 2,695 had ABAM certification), there is far less literature illuminating this question. The Accreditation Council for Graduate Medical Education has set forth six competencies (see table below) to guide fellowship education. But for this

ACGME CORE COMPETENCIES

1. **PATIENT CARE** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
2. **MEDICAL KNOWLEDGE** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
3. **PRACTICE-BASED LEARNING** and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. **INTERPERSONAL AND COMMUNICATION SKILLS** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. **PROFESSIONALISM**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. **SYSTEMS-BASED PRACTICE**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care

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The Five Skills Every Addiction Specialist Should Have

By MARK HRYMOC, MD



The special medical and psychological pathology of addicted patients requires the physician treating them to possess a unique skill set. The fields of addiction psychiatry and addiction medicine each offer a route for a qualified physician to obtain a post-residency certification in the treatment of addiction. To acquire and maintain such a certification, a physician beginning a career as an addiction professional should certainly possess these five vital skills.

Addiction Psychopharmacology

Addiction is biochemically different from most other medical conditions in several respects, so knowledge of the unique aspects of addiction psychopharmacology is vital. An addictionologist should be comfortable in both the treatment of acute withdrawal as well as assistance in the maintenance

“Initial detoxification, whether inpatient or outpatient, is also the first opportunity to build the therapeutic rapport with a patient that is required to have a good long-term outcome.”

of long-term sobriety through the proper use of anti-craving medications. The first presentation of many chemically-dependent patients is in the context of withdrawal from their drug of choice. Withdrawal from drugs of abuse, especially alcohol, opioids, benzodiazepines, and other sedatives can be uncomfortable at best and life threatening at worst. Thus, the speedy and efficient management of withdrawal symptoms is paramount to the course of the patient's treatment. Initial detoxification, whether inpatient or outpatient, is also the first opportunity to build the therapeutic rapport with a patient that is required to have a good long-term outcome.

Medications employed in the treatment of addiction have a unique pharmacology. Multiple mechanisms of action, ranging from full antagonism to partial agonism to neuromodulation, require the addiction specialist to be adept in the use of various medications to help a patient avoid the risks of relapse. Knowledge of these medications should also include the practical aspects of their use: e.g., how to inject depot naltrexone or how to induce a patient onto buprenorphine.

Dual Diagnosis Treatment Knowledge

Due to the high comorbidity of psychiatric and substance use disorders, an addiction specialist must feel comfortable identifying and then treating or referring a patient with a psychiatric disorder to an appropriate specialist. Depression,

anxiety, insomnia and other psychiatric disorders frequently accompany and exacerbate a person's substance abuse. Therefore, treatment of these disorders is crucial for addressing the patient's substance use as well as preventing subsequent relapses. Basic knowledge of antidepressants, mood stabilizers and non-addictive hypnotic alternatives is important for any addictionologist. Because dual diagnosis treatment can include therapy, psychiatric medications, or both, an addiction physician should be able to coordinate care of a patient with a variety of mental health treatment modalities. These include individual or group therapy, psychopharmacology, or intensive outpatient treatment.

Knowledge of Local Resources for Addicted Patients

A physician specializing in addiction should have some familiarity with specific local referrals for a variety of levels of care. Addiction is a complex, multi-factorial disorder where treatment frequently involves the coordination of various practitioners at varying levels of care. A patient may benefit from drug and alcohol counseling, case management, psychotherapy, intensive outpatient group therapy, sober living, and/or residential treatment. The ability to make a fast and appropriate referral with confidence will stand to benefit the patient immensely. The patient will continue to benefit from close communication between his various practitioners if the need arises.

Motivational Interviewing

The delivery of effective addiction treatment requires familiarity with techniques of motivational enhancement therapy (MET), one of the fundamental and most effective therapies developed specifically for the treatment of substance-abusing patients. MET targets ambivalence that patients frequently have about implementing healthy but challenging lifestyle changes. Knowledge of the MET approach also

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Essential Education

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issue of *CSAM News*, we wanted to find out what addiction specialists themselves most value when it comes to training future specialists. We asked a series of leaders at various career stages, from chief residents to program directors, what five skills they thought it most important to impart.

As always, we would love to hear what you think. Please send comments, letters or submissions to us at csam@com-puter.com with the subject heading "Newsletter." ■

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The Five Skills Every Addiction Specialist Should Have

By STEVEN EICKELBERG, MD



Our therapeutic work with addicts becomes more and more effective when we as addiction medicine specialists expand beyond knowledge and develop skills in the following domains: 1) respect and empathy for persons with the disease of addiction, including their mechanisms of defense, 2) physician self-care, 3) working as part of a multidisciplinary team, and 4) serving as educator and role model.

Empathy is the capacity to understand another person's experience, to convey that understanding, and to use it to interact with a person respectfully. Empathy is critical to building a successful therapeutic alliance, instilling hope, and fostering the trust that is requisite for patients to begin the essential self-reflective work of dismantling their resistance and defenses. Moreover, physician empathy is the cornerstone of the trust and understanding that fortifies the patient.

Respect and Empathy for Patients with Addiction

Addictionists must remember that for the disease of addiction to be manifest in a patient, unconscious defense mechanisms must have become installed in that patient. The hallmark defense is, of course, denial – an unconscious mechanism that serves to protect addicts from conscious awareness and insight into their loss of control, perverted motivational priorities, shame, guilt, and (too numerous to list here) consequences of use.

Addictionists work with persons affected by the most misunderstood and stigmatized disease. They exhibit symptoms that are mischaracterized and misattributed. They feel immersed in toxic or malignant shame and live in a culture prejudiced against and absent understanding and acceptance of addiction as a disease. To make matters more challenging, these persons, for a variety of different reasons often get inadequate or inappropriate care.

Persons with addiction are often enmeshed in contemptuous relationships with employers, friends, and families. Understanding and respect for addicts includes understanding how denial affects an addict's family system and significant others.

When we fail to take all these factors into consideration and fail to respect and empathize with the person who is making use of the powerful psychological forces of resistance and denial, we render ourselves clinically impotent. We cause patients' resistance to stiffen, and that, in turn, provokes in ourselves feelings of shame, guilt, inadequacy, weakness, anger, and frustration.

Physician Self Care

Working effectively with addicts requires us to make our own physical, mental, emotional and spiritual health our top priority. I recommend that addiction medicine trainees develop a keen

awareness of their own psychological strengths and weaknesses, the limits of their power and influence, an awareness of how patients' expectations, misperceptions, denial and defenses affect them, and how their own developmental experiences affect their relationships with others. I recommend trainees utilize 12-step sources of recovery and support such as Al-Anon in addition to the professional support available to them (such as

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their clinical supervisors, mentors, and advisors.) These are places where it is safe to examine one's self and to process anger, transference, counter-transference, personal limitations, power struggles, powerlessness, loss, and other, sometimes nearly overpowering aspects of our own personal responses.

Be Part of a Multidisciplinary Team

Whether they are consultants or team leaders, and regardless of the setting or the severity of the patient's addiction, addictionists play a key role in the care of patients with substance use problems and must collaborate and communicate effectively with others in many disciplines, areas of expertise, and from different community resources.

To fulfill their role as leaders and/or members of a multidisciplinary team, addiction trainees are obligated to develop a wide spectrum of knowledge and skills. These include an abiding respect for the disease and the patient with the disease, the ability to form a therapeutic alliance, knowledge of addiction science and evidence-based clinical practice guidelines, understanding of an array of effective treatments and how to apply them to individuals, recognition of the natural course of relapse and the myriad paths of recovery, familiarity with community resources, expertise to assess and identify appropriate levels of care. There must also be an awareness of the effect of addiction on family systems and an understanding of the role of spirituality in recovery.

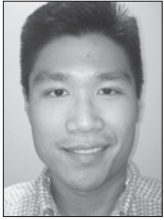
Our responsibilities as addictionists and members of a multidisciplinary team require an ability to forge positive working relationships with both patients and treatment team members.

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The Five Skills Every Addiction Specialist Should Have

By ERNEST RASYIDI, MD



The treatment of substance use disorders is an important part of resident training in many disciplines. I have found that there is a strong foundation for this training in the Bio-Psycho-Social model. However, one soon finds there are aspects insufficiently considered within this model which become important when working with addicted populations. These aspects require the addition of two more arms covering the legal and moral aspects of diagnosis and treatment. Proper training on these five salient dimensions is critical for clinicians to evaluate patients comprehensively and ultimately, to develop treatment plans that address the multifaceted needs of individuals with substance use disorders.

The Bio-Psycho-Social model is the standard for diagnostic training in Psychiatry. It emphasizes consideration of a broad array of biological factors. These would include family history, altered physiologic states due to pathology, and current theoretical models on the role of neurotransmitters both at baseline and after exposure, either prescribed

“Moral beliefs are like the elephant in the room that is obviously there, yet no one seems to talk about”

or illicit. Psychologically we are taught to consider history of traumas and losses. Socially, we are on the lookout for problems in employment, living situation, and support systems.

These are all critical considerations and should continue to be a core of resident education. However, an important area that is often overlooked is the legal ramification of substance use. Individuals who engage in substance use often pass between the two worlds of medicine and the criminal-justice system. Residents can gauge severity of medical consequences of drug use by appreciating the differences between gastritis and a Mallory-Weiss tear; however, we are insufficiently trained to appreciate the differences between parole and probation, or a misdemeanor and a felony. This inability to distinguish can severely impair assessment quality. Similarly, on the treatment end, we do not receive sufficient education on how to balance reporting requirements and disclosure versus confidentiality, an increasingly important issue in the treatment of professionals with substance use. What am I required to do if I am treating an elementary school teacher for depression and she tests positive for cocaine? What if it were an airline pilot? A law enforcement officer? A surgeon?

Finally, there are moral implications to treating addictions based on the values of the societies we live in as well

as the individual beliefs of treatment providers. Moral beliefs are like the elephant in the room that is obviously there, yet no one seems to talk about. As part of residency education, clinicians need to explicitly consider what the prevailing views of substance use are within society and oneself. Is it a character weakness? Is it an acceptable means of expanding one's consciousness? Is it a disease, and if so, should consequences that arise from substance use somehow be mitigated? Philosophers and theologians have debated these questions for quite some time and as medical professionals, we have a lot of catching up to do if we are to live in an age where custody of these problems is placed in our hands.

More important than learning rote facts which soon become outdated and replaced by new developments, having a reliable process will allow clinicians to approach ever-evolving problems, be it alcoholism today, designer drugs tomorrow, or the unforeseen substance use disorders which lie beyond. Being trained to systematically consider these five areas will be crucial for tomorrow's clinicians in order to properly diagnose and treat addicted populations. ■

Dr. Rasyidi is Chief Resident of Psychiatry at Cedars-Sinai Medical Center, Los Angeles, CA.

Welcome New CSAM Members!

Rod Amiri, MD - West Hollywood
 Sanjoy Banerjee, MD - Corona
 Hooman Behravan, DO - San Leandro
 Jody Brkich, MD - San Pedro
 Richard Brumley, MD - Downey
 Rodney Collins, MD - Los Angeles
 Ray Ehsan, MD - Los Angeles
 Mohamed El-Gabalawy, MD - Pasadena
 Hope Ewing, MD, MS Ed. - Jamestown
 Dana Harris, MD - Los Angeles
 David Hersh, MD - San Francisco
 Valeh Karimkhani, DO - Irvine
 Mohammed Mollah, MD - Los Altos
 Sheila Naghshineh, MD - Los Angeles
 Darren Neal, DO - Torrance
 Maher Saleeb, MD - Alta Loma
 Brett Shurman, MD - Los Angeles
 Valerie Totson, MD - Los Angeles
 Sally Vrana, MD - San Francisco
 Norman Wall, DO - St. Helena

The Changing Face of Continuing Medical Education (CME)

By MONIKA KOCH, MD



If you go to an AA meeting, you may come across the aphorism “Sit down, shut up and listen.” This may be a good approach for AA meetings; however it may also remind some of us of some less beneficial educational experiences in medical school and would definitely not be acceptable for CME of the future. Behind the scenes of the CSAM Education Committee is the changing world of Continuing Medical Education (CME).

The first documented CME program, sponsored by medical schools, was the “Blackburn Plan” in the 1930’s. Weekly one-hour sessions taught basic science and treatment techniques to general practitioners with the opportunity for questions and answers. In the 1960’s CME programs sought funding by shifting to commercial sponsors and in the 1980’s there were more than 9,000 offerings from more than 1,000 sponsors. More recent numbers are hard to find but likely increased exponentially and include many more venues. In 2007 the United States Congress took notice and publicly criticized the Accreditation Council for Continuing Medical Education (ACCME) for not doing enough to prevent industry influence over commercially supported CME. In 2009, the Institute of Medicine published a consensus report “Redesigning Continuing Education in the Health Professions.” ACCME responded and now certifying CME events has become a much more comprehensive process. CSAM has received a renewed certification for four years from the Accreditation Council for Continuing Medical Education in 2010 and is well prepared to comply with the new rules.

I started in the CSAM Education Committee twelve years ago as an addiction medicine fellow and have been honored to be committee chair for the last five years. Given CSAM’s mission, the Education Committee has always been one of the core committees of CSAM and over the years has developed various traditions in conference planning. Conference planning begins with a group of smart, well-educated physicians, idealistic enough to spend their weekend in a committee to further the cause of teaching addiction medicine. CSAM organizes an annual conference, alternating Review and State of the Art courses, and also half or whole-day conferences as well as dinner meetings. The initial planners’ meeting consists of sharing news in the field as well as experiences with speakers, defining the educational needs from feedback of prior conferences and the curriculum for the ASAM exam, all this is then gradually shaped into a conference schedule.

CSAM has initiated many planners into its “way” of conference planning. It includes making sure we focus on evidence-based talks, find engaging and expert speakers, and bridging cutting-edge science with the clinical needs

of patients in the community. Speakers for CSAM receive a lot of feedback to ensure that the talk matches the educational goals. This actually requires some diplomatic skills and the experienced planners coach the new members of the Planning Committee. Speakers are usually open and accepting of suggestions. We run our conferences on time and some CSAM veterans have perfected the skill of looming over a speaker who tries to use more time than allotted. Last but

“While obtaining new knowledge is necessary, it is not sufficient to improve patient care.”

not least, John Chappel, MD championed the popular small table case discussions during the Review Course (showing us that once again he was ahead of his time) that assured options for social interactions during breaks around the coffee stand and in the evenings.

None of the above will change, so what is new? There are three main areas: commercial support, cultural and linguistic requirements, and teaching tools and effectiveness measures.

As mentioned above, industry influence on CME had become problematic and over the last years, ACCME has acknowledged that their approach was not adequate. There was a lot of conflict of interest, when some speakers and talks were coached by pharmaceutical companies, who then also paid for many conferences altogether so physicians could attend for free. New rules have been established that require clear disclosure of any potential conflicts of interest and documentation of how they were resolved prior to the conference. Brand names are banned from slides and the planners are required to assure that talks are evidence-based and balanced, rather than promoting just one approach or medication. Financial sponsors are not allowed to influence content or insist on certain speakers.

For a non-profit organization such as CSAM it is not easy to just exclude one source of income as this might jeopardize the ability to finance activities in other areas, such as public policy. On the other hand, CSAM had always been reluctant to rely on much commercial support; this was mainly due to the idealism of the planners and in part also to the fact that in addiction medicine, there are not many medication options or medical devices to promote. We ultimately hoped to attract enough participants to our conferences and also to secure some grants. Given the record attendance over the last years this strategy seems to work, so that we are now much closer to complete independence from commercial support.

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The Changing Face of CME

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ACCME also added some content requirements. In a country known as "a melting pot" it is clear that it is essential to be aware of cultural and linguistic differences to assure providers can communicate with and are able to tailor treatment to each individual patient. This is the reason each speaker is asked to describe cultural aspects relevant to his topic in order to make the audience aware of potential impediments in treating our patients effectively.

The biggest change, however, is in the teaching methods. Medical education used to be based on lectures that reviewed the knowledge considered necessary to be up to date in your field. It was assumed that by listening to descriptions of the new developments, the physicians would be able and willing to apply it as needed. The lecture format has been the traditional teaching method and this was what most physicians expected. It turns out, however, that lectures are the least effective way to teach as they are entirely passive and often have too many teaching points. It also turns out that while obtaining new knowledge is necessary it is not sufficient to improve patient care.

So conference planners are now asked to identify specific gaps between current and ideal practice and come up with ways to fix them. An example in addition would be: primary care physicians often suspect alcohol abuse or dependence in their patients and are aware that this is a treatable disease, however most doctors never talk to their patients about the alcohol use or get referred to treatment. There are several options where education can help address this discrepancy. For example, physicians can learn to feel more competent to talk to their patients about this topic by learning about some basic motivational enhancement tools and then apply them in role plays or by observing and then reflecting on a sample conversation on the podium or in a video. The main ingredient of this learning experience is not just ingesting the information but also reflecting on it and applying it in a practice setting. The case studies at CSAM's Review Course conferences mentioned above include just this strategy and over the years CSAM has received a lot of positive feedback on how it enhances the understanding and application of the lecture contents.

The next challenge is to improve implementing new practices taught in the CME activity. CME programs will be required to attempt to find out if physicians are using what they learned. For now it means CME providers will conduct follow-up surveys or phone calls and ask physicians if they recall what they learned and how often they used it. For learners it means they will be asked to briefly revisit the topic of the education weeks and months after it is over. It seems tedious and clearly the implication will vary from topic to topic, however remembering and reiterating content is what learning and behavior change are all about. If you ever tried

to treat hypertension you know that just telling the patient about the illness of hypertension, prescribing medication and advising some lifestyle changes will work only for a select few. Most patients need a lot of reminders of checking their blood pressure, taking the medication regularly and re-considering some lifestyle changes, before they "get it" and the blood pressure goes down.

Physicians usually are motivated to practice good medicine and are willing to incorporate new tools if their patients benefit, however they are not immune to reluctance to change and may encounter obstacles to incorporating a new skill to the specific practice. Demonstrating the ability to overcome these obstacles will also be reflected in the requirements for maintenance of certification in most specialties. In the next year, doctors will be required to review their own cases with a certain diagnosis, identify areas of improvement and then document cases where they actually used the improved strategies.

Finally, the main objective of medical education is, obviously, to improve patient outcomes. While we all hope this is the case, CME will try to measure its effect, similar to evidence-based medicine approaches. While many CME providers currently do not yet have the tools, in the age of electronic medical records, we may be able to actually demonstrate long-term results of improved care. We may be measuring Screening, Brief Intervention, Referral and Treatment (SBIRT) rates in primary care of certain provider groups, monitoring if the patients have lower liver function tests, using less of gastric acid blockers, lowering incidence of pancreatitis, etc. Other data could include fewer DUI's, attendance at a treatment program (an outcome measure as we know), etc.

So we are entering a new era of medical education. We will not rely on industry to teach us about what is new, but come up with independent needs assessments ourselves. CME is focused on learning and practicing new skills and evidence-based strategies / algorithms followed by showing that the education was effective and met its goals. We are using teaching tools that are more interactive and targeted, rather than just knowledge dissemination. In the field of addiction medicine and within CSAM this is going to translate into a lot of spirited debates and hopefully further closing of the gap between research and practice. CSAM and its community-building approach is well situated for the new CME approaches and the Education Committee is always interested in feedback and suggestions from its members. I hope to see you check out the new developments in October at our State of the Art conference in Long Beach, CA and remember; this will be different from "sit down, shut up and listen". ■

Dr. Koch is an Addiction Psychiatrist at Kaiser Permanente Chemical Dependence Recovery Program, Vallejo, CA.

Book Review Corner

In the Realm of Hungry Ghosts

Close Encounters with Addiction

WRITTEN BY GABOR MATÉ, MD



BOOK REVIEWED BY
KEN SAFFIER, MD

Addiction to alcohol and drugs is perplexing and often frustrating to medical professionals as well as to family members, friends and so many in our communities who see or experience its destruction and waste. In his newest book, *In the Realm of Hungry Ghosts*, Gabor Maté, MD teaches us how to be more compassionate and understanding to assist

our patients overcome the chronic, relapsing nature of this bio-psychosocial-spiritual disease.

There are many unanswered questions about why people become harmfully involved and then addicted to drugs, as well as to other unhealthy behaviors, such as pathological gambling, Internet use, and compulsive sex. In this comprehensive examination of addiction, Dr. Maté challenges us to rethink our conventional assumptions about addictions. Dr. Maté presents thought provoking research on the behavioral neurobiology and physiology of addiction, possible causes and factors in the perpetuation of addiction, the rationale for harm reduction to complement the goal of abstinence, how people can recover, how we can help those who are addicted, and the failure of the "War on Drugs". Using recent findings from developmental neurobiology and physiology, as well as insights from his extensive clinical experience and personal life, Dr. Maté guides us to new and fresh perspectives to better understand not only our addicted patients but also ourselves.

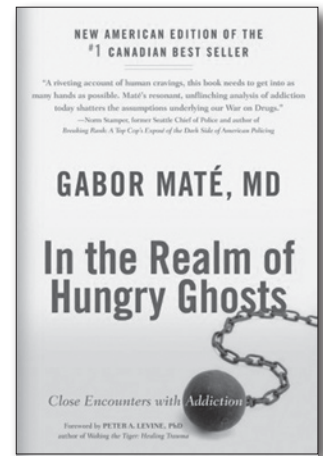
Vancouver's Downtown Eastside community, Maté's primary practice as a physician with the Portland Hotel Society, is home to countless dislocated people addicted to alcohol and/or drugs. His intimate accounts of several patients' lives throughout these 480 pages reach into their past traumas, their current medical and social realities, and often their premature deaths from the ravages of substance abuse. Intertwined in these powerful narratives, he develops scientific, social and political frameworks which reveal the complexity of addictive disease.

Dr. Maté explains how three neural integrated systems, the opioid-based attachment-reward, the dopamine incentive-motivation and the prefrontal cortex impulse-control systems create the foundation for a variety of addictions. However, as he emphasizes throughout, for better

and for worse, we humans have brains that exhibit neural plasticity that are constantly adapting to our environments and social interactions. Given the contemporary focus on genetics, Dr. Maté questions whether sufficient emphasis is placed on developmental neurobiology. He explains how the individual maternal intrauterine and surrounding social environment can be an equally or more potent etiologic basis for addictions, beginning before birth, and continuing after, especially when newborns and infants need protection and nurturing. Hence, he advocates for providing family and social support for parenting and child-rearing as a means to prevent addiction. Early childhood traumatic experiences, in particular, are common to most, if not all, of his patients. The absence of a parent at crucial stages in a child's development can produce neural patterns of functioning that may, in later years, influence behaviors to seek fulfillment or pleasure or release of stress. Genetics, he explains, although a powerful factor may be secondary to how nerve pathways grow and function in response to the environment and stimuli. His appendix, "The Fallacies of Twin and Adoption Studies", elaborates and questions some of addiction medicine's assumptions and blindspots about this evidence. It truly is not "nature vs. nurture" but nature and nurture.

The power and relevance of Dr. Maté's book reside not only in his use of evidence-based research and case histories, but also through his disclosure of personal experiences. He reflects on the destructive aspects of his own process addiction, buying thousands of classical CD's, and his diagnosis of Attention Deficit Disorder. His revelations about his personal, family and professional life encourage readers to consider the basis of their own behaviors.

In the final section, "The Ecology of Healing", Dr. Maté examines recovery from individual and social contexts. Although his personal experience with 12-Step recovery programs was fleeting, he respectfully and analytically describes their strengths and benefits. Complementing the 12 Steps with a UCLA obsessive-compulsive disorder treatment program's principles, he synthesizes an approach to addiction recovery that is a practical guide for patients,

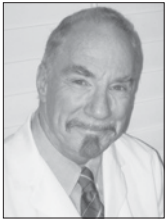


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CSAM members are invited to submit books and film reviews for consideration. Send email to: csam@compuserve.com

Addiction Training for Pediatricians and Family Practice Physicians: A Critical Step to Reduce Underage Drinking

BY JEFFERY N. WILKINS, MD



This article represents a call to action to CSAM and its members regarding drinking. While many of us in CSAM are concerned about this issue, the physicians who have frequent contact with children and youth, e.g., pediatricians and family practitioners, are mostly outside of

CSAM's contact or influence. This article outlines potential action items towards developing partnerships with our pediatrician and family practice colleagues; it is also a reminder to our members and newsletter readers that we welcome suggestions on this and other issues by email at csam@compuserve.com and through the website www.csam-asam.org.

The Clinical Problem

Underage drinking is associated with significant morbidity and mortality (e.g., automobile accidents from drinking and driving). Recent national surveys of 12-year-olds through college age demonstrate significant alcohol use, binge drinking and driving while intoxicated or riding with someone who has been drinking. Within a 30-day period, 1/4th (24%) of high school students binge drank, 10% drove after drinking and 28% rode with a driver who had been drinking¹. The 2008 National Survey on Drug Use and Health found that 28% of 12 to 20 year olds drink alcohol with 19% reporting binge drinking², while the *Monitoring the Future Survey* found that 15% of 8th graders drank during the past month³. Further, there has been a disturbing increase in college students reporting driving under the influence of alcohol from 26.5 to 31.4%, an increase from 2.3 million students to 2.8 million students nationwide⁴. In essence, alcoholism is a disease of

children and young people: evaluation of 4,778 persons who at some point in their lives were alcohol dependent revealed that 15% were diagnosable before age 18, 47% before age 21, and two-thirds before age 25⁵.

The Proposed Educational Plan: Rationale

The plan is for CSAM to provide and/or facilitate "Screening, Brief Intervention, Referral to Treatment (SBIRT) training programs to in-training and in-practice physicians. Consistent with guidelines from the American Academy of Pediatrics (www.aap.org) and the American Academy of Family Practice (www.aafp.org), pediatricians and family practice physicians can employ the physician-patient relationship to deliver SBIRT. Of course, proposed training will take into account the realities of organized medical practice where physician contact with patients is limited and most patient contact occurs with non-physician medical staff. A plan of having CSAM provide or facilitate training programs to pediatricians and family practice physicians is supported by published findings from the U.S. Preventive Services Task Force, whose aim was to rank clinical preventive services efficacy in reducing disease burden (e.g., morbidity and mortality) and cost (Coffield, et al., 2001⁶ and Maciosek et al., 2001⁷). The report covers 25 clinical preventive services ranked by clinical efficacy and cost effectiveness. Indeed, 3 of the top 5 preventive services target alcohol, drugs of abuse and tobacco use: SBIRT approach to adolescent drinking and drug use, screening for tobacco use coupled with an anti-tobacco message plus, in adults, screening for tobacco use coupled with cessation counseling. While it is unfortunate that these 3 clinical prac-

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Three of Top Five Evidence Proven Prevention Methodologies, Address Alcohol, Drugs & Tobacco

1. Vaccinate children: DTP/DTaP, MMR, Oral Polio/IPV, Hib, Hep B, Varicella 5 5 10
- 2. Assess adults for tobacco use and provide tobacco cessation counseling 5 4 9**
3. Screen for vision impairment among adults aged >65 4 5 9
- 4. Assess adolescents for drinking and drug use and counsel on alcohol and drug abstinence 3 5 8**
- 5. Assess adolescents for tobacco use and provide an antitobacco message or advice to quit 4 4 8**
6. Screen for cervical cancer among sexually active women or \$18 years 5 3 8
7. Screen for colorectal cancer (FOBT and/or sigmoidoscopy) among all persons aged >50 years 5 3 8

* Top 7 of 25 ranked clinical preventive services (Maximal score is 10, Efficacy 1-5 and Cost 1-5)

Coffield, AB, Maciosek, MV, McGinnis, JM, Harris, JR, Caldwell, MB, Teutsch, SM, Atkins, Richland, JH, and Haddix, A. Am J Prev Med 2001;21(1):1-9

continued from page 8, Wilkins

tices, and certainly the 2 adolescent ones, are inadequately being provided, they *are* ranked in the top 5 preventive services together with procedures and diseases that are widely recognized by general society: vaccination in children, vision impairment in adults, and screening for cervical and colorectal cancer (see on page 8).

The Proposed Educational Plan: Logistics

An education model with two arms is proposed, to be coordinated by the CSAM Adolescent Addiction Treatment Task Force. First, identify select California pediatric and family practice residency training programs where CSAM might prove helpful in providing/coordinating ACGME required training in substance abuse, including SBIRT and screening/brief interventions for tobacco use. Second, provide CME programs for pediatricians and family practice physicians at their local, state and national meetings and conferences. In both arms the goal will be to develop relations with the American Academy of Pediatrics and its California branches and the American

Academy of Family Physicians. The above plans are consistent with recent calls from the Accreditation Council for Graduate Medical Education (ACGME) that accredits residency programs and The Institute for Medical Quality (IMQ) that accredits continuing medical education (CME) programs. Both agencies are requesting that medical educators demonstrate immediate and long-term post training changes in participant clinical methods. Both agencies are also moving towards requiring evidence of post training improvements in the participants' patients as a result of the training.

We encourage CSAM members to join us in this effort, including serving as advisors or as members of the Adolescent Addiction Treatment Task Force (email csam@compuser.com, website www.csam-asam.org). ■

Dr. Wilkins is the Lincy/Heyward-Moynihan Chair in Addiction Medicine and Vice Chair, Department of Psychiatry at Cedars-Sinai Medical Center, Los Angeles, CA, and Professor of Psychiatry, David Geffen School of Medicine at UCLA.

¹ Eaton DK, Kann L, Kinchen SA, et al. Youth Risk Behavior Surveillance—United States, 2009. CDC Morb Mort SurveilSumm 2010;59(SS-5):1–148. Available at <http://www.cdc.gov/mmwr/PDF/ss/ss5905.pdf>

² Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD. Available at <http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.pdf>

³ Johnston, L D, O'Malley P M, Bachman, J G, & Schulenberg J E (December 14, 2009). "Teen Marijuana Use Tilts Up, While Some Drugs Decline in Use." University of Michigan News Service: Ann Arbor, MI. [Online]. Available at www.monitoringthefuture.org

⁴ Hingson RW, Heeren T, Winter MR, Wechsler, H. Magnitude of alcohol related mortality and morbidity among U.S. college students ages 18-24. *Annu.Rev. Public Health* 2005. 26:259–79

⁵ Hingson RW, Heeren T, Winter MR. Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Pediatrics* 2006;160:739–746

⁶ Coffield AB, Maciosek MV, McGinnis JM, et al. Priorities among recommended clinical preventive services. *Am J Prev Med* 2001;21:1–9.

⁷ Maciosek MV, Coffield AB, McGinnis JM, et al. Methods for priority setting among clinical preventive services. *Am J Prev Med* 2001;21:10–9.

Book Review

continued from page 7, Saffier

professionals as well as the public. In doing so Dr. Maté shows how our compassion not only for our patients' struggles with addictive disease, but for our own life challenges, as individuals and professionals, can transform ourselves and many who we serve.

Whether you are an addiction medicine professional, a family member of a loved one struggling with addiction, a student or a curious member of the public, *In the Realm of Hungry Ghosts* is a clarifying and positive work that can bring optimism and hope for transformation and change. Dr. Maté's experience, eloquence, insights and conclusions contribute to improving ourselves, our work and society. ■

Dr. Saffier is a Family Physician at the Contra Costa Regional Medical & Health Centers in Martinez, CA.

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The Five Skills Every Addiction Specialist Should Have

continued from page 2, Hrymoc

guides a clinician in navigating through his or her own negative countertransference towards patients. The approach is formalized in the concept of SBIRT (screening, brief intervention, referral to treatment) that can be used in one's daily practice. Finally, consultation with other treatment providers should include helping them understand the MET approach so as to establish the same therapeutic rapport in their own work with the patient.

Family-Based Intervention and Support

Addiction is a condition affecting a person's motivational circuitry. Therefore, it's not surprising that family members, and not the patient, frequently make initial contact with treatment providers. At times, the addicted individual does not even come in for treatment at all. This leaves the family with the difficult task of examining their role in the addicted pattern of behavior. It is therefore crucial that an addiction specialist be equipped to educate, support, and help families make the right decisions in such situations. This type of self-examination and action is extremely difficult for the families of addicts — after all, if it was simple, they may not be calling for help in the first place.

How These Skills are Imparted

These five fundamental skills can be imparted in a variety of ways. Quality didactics and journal review should form the foundation of addiction training. Next, close case supervision with highly-skilled mentors should guide the trainee in the application of these therapeutic principles. Participation as part of a multi-disciplinary treatment team can help a trainee understand multiple aspects of substance abuse treatment and coordination of care by different providers. We are fortunate to have high quality conferences on addiction treatment put on each year by CSAM, ASAM, and AAAP. One of the most exciting aspects of our field is its recent advances and any of these conferences will afford a trainee the opportunity to hear and interact with experts in our field. Significant focus on the above core competencies will result in the training of highest quality and most empathic addiction specialist physicians. ■

Dr. Hrymoc is the founder and medical director of the Addiction Medicine Group at Cedars-Sinai Medical Office Towers in Los Angeles, CA.

continued from page 3, Eickelberg

We need the capacity to recognize and redirect addicts' uncanny ability to pit team members (and others) against one another and guide the clinical focus to providing quality patient care and facilitating patients' ability to change without taking responsibility for patients' choices and behaviors.

Be an Educator and Role Model

Practiced responsibly, our profession requires us to stay up to date with scientific and clinical advances so that we continue to offer state of the art patient care and translate our knowledge to patients, families, and colleagues. It is an acknowledged fact that many if not most of our medical colleagues lack the knowledge, skill and training to recognize and appropriately treat addiction. Therefore I encourage addictionists to take full advantage of the opportunity afforded us to be part of the treatment team where patients and others witness (and learn from) our approach. We teach by example.

Addiction trainees learn to provide a spectrum of evidence-based medical care for persons with addiction, a process that is taken for granted for those patients who suffer from other common chronic diseases. As ethical, understanding and effective physicians, addictionists function as role models for others who we hope will emulate the manner with which we approach patients with addiction — with therapeutic optimism, professionalism, and always respect for patients and colleagues. ■

Dr. Eickelberg is president of the Medical Education and Research Foundation (MERF) and is coordinator of MERF's annual addiction education scholarship program for residents and faculty.

Special appreciation extended to Gail Jara for her contributions and editing assistance.



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John Nelson Chappel, MD 1931 - 2011



As we go to press, we learned of the passing of Dr. John Chappel, one of the giants in the development of addiction medicine. John joined CSAM in 1974. He burned with a fire for educating physicians, especially young physicians and was the architect of CSAM's educational principles. In 1982 he took on the lead role in developing the first certification examination for specialists in addiction

medicine. He was a passionate advocate for spirituality and the importance of the 12-steps in addiction treatment. In 1997, he received CSAM's highest honor, the Vernelle Fox Award. In 2009, he was recognized again by CSAM and the Medical Education and Research Foundation for the Treatment of Alcoholism and Other Drug Dependencies (MERF).



Newly Certified by the American Board of Addiction Medicine

CSAM Review Course Attendees have 90% Pass Rate

Congratulations to the following California physicians who were recently Certified or Re-Certified by the American Board of Addiction Medicine (ABAM) in 2010. We also congratulate those who took the CSAM Addiction Medicine Review Course in Newport Beach who had a 90% pass rate on the certification exam (compared to an 82% pass rate for all those sitting for the exam).

Certification by the American Board of Addiction Medicine represents the highest standard in Addiction Medicine, and has meant that ABAM-certified physicians have demonstrated – to their peers and to the public – that they have the

clinical judgment, skills and attitudes essential for the delivery of excellent patient care. It also indicates that an Addiction Medicine physician has met the clinical and educational criteria to be eligible to sit for a rigorous six hour written examination, and has successfully passed the examination.

The next exam will be given in December 2012. CSAM will offer a Review Course September 5-8, 2012 at the Hyatt Regency Embarcadero in San Francisco, for those who are planning to sit for the exam. Applications to sit for the examination, which will be similar to the 2010 application, will be available in mid-summer, 2011. For more information see www.abam.net. ■

Newly-Certified in Addiction Medicine:

Sharone Ann Abramowitz, MD
 Paul D. Abramson, MD,
 Carrick Jean Adam, MD, MSPH
 Bushra Farooq Ahmad, MD
 Miguel Angel Dario Alvarillos, MD
 Clarissa Andic, MD
 Noorulain Ahmed-Khan Aqeel, MD
 Kamal Haydari Artin, MD
 Margaret Bourne, MD,
 Anthony K. Boyce, DO
 Barbara Bruton, MD
 E. Duane Carmalt, MD
 Chandandeep Chahal, MD
 Chwen-Yuen Angie Chen, MD
 Rodney Daniel Collins, MD
 Edward John Davis, MD
 Py Louise Driscoll, MD
 Khurram Durrani, MD
 Godfrey David Dyne, MD
 Ryan Felipe Estevez, MD, PhD, MPH
 Jennifer Love Farrell, MD
 Jennifer Ruth Firestone, MD
 Christina Helen Fritsch, MD
 John Hampton Fullerton, MD, CMD, CFP, FACP
 Vanessa Rose Greenwood, MD
 Layth K. Hakim, MD
 Erika W. Hammers, MD
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 Randolph Peter Holmes, MD
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 Jill Ann Kimm, MD
 Soe Moe Kyaw, MD
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 Rosalyn Ventura Milenkiewicz, MD
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 Rafael Penunuri, MD
 Peter Robert Przekop, DO, PhD
 Jerry Rand, MD
 Scott David Reiter, MD
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 Keerthy Sunder, MD
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 Lawrence Vernon Tucker, MD
 Jacqueline Peterson Tulskey, MD
 Valerie J. Tutson, MD
 Gabor Vari, MD
 Lawrence M. Weinstein, MD, ABHM
 Gabriel Sorin Williams, MD

Re-Certified:

Ralph Hudson Armstrong, MD
 Michael Fawzy Bishara, MD
 Thomas G. Carlton, MD
 Edgar Hugo Castellanos, MD



MEMBERS OF THE 2010 CONFERENCE PLANNING COMMITTEE

Special Thanks to those CSAM members who coordinated the CSAM Addiction Medicine Review Course and the Exam Track:

Mason Turner, MD, *Conference Chair*
 Monika Koch, MD, *Chair, Education Committee*
 Karen Miotto, MD, *Previous Conference Chair*
 Murtuza Ghadiali, MD, *Chair, Exam Track*
 William Brostoff, MD, *Small Group Facilitators*
 Steven Eickelberg, MD, FASAM, *President, MERF*
 James Golden, MD, *Exam Track*
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