

Addiction Treatment Belongs in the Community

CSAM members meet with legislators at Annual Legislative Day in Sacramento

BY PETER BANYS, MD, MSc



Recently, I joined a group of CSAM physicians at the State Capitol to speak with legislators and staffers about bringing common sense back to drug policy. Since the war on drugs morphed into a war on the addicted two decades ago, legislators have heard a great deal more from the criminal justice industry than from front-line physician

specialists. Even so, we found California legislators to be genuinely concerned about effective interventions. Here are some of the state's drug problems, and our recommendations:

California's Methamphetamine Epidemic: Methamphetamine has surpassed alcohol as the drug of choice for Californians presenting for treatment. Last year, Senator Jackie Speier asked CSAM to prepare Methamphetamine Policy Recommen-

dations for California.

CSAM noted at that time that: (a) methamphetamine addiction is as treatable as other addictions; (b) that it requires extended courses of treatment and often adjunctive antipsychotic medications, and; (c) that methamphetamine is the reported drug of choice for 53% of those diverted to treatment through the criminal justice system under Proposition 36, the state's voter-enacted treatment-instead-of-incarceration law.

CSAM recommended that hospital emergency rooms routinely screen for stimulants and other drugs of abuse in high-risk presentations; something not done because (under 50-year-old UPPL laws) insurers can deny payment for injuries related to addictive drugs.

We believe that ERs should be gateways to treatment, and that California needs to join many other states that have

continued on page 15

CSAM Introduces Emergency Room Screening Bill

AB1461, an ER Screening/Brief Intervention Bill was recently introduced for CSAM by Assembly Member Paul Krekorian. This bill would require emergency rooms to screen patients for drug and alcohol abuse and provide brief intervention and resource referral.

This bill also seeks to repeal the Uniform Accident and Sickness Policy Provision Law (UPPL), a relic of the 1950s that deterred screening in emergency rooms. This outdated law provided a loophole in which the insurer may not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.



DR. DENISE GREENE, ASSEMBLY MEMBER PAUL KREKORIAN (D-GLENDALE), AND DR. DAVID PATING AFTER KREKORIAN SPOKE ABOUT THE CSAM-INITIATED BILL HE INTRODUCED: AB 1461 AT CSAM LEGISLATIVE DAY ON FEBRUARY 28TH.

CSAM's Forum for Dialogues in Addiction Medicine

Medication-Assisted Therapy and Sobriety

BY TIMMEN CERMAK, MD, EDITOR

As the editor of CSAM's newsletter, I am excited to introduce the second in our FORUM series. Each newsletter, I am choosing an issue that would benefit from being elevated to the surface, where open discussion of different perspectives can advance our understanding of the issue, and of each other. Views are presented not in a pro-con, point-counterpoint framework, but rather as examples of differing perspectives. Dialogue is the most important goal for each FORUM.

ABOUT MEDICATION-ASSISTED THERAPY AND SOBRIETY

The chemical dependence field works in part by extending the patient role to addicts/alcoholics. By non-judgmentally embracing anyone who is suffering from substance use, we are able to include them in the medical approach to diagnosis and treatment – and to bring to bear the resources for payment that make their care possible.

An issue of when the use of medications – prescribed

to aid sobriety, most often by treating symptoms of other psychiatric problems – begins to detract from sobriety would benefit from a more frank and open discussion. This is especially true when medications such as methadone and buprenorphine are used to replace the opiate to which a patient has become addicted. Does this process differ substantially from the use of an SSRI to treat depression, mood stabilizers or dopamine blockers to treat bipolar disorder, and naltrexone or disulfiram to block the effect of addictive substances?

The relationship between medication and sobriety is a sensitive issue, in part because it borders on importing a quasi-moralistic perspective back into our field. I have asked Donald Kurth, MD and Joan Zweben, PhD to weigh in on the topic, as they did last fall in CSAM's pre-conference workshop.



Is Abstinence Possible Using Prescribed Medication?

BY DONALD KURTH, MD

Let me start by making it clear that I do not speak for Alcoholics Anonymous, Narcotics Anonymous, or any other Twelve Step program. I hope only to provide material contained in *The Big Book* of Alcoholics Anonymous and the *NA Basic Text* that, to the best of my understanding, are relevant to the questions before us.

I define abstinence, in the broad addictive disease sense, as total abstinence from all addictive, mind-altering or potentially mind-altering medications and chemicals. When members of Twelve Step groups use the word sobriety, they are referring to somebody who is not only totally abstinent, but who is also working a spiritual program of recovery. Many believe that the basis for sobriety is a spiritual connection with a higher power and that that relationship is disrupted by taking mind altering medications on a regular basis. Sometimes we describe a person who is abstinent but not "sober" (i.e., is not working a spiritual program of recovery) as being "dry." In these cases, the chemicals have been removed, but there is not yet substantial change in one's personality.

Is it possible to be "abstinent" or "sober" while taking potentially habit forming (or addictive), mind altering medications or chemicals? I suppose it could be – we can define these terms any way we please – but it is not what I believe for myself.

Generally speaking, SSRIs, mood stabilizers, naltrexone, and disulfiram are not considered habit forming (or addictive), mind altering medications, although some Twelve Step people might disagree. On the other hand, although we use both methadone and buprenorphine in the treatment of addiction, I think most would agree that they have habit forming (or addictive), mind altering properties, at least within certain dosage ranges. Therefore, many would believe that these medications would inhibit the sense of "God consciousness" that was discussed previously.

The Big Book tells us to "...remember that though God has wrought miracles among us, we should never belittle a good doctor or psychiatrist." And the AA pamphlet, *The AA Member: Medication and Other Drugs* states that "...just as it is wrong to enable or support any alcoholic to become readdicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems."

From the standpoint of the opioid replacement patients who want to become drug-free, inclusion in therapy groups to help them become drug-free might be beneficial. However, if the stated purpose of the therapy groups is to help people become or remain drug-free, and the opioid replacement patients plan to continue using these sorts of medications, what would be the point in having them attend?

continued on page 3

Let me put that another way. How about if I organized a group to practice synchronized swimming or relay racing? Would you send somebody to participate who did not want to get into the water or run with the team? I suppose they could sit in the bleachers and watch but they could not be included unless they were willing to participate in the activity.

Is there a hierarchy among recovering people, with people who are entirely drug free at the top and those requiring medication lower, with agonist replacement at the bottom? [A question posed to both Kurth and Zweben by the Editor] If

we are truly honest with ourselves, it seems that as human beings we all seem to want to feel that we are better than somebody else. In the recovering community this is no different. Sometimes we good-naturedly call ourselves “gutter snobs”. That is, the alcoholic lying in the gutter looks down at the addict and the addict in the gutter looks down at the alcoholic. Perhaps that is just human nature.

Unfortunately, those who suffer from severe psychiatric illness may be treated with disdain by many in society. And, they are often the least capable of defending themselves. ■

The Use of Medications to Achieve Sobriety

BY JOAN ZWEBEN, PHD

Consider a patient to be abstinent when he or she is not using alcohol or illegal drugs and using legal ones as appropriately prescribed. This applies to agonists (methadone) or partial agonists (buprenorphine), as well as psychotropic or other medications. Sobriety also refers to abstinence from alcohol and illicit drugs, or misuse of prescribed drugs.

Recovery refers to a process of personal development that addresses unhealthy psychological states, interpersonal relationships, behaviors characteristic of addiction and spiritual development.

Regarding the impact of medications on sobriety, there is no virtue in preserving a pathological mood state. SSRIs, mood stabilizers, methadone and buprenorphine change mood by virtue of normalizing brain chemistry. For example, treatment-seeking opiate users have high levels of depression. In some cases, methadone or buprenorphine is adequate to restore a normal mood. Others will need the addition of antidepressants.

The pamphlet, *The AA Member: Medication and Other Drugs* (Alcoholics Anonymous 1984) defined the guidelines more than 20 years ago. Medication, appropriately prescribed by a physician familiar with addiction, is compatible with recovery.

The question of treating patients on methadone or buprenorphine together with those not on agonist therapy raises a variety of issues. The key is the understanding and attitude of the clinician. If the clinician is knowledgeable and his/her attitude is positive, the issues that emerge can lead to a fruitful discussion. One key issue is the tendency to make comparisons. Other patients may believe that the methadone or buprenorphine patient is “getting off easy.” Comparing one’s inside to someone else’s outside is a larger issue in recovery. The guiding principle is that people need to “work their own program,” not someone else’s.

Oversedation in groups is a common problem, frequently attributed to methadone (buprenorphine is less sedating) even when there are many other likely sources. It is possible for a patient on an appropriate dose to become sedated

when sedentary for a period of time. A variety of simple interventions can remedy this: standing up and moving around a little, using a wet towel, perhaps splitting the methadone dose. Patients and naïve staff may immediately assume the dose is too high, and dismiss other reasons for a patient’s inability to stay alert. These may include sedating antidepressants, insomnia, child awake much of the night, overheated group room, etc.

Many issues surrounding medication-assisted therapy are based on misunderstanding and stigma. The former can be addressed with information (e.g., “they are getting high” or “they are just substituting one addicting drug for another.”) In the case of stigma-based attitudes and feelings, these can be explored like any other clinical issue. At bottom is the question: what is in the way of a respectful acceptance that people each have their own path?

In order to treat methadone and buprenorphine assisted patients together with those not on agonist therapy, it is important to do extensive work with staff, educating them about the medications and giving them an arena to work on their attitudes. In addition to discussion, it is useful to give them an opportunity to role-play how they would handle issues presented by other patients.

Is there a hierarchy among recovering people, with people who are entirely drug free at the top and those requiring medication lower, with agonist replacement at the bottom? I think there is a hierarchy in the minds of some, but this is diminishing as awareness grows of the prevalence of co-occurring disorders and the importance of medications to a quality recovery. Patients may wish they did not need medication, or did not need to attend two meetings a week, or did not need to avoid triggers to relapse.

Regardless, it’s important to support patients in doing what it takes to control the addiction. Compliance with good treatment provides hope for control of the disease. It’s important that we give patients information about what they need to do to get better, so they can participate in their treatment and make informed choices. ■





FORUM Commentary

By TIMMEN CERMAK, MD, EDITOR

Medication-Assisted Therapy and Sobriety

continued from page 3



Both opinions express essentially the same distinction among patients who are adhering to medical recommendations. There are those who pursue a full (usually spiritually-based) program of recovery and those who limit their efforts only to abstaining from ingesting chemicals. It is important not to get tripped up on mere semantics. As Don

Kurth states, we are free to define “abstinent,” “sober,” and “in recovery” however we wish. The critical distinction we seem to agree upon is that those patients who work to develop a lifestyle that is inconsistent with substance abuse are more likely to avoid relapse.

A critical difference does appear when a distinction is made between those patients who employ agonist medications to support their recovery versus all other medications. I wonder if the distinction is truly as clear as some might believe. If I use gabapentin to tickle gaba receptors in a patient recovering from benzodiazepine addiction, is this using a “mood stabilizer” or an agonist? If I add buprenorphine or methadone to the medications taken by a patient with treatment-resistant depression, is this using an agonist or an antidepressant? If we postulate that some patients suffer depression as a result of serotonin or norepinephrine deficits, wouldn't it be likely that people could also suffer from endorphin or endocannabinoid deficits that require treatment with an agonist?

Bill W. wrote in *Pass It On* that medications cannot get rid of a person's defects of character, but they sure can “take the heat off.” Perhaps “taking the heat off” is a lot of what we do in treatment, permitting patients to do their personal work of recovery more effectively. As physicians, we apply scientific principles and empirical evidence to help each individual operationalize how to make recovery most possible. Then, the nonjudgmental perspective of *Live and Let Live* offers each patient the respect to find his or her own way toward maximum health. ■

Pharmacotherapy in the Treatment of Opioid Dependence

CSAM position developed by the Committee on the Treatment of Opioid Dependence

Medication Assisted Treatment for Opioid Addiction

CSAM aligns itself with the NIH Consensus statement of 1997, which defines opioid addiction as a chronic disease, and calls for increased access to long-term treatments. The World Health Organization also supports maintenance pharmacotherapy as a way to save lives and prevent HIV transmission among persons who are opioid dependent, and has declared buprenorphine to be an “essential medication.” Maintenance pharmacotherapy with psychosocial treatment (currently known as Medication-Assisted Treatment or MAT) represents the medical standard of care. Methadone maintenance treatment (MMT) was the first and still the most common form of such treatment in the US. Since 1965 MMT has been shown to reduce mortality, lower criminality, enhance functionality, and to reduce the incidence of seroconversion to HIV. The NIH Consensus statement called for increased access to maintenance pharmacotherapy, and reduction in the severely restricting regulations that have governed methadone maintenance. The Institute of Medicine (IOM) 2006 report also promotes integration of substance-abuse care across health-care settings, including primary care.

To download the complete copy of the position statement, go to: www.csam-asam.org.

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

CSAM Introduces New On-Line Blog

Give us your opinion at www.CSAM-ASAM.org

By TIMMEN CERMAK, MD, EDITOR



As the new editor of CSAM's Newsletter, I am pleased to introduce the FORUM and a new on-line blog to allow exchange of ideas beyond the newsletter. In each newsletter, I choose an issue that would benefit from being elevated to the surface. Views will be presented not in a pro-con, point-counterpoint framework, but rather as examples of differing perspectives. Dialogue will be the most important goal for each FORUM.

In the last issue, we heard from two perspectives on Hythiam's Prometa that possess particular relevance for addiction medicine, both in terms of their impact on the practice of treating addiction and the special expertise practitioners in our field can bring to an understanding of these themes. Both themes are far larger than the issues presented by Hythiam's Prometa; but the perspectives expressed by David Smith, MD/Matthew Torrington, MD and Richard Rawson, PhD/Thomas McLellan, PhD clearly illustrated the two themes (previous issue of CSAM News available for download at: www.csam-asam.org)

Here are some of the comments we received on our Blog as a result of the FORUM article:

Thanks for having this blog to make us think. I have read lots of articles recently in the medical journals and in the press about conflict of interest, and how it affects our medical care and our medical education. For example, the anti-inflammatories that were shown to be associated with increased heart disease, and how that was not reported to FDA, etc. I think an organization like CSAM, that provides continuing education for physicians, should avoid commercial conflict of interest as much as possible, and apply for funding from non-profits, and depend on subscription fees for its budget. Unrestricted educational grants from corporations are sort of a gray zone. As physicians we are part of a big complicated establishment, and need to have some critical distance to practice consciously – [Comment by Judy Martin, MD...\[read more on-line at \[www.csam-asam.org\]\(http://www.csam-asam.org\)\]](#)

Although physicians frequently use drugs "off-label," I do not think that exhibits at CSAM and ASAM should PROMOTE unapproved uses for drugs. The FDA does not allow such marketing by pharmaceutical companies, and we should be in accordance.

FDA protects patients by having informed consent for experimental medications and procedures, justification of safety and efficacy, and post-marketing safety surveillance. I would be interested if others have alternative viewpoints and their rationale. – [Comment by Lori Karan, MD \[read more on-line at \[www.csam-asam.org\]\(http://www.csam-asam.org\)\]](#)

I appreciate the availability of this blog to facilitate communication amongst our colleagues on important issues, such as the Prometa Protocol for the treatment of stimulants and alcohol dependency. There being no further comments on this blog, I felt compelled to add the following: Strong anecdotal evidence appears to highlight the efficacy of three common-place drugs (i.e. none include compound #PP00247!?), which when used in scripted fashion has led to an enthusiastic response from both patients and investors. Although I've not actually had the pleasure of speaking to a patient, I did reach a treatment center. Ultimately, I learned that a license fee would be calculated based on my charges for the treatment. I was immediately elated and quickly replied that my charge would be about \$300. At this point, this very congenial gentleman (letting me down gracefully) informed me that treatment is based on a figure closer to \$15,000 – [Comment by Ernie Vasti, MD \[read more on-line at \[www.csam-asam.org\]\(http://www.csam-asam.org\)\]](#)

Post your own comments to the On-Line Blog discussion of this previous topic and our latest topic discussed in this issue. Go to: www.csam-asam.org and click on "CSAM BLOGS".

Resources

CSAM offers the following resources available on-line at www.csam-asam.org

- [Addiction Medicine: Certification Exam Study CD-ROM](#)
- [Buprenorphine Resources](#)
- [Methamphetamine in CA: Recommendations for Addressing](#)
- [Narcotic Treatment Programs: Guideline for Physicians](#)
- [Pain & Addiction \(Guidelines coming soon\)](#)
- [Proposition 36: Recommendations](#)

For more information, contact CSAM at 415/927-5730.

Statement of CSAM Principles RE: Evidence-Based Medicine

Adopted by CSAM Executive Council, March 2007

BY TIMMEN CERMAK, MD

CSAM members receive multiple inquiries from the news media seeking information about addiction treatment. If you are contacted, you may, of course, speak freely as an individual physician; however, if you include your CSAM membership in your response or bio, we ask that you provide the following position of the society.

In the absence of an established scientific evidence base supporting the efficacy of a treatment, CSAM considers support for it largely anecdotal and awaits outcomes of well-designed clinical trials before supporting the use of public California funds to pay for this treatment.

Evidence-Based Treatment:

Although our organization has never served the function of evaluating or policing specific treatments or treatment providers, we do stand for excellence in the scientific rationale underlying addiction treatment. The two most fundamental principles guiding CSAM are our commitment to:

1. Evidence-based medicine (EBM) and
2. A Public Health approach to the treatment of addiction that combines concern for both the health of the individual and the safety of the general public.

A closer look at what evidence-based medicine means is helpful. The term first appeared in the medical literature in 1992 (G. Guyatt et al, *JAMA* 268:2420-5) as an evolving approach to the teaching of medicine. EBM offers a tested scientific point of view that references applied clinical research when filtered through standards of evidence designed to minimize bias by the use of strong statistical designs.

Several frameworks have been advanced for evaluating the level of credibility of research findings. A simple framework, recommended by the US Government Agency for Health Care Policy and Research, has three levels:

- A. Requires a least one randomized controlled trial (RCT) as part of the evidence
- B. Requires well-controlled clinical studies, but no RCT
- C. Requires clinical experience of respected authorities

Other frameworks make finer distinctions among different levels of evidence (e.g., Oxford Centre for EBM Levels of Evidence), but the thrust of each is the same. The "gold standard" for credibility is met by randomized, double-blind, placebo-controlled trials, with multi-site studies being preferred to single-site studies. The unique advantage of randomization is that it enables researchers to evaluate whether the intervention (or product) itself, as opposed to other factors, causes any observed benefit. RCTs are the only method capable of eliminating bias. Less reliable are controlled studies without randomization. Single group "pre-post" studies, for example, run the risk of attributing

improvement to an intervention when the improvement would have happened without the intervention.

Still less reliable are "open label" studies in which there is no placebo and patients know the treatment they are receiving. Prospective longitudinal studies are more highly rated than retrospective. The least reliable evidence comes from patient testimonials, case reports, and even expert opinion because of placebo effects and biases inherent in expectations. In contrast to traditional medical practice, evidence-based medicine has downgraded the power of ad hoc clinical experience. When "experts" also have a professional or financial stake in the success of any treatment that they are promoting, anecdotal evidence loses validity.

Although randomized controlled studies remain the gold standard for EBM, they must be well designed and implemented. The following OMB criteria defined a well designed and implemented RCT (www.whitehouse.gov/omb/part/2004_program_eval.pdf):

1. The study should clearly describe the intervention.
2. The study should use placebo controls if participants' beliefs that they are receiving an intervention may plausibly affect their outcomes.

continued on page 7



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Addiction Medicine Inland Empire, Los Angeles and San Diego

Cross-specialty collaboration and a comprehensive network of support are just a few of the advantages that make working with us so enjoyable. We also offer a highly competitive compensation and benefits package plus a location that's known the world over for its amazing climate and natural attractions.

For consideration, please email your CV to: Joan.X.Little@kp.org or call (800) 541-7946. We are an AAP/EEO employer.
<http://physiciancareers.kp.org>.

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continued from page 6

3. The random assignment process should include safeguards to ensure it is not compromised.
4. The study should provide data showing that, prior to the intervention, the intervention and control groups do not differ systematically.
5. The study should use valid outcome measures – i.e., that accurately measure the true outcomes that the intervention is designed to affect.
6. The study should have low overall attrition, with no differential between controls and intervention groups.
7. The study should use an intention-to-treat approach.
8. The study should preferably obtain data on long-term outcomes.
9. Power analyses should assure that sample sizes are adequate.
10. All outcomes should be reported, not only positive effects.

Evidence-based medicine does have limitations. Not all research conclusions make it into the literature, which often obscures negative results. Some forms of treatment do not permit placebo controls for ethical or practical reasons (i.e., sham treatment). Expense can limit research. Lack of evidence and lack of benefit are not the same. Results that apply to populations may not apply to a single individual. The generalizing of results from one population to other populations is often in question (i.e., from a population of men to one of women). Slavish adherence to EBM could promote a “cookbook” approach to medicine. The more complex problems are poor subjects for RCT research.

CSAM supports the longstanding authority of physicians

to do “off-label prescribing,” that is, to try previously approved medications for new indications. However, under such circumstances their patients should be thoughtfully informed that the prescription is an off-label trial.

CSAM has concerns whenever the marketing for a new product or treatment protocol gets ahead of the evidence for both its safety and efficacy. While not every form of treatment can be researched with protocols that meet the gold standard for credible evidence, CSAM supports the principle that those products and protocols that can be researched at high levels of evidence-credibility should be before their benefits are promoted and adopted as proven forms of treatment.

CSAM’s endorsement of evidence-based medicine leads us to support the position expressed by Nora Volkow, Director of NIDA, regarding any addiction treatment that lacks sufficient evidence of its efficacy and safety:

...it has become extraordinarily important for us to provide objective evidence of the effectiveness of treatment interventions...Do I support the utilization of treatments that are not evidence-based? No, I do not.

In the field of drug addiction, it has been very, very difficult to change the culture to accept drug addiction as a disease and as you know, we are treated differently in that private insurances do not cover the treatment. Why? Because they say drug addiction treatment does not work.

And so it has become extraordinarily important for us to provide objective evidence of the effectiveness of treatment interventions. And it is harmful to the field to promote any treatment without that evidence, because it serves to... propagate the sense that treatment does not work.”

CSAM recommends that physicians use caution when recommending unproven treatments for substance abuse. ■

Doctors in Distress - Confidential Help Available

Concerned about a colleague, or yourself, a family member, who may have an alcoholic, chemical dependent, mental/behavioral problem? The CA Medical Association offers the Confidential Assistance Line, a 24-hour, voluntary phone service for physicians, dentists, medical students, residents, their families and colleagues. This service is completely confidential and using it will not result in any form of disciplinary action or referral to any disciplinary body. Physicians and dentists who volunteer their services on the line are experienced in treating professionals, including physicians, with impairment problems. The goal is treatment not discipline.

In Northern California, please contact 650/756-7787. In Southern California, please contact 213/383-2691.

Information: Kathleen de Fabrique, 415/882-5107, kdefabrique@cmanet.org

California Society of Addiction Medicine

Blueprint for Treating Drug and Alcohol Addiction in California

By DAVID PATING, MD

1. ADDICTION IS A BRAIN DISEASE

Research shows that addiction begins in the brain's disordered response to drugs, leading to craving, loss of control, and resultant family and social disruption.

- CSAM supports a public health approach to addiction.
- California's approach to addictive disease should be guided by scientific principles and evidence-based practices.

2. TREATMENT SAVES LIVES

Addictions are chronic, relapsing disorders, with treatments that are as effective as those for other chronic medical diseases. Even methamphetamine addiction is as responsive to treatment as diabetes and hypertension.

- CSAM supports effective evidence-based treatments.
- Successful addiction treatment may require multiple episodes of intervention and care.
- FDA-approved medications exist for reducing relapse rates to alcohol and to opiates; however, no medications to date have been approved for primary treatment of stimulant abuse.

3. FULL ACCESS TO TREATMENT

Large-scale studies have demonstrated that parity for chemical dependency treatments does not significantly increase premiums. CSAM believes that limiting full access to treatment is unfair to consumers and discriminates against those suffering from addiction.

- CSAM supports insurance parity to end discrimination in medical care.
- CALPERS should lead the nation in redesigning the benefits for all state employees covered by its plans.
- Lifetime benefit limits should be similar to medical/surgical limits.



CSAM MEMBERS WHO PARTICIPATED IN LEGISLATIVE DAY IN SACRAMENTO ON FEBRUARY 28TH RECEIVED T-SHIRTS TO WEAR TO THE STATE CAPITOL TO EMPHASIZE CSAM'S BLUEPRINT FOR CALIFORNIA.

4. TREATMENT, NOT PRISON

Our courts and prisons are overburdened by nonviolent drug-related offenders. CSAM believes that the social disruptions caused by disease are best ameliorated by medical treatment.

- Evidence proves that treatment is more effective in reducing recidivism and more economical than incarceration.
- CSAM advocates annual (cost of living) budget increases for Proposition 36 (Substance Abuse and Crime Prevention Act, Public Initiative 2000).
- CSAM opposes proposed 2007 state funding cuts to Prop 36 disguised as county matching plans.
- CSAM supports stratification of courts and treatment providers, with clinical case management for high utilizers, and drug courts for more intensive supervision of chronic relapsers and recidivists.

5. EARLY DIAGNOSIS AND INTERVENTION

Emergency rooms are heavily burdened by addicts needing treatment. Withholding insurance reimbursement following positive drug screening is counterproductive.

- California ERs need to screen for alcohol and drugs when clinically indicated.
- Toxicology results should be confidential and lead to treatment referrals rather than to criminal justice sanctions.

- CSAM supports repeal of the Uniform Policy Provision Law (UPPL), which allows insurers to refuse to pay the costs for patients injured while under the influence.

6. INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS

CSAM supports access to integrated treatment for patients with co-occurring medical, psychiatric and substance use disorders. There should be “No Wrong Door” into treatment.

- Public programs in California need to reimburse community programs for services rendered, not for diagnoses.
- Significant Proposition 63 resources should be directed to demonstration programs for integrated care.
- California should take steps to maintain an appropriately trained substance abuse treatment workforce.

7. SPECIAL POPULATIONS REQUIRE OUTREACH

CSAM supports a full range of comprehensive and individualized programs to meet the special needs of adolescents, women, the homeless, and the incarcerated.

- Publicly-funded residential treatment programs are needed for adolescents and women.
- Payee systems for the marginally-housed receiving public benefits need to expand to protect benefits for the provision of shelter and food.
- California prison and probation populations need improved medical and psychiatric services, including diagnosis and treatment of co-occurring mental health disorders, Hepatitis C, HIV and injection needle use.

8. METHADONE WORKS

CSAM supports methadone and buprenorphine treatment as the Gold Standard for opiate addiction in all settings, including prison and probation programs.

- Rural counties without methadone maintenance clinics need to support office-based opiate agonist treatment utilizing buprenorphine.

9. GOOD TREATMENT REQUIRES GOOD SCIENCE

Addiction treatment should be subject to the same level of outcome studies required by other medical diseases. “Magic bullet” cures, however highly touted initially by testimonials, are generally not effective, and should not be supported until positive results are scientifically proven.

- Publicly funded agencies should explore reimbursement based on demonstrable treatment outcomes.
- Consumers should be informed about effective treatment options and advised not to support unproven or risky treatments.

10. RECOVERY TAKES COMMUNITY

Stigma creates an invisible barrier that hinders patients and families from seeking addiction treatment. Communities must work to overcome the public stigma of addiction. Hope is realistic. Treatment works and can restore the health of patients, families and their communities.

- CSAM supports prevention and education to reduce barriers to treatment.
- CSAM supports community efforts to foster hope and recovery among patients, friends and families touched by addiction. ■

CALL FOR VOLUNTEERS - DIVERSION PROGRAM

The California Medical Board/Diversion Program needs assistance in Northern California to fill voluntary Diversion Evaluation Committee positions. The program is looking for MDs specializing in Psychiatry, and Addiction Medicine. If you wish to volunteer, please send a letter of interest with attached curriculum vitae to the Diversion Program, 1420 Howe Avenue, #14, Sacramento, California 95825.

ATTN: Frank Valine, Program Administrator, Diversion Program - Medical Board of California
phone: (916) 263-2600 • email: fvaline@medbd.ca.gov

President's Column

The Value of CSAM Membership

BY DAVID PATING, MD

As a member of more than one medical society, all with expanding dues, I find it increasingly necessary to see value in my professional memberships. I must not only know these societies have lofty goals; I must also be reassured they are acting directly on my behalf.

At CSAM, we have long recognized the importance of our members. Our members are our lifeblood and vital spokespersons for our mantra of "evidence-based care." Whether by delivering open mic comments at our Annual Review Course or speaking to our state senators and representatives at our annual Legislative Day in Sacramento, the personal commitment and clinical experience of our members is CSAM's strength.

That CSAM is a member-driven organization is elegantly exemplified by the contributions of **Judy Martin, MD** (chair, Committee on the Treatment of Opioid Dependence) who recently investigated concerns -- based on comments of CSAM members to our opiate committee -- that patients on buprenorphine were being denied pharmacy approval by some large insurers. After an email survey to CSAM members, Dr. Martin arranged to meet with the P&T com-



DAVID PATING, MD, REVIEWS THE BLUEPRINT FOR CALIFORNIA WITH THE CSAM EXECUTIVE COUNCIL AT THEIR MEETING ON JANUARY 26 IN LOS ANGELES.

mittee of one large insurer, Blue Shield. Together, with Dr. Martin's assistance, CSAM and Blue Shield clarified criteria for approval of opiate treatment which were consistent with CSAT's national treatment recommendations for opiate dependence.

In another example of CSAM's commitment to our members, we have begun to develop addiction assessment criteria for several California state licensing boards. Under the direction of **Mickey Ask, MD** (chair, Committee on Physician Well-Being) **William Brostoff, MD**, CSAM is formulating standards for proper medical assessment when licensees are suspected of addiction. These standards not only bring recognition to our CSAM member-experts for their ability to do high quality evaluations but also create an opportunity for members to self-identify their willingness to accept these referrals. Stay tuned for more developments on our CSAM website.

The latest example of our commitment to our CSAM members stems from our expanded commitment to our CSAM regional dinners. In January, thirty addiction medicine physicians convened in Los Angeles for an update on pathologic gambling. Besides enjoying a dinner hosted by **Romana Zvereva, MD** (chair, Committee on Membership) our members had the opportunity to meet, share cases, talk and learn. Another regional meeting was held in Sacramento recently and we look forward to more of these to come. I believe these dinners will provide an important venue to stay connected to important local issues facing our field.

CSAM works because our members do the work. They are us—acting on our behalf. If you do not believe this, I hope you will join one of our many CSAM activities throughout the state to see this firsthand. Or call me for the scoop on what's happening.

Welcome New Members!

Prakashchandra Chhotabhai Patel, MD - Hemet

Gregory E. Freed, MD - Orange

Michael Gitter, MD - Pacific Palisades

Peter F. Grimes, MD - Irvine

Geraldine Idoniboye, MD

Raymond Kramer, MD - Redlands

Willa Ann Lilly, DO - San Clemente

David M. Martorano, MD - Malibu

Jessica McCoy, MD - West Sacramento

Daniel B. Saal, MD - Los Altos

Carolyn A. Schuman, MD - Oakland

David Lee Shepard, MD - Fairfield

Anjali Taneja, MD - Culver City

Phuong C. Truong, MD - Los Angeles

Blue Shield Meets with CSAM to Address Reimbursement Issues

Editor's Note: *The following letter was received following a meeting CSAM held with Blue Shield to address the issue of reimbursement for buprenorphine following 12 months of treatment. Attending the meeting were CSAM President Dr. David Pating, CSAM President-elect and Chair of the Committee on the Treatment of Opioid Dependence Dr. Judith Martin, and CSAM Executive Director Kerry Parker. CSAM wishes to thank Dr. Tom Brady and Suzanne Gelber, PhD, for their assistance in preparation for the meeting.*

December 22, 2006

Kerry Parker
Executive Director
California Society of Addiction Medicine
575 Market Street
San Francisco, CA 94105



Dear Ms. Parker:

It was a pleasure meeting with you and your colleagues a few weeks ago. Blue Shield of California (BSC) considers comments from our providers as an important part of determining medication policy. The discussion regarding the treatment options for opiate-addicted patients as well as the specific dialogue around Suboxone therapy for greater than 12 months was useful. In general, there was broad agreement for Blue Shield of California's current treatment policy, including the role of methadone as well as the duration of Suboxone therapy and our process for extending the length of therapy beyond one year.

As part of the prior authorization process for Suboxone, an initial treatment plan is submitted and as necessary an updated plan is provided at three month intervals. To be more clear with providers, we will be asking specifically for the induction, stabilization and maintenance plan, including a taper-to-discontinuation strategy. When there is a treatment plan that requires greater than one year of Suboxone use, BSC will continue to review these requests on a case-by-case basis.

The mission at Blue Shield of California is to provide our members access to affordable quality care. Medication policies are developed and finalized after exhaustive research of the literature, specialty input on efficacy and safety, and discussion at our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee, comprised of physicians and pharmacists, none of whom are BSC employees, is a mix of specialists and generalists. The committee reviews all of the data and after discussion, votes on the recommendation; the vote of the P&T Committee is binding to the health plan.

Thank you for your offer to be a resource for specialty input in the future. We look forward to our continued professional relationship and appreciate CSAM continuing to serve as a voice for their constituents.

Sincerely,

A handwritten signature in black ink that reads "Geo. Jaresko".

George Jaresko, Pharm.D
Manager, Drug Information

Utilization Review 101: A Practical Guide to Obtaining Benefit Authorization

BY THOMAS J. BRADY, MD, MBA, CHAIR, CSAM COMMITTEE ON ACCESS TO TREATMENT



Utilization Review is the process Managed Care insurance companies use to authorize or deny treatment, or more to the point, for a patient's treatment to be paid for by their healthcare insurance. Employers limit healthcare benefit expenses by purchasing benefits requiring this "gate keeper" review process. Reviews verify

a match between a patient's presenting symptoms, an individualized and targeted treatment plan, and the appropriate treatment, level of care, and length of time needed to accomplish the treatment.

In the ideal Utilization Review process, a healthcare professional presents brief clinical information justifying a treatment plan and the treatment is paid for, in concert with a patient co-pay, by the Managed Care company. Insurance authorization problems can arise, however, in the numerous steps along the way.

For healthcare professionals to be effective in the utilization review process, it's important to know what a patient's benefit package does and does not contain, and also the "rules of engagement" to tap into the benefit. From Managed Care's perspective, they first need to verify a patient's benefit eligibility, and second, ensure that the requested treatment is "medically necessary."

A general definition of medical necessity:

1. To identify or treat an illness that has been diagnosed or suspected.
2. Treatment services are consistent with...
 - a. the diagnosis & treatment of a condition (no experimental treatment)
 - b. the standards of good medical practice
3. Treatment services required are for other than convenience.

Managed Care has a fiduciary responsibility to employer clients to ensure that the healthcare benefits they administer for them are appropriately used. They do this by preserving patients' benefits, adhering to Level of Care Guidelines (the rules of engagement that are available online to both healthcare provider and patient—before your insurance review it helps if you become familiar with the specific guideline and speak to it, as that is what the Managed Care reviewer is doing on their end), and verifying that the treatment is comprehensive and of high quality. Managed Care requests frequent treatment plan adjustments based on frequent re-assessments, and they frown on 'cookie cutter' treatment plans (e.g., 28-days of residential treatment, 18 IOP sessions, medication-assisted opiate replacement for a fixed period of time).

Here are steps a healthcare professional can go through to maximize success in securing insurance authorization:

1. Verify the patient's insurance eligibility and that the treatment requested is a covered benefit. If it's not a covered benefit, stop here as it's pointless to seek authorization.

How do you and the patient know what the benefit covers? You can ask the patient to bring in their benefit coverage booklet sent to them when they enroll in a health plan and review it for them (make sure you're looking at the latest version), or you can telephone the Managed Care company to clarify coverage.

Regarding helping patients understand healthcare benefit coverage/non-coverage in general, I have explained to a patient or two that Managed Care insurance is like the company car that comes with the job for some employees. This car has no air conditioning because the employer decided it was the most economical way to supply more cars to more employees. Now it's July and very hot, and life would be a lot more pleasant with air conditioning. But unless employees are willing to pay for it to be installed themselves, the air is coming from the rolled-down window. Like it or not, Managed Care insurance is an employee benefit similar to that no-option car.

2. Provide clinical information that justifies the requested treatment services and/or medication. Focus on answering the question: "What in the patient's current clinical symptoms, symptom history, and/or prior treatment necessitate the requested medication(s) and/or level of care treatment services for the requested number of sessions?" Be organized, brief, and give only pertinent history. This is not Grand Rounds, but rather hallway morning report from 3x5 cards after a night on call. If you are giving your clinical justification for more than about a minute or two, you're taking too long for both of you.

Be immediately prepared to answer a second question: "Why will an alternative medication, lower level of care, and/or fewer number of sessions be ineffective for this patient at this time?"

Note that rarely will you obtain authorization in one review for an entire course of treatment, such as 12, 18, or 24 IOP sessions. Managed Care wants you to update them with progress reports and perhaps a revised treatment plan, and generally authorizes 3-6 sessions per review and/or for a specific time period. Request subsequent reviews while you still have 1-2 unused sessions "in the bank" and don't wait until after all authorized sessions have been used—it's better to discuss treatment and payment options with the patient when there is a bit of grace time. In certain cases, a Managed Care company allows some flexibility with a benefit (e.g., Suboxone® for Opiate Dependence after 1-

continued on page 13

year, exchanging 1 residential day for 2 IOP sessions) and this is worth an inquiry, again, before the authorization is exhausted or has expired. exchanging 1 residential day for 2 IOP sessions) and this is worth an inquiry, again, before the authorization is exhausted or has expired.

3. If the request is not authorized, request the specific reason(s) and immediately address the reason(s) with further pertinent clinical data. If the extra information doesn't result in treatment authorization, request a Peer-to-Peer Review with a Managed Care Medical Director and make your case again. Take a respectful and collegial tone, stick to the clinical information and your treatment request, and don't engage in a fight with the Managed Care Medical Director. Take an assertive, but not an aggressive nor "hat in hand" approach. Both of the latter tones can result in a denial that need not have occurred.

Managed Care companies are highly regulated by each state, particularly in California. Denial rates are between 2% - 4%. Managed Care Medical Directors try to avoid denials.

4. Stick to your treatment plan when you review with Managed Care. Do not bargain and accept less of a treatment authorization, such as a lower level of care and/or for fewer sessions, or a different medication than requested. It's a slippery slope to start with an inflated initial treatment authorization request and take a "something is better than nothing" approach. You lose credibility and it makes your future Utilization Reviews suspect.

That being said, however, you may decide, if your treatment request is denied and after you have exhausted all appeal options, for example, that 10 authorized sessions of IOP out of the 18 you requested is an acceptable compromise. In this case, state your medical opinion to your patient regarding your treatment plan, maybe also share the no-air conditioning company car story above, and suggest they self-pay for the final 8 sessions. Double-check with the Managed Care company that they have no prohibition against the practice of a patient switching to self-pay for further treatment after an insurance denial. Most companies allow this practice and patients are grateful that at least a portion of their treatment cost is covered.

5. Do not accept a 'pending' treatment authorization--that is, where a Managed Care reviewer neither authorizes nor denies but instead 'pends' your treatment request. You are invited to send in clinical information during or after the completion of treatment, at which point the treatment is authorized or denied. This is tempting to agree to, as it quickly ends what can be a tedious telephone call and is not an actual denial, at least not then. However, with the "heat off," the likelihood of a denial increases. And it is just not right to negotiate with the patient to self-pay after the treatment has been provided and then denied by insurance. The patient feels resentful that you didn't take care of business and it's easier to hand the bill to them rather than their Managed Care company. Likely, you'll end up writing off the loss and being resentful yourself.

6. If your treatment request is denied, appeal as quickly as possible. Learn and follow the sequence of appeals the

Managed Care company offers based on state regulation. Write appeal letters & send documentation that justifies the points raised in your letter. Just as in telephone reviews, keep letters brief and to the point, and even reference specifics from the Managed Care company's level of care medical necessity guidelines. California regulation calls for an Independent Medical Review (IMR) separate and external from the Managed Care company as the final appeal option for non-ERISA¹ benefit plans, after exhausting all other appeals with a specific Managed Care company. Check with the Managed Care company to see if an external IMR is a possibility in the case you are pursuing. With an external IMR, the California Department of Managed Health Care (www.dmhc.ca.gov) contracts with physicians not affiliated with a Managed Care company to review your appeal, and the cost is covered by the insurance company. Again, stick with the clinical facts and focus on answering the questions above.

Don't use appeal letters to attack the Managed Care company or ventilate frustration as this distracts from your clinical case and diminishes your chance for success. Note that approximately 50% of denials are reversed on appeal.

Finally, how can healthcare providers be compensated for their time in securing a patient's Managed Care insurance authorization? In most cases, you can explain up-front to a patient that you will charge them for the time it takes you to accomplish this task, just as you might charge for the time it takes to write a letter or complete a specific medical report they request. However, be sure to first check with the patient's Managed Care company, as some companies permit this patient charge and some don't (but none will pay for the time themselves). In any case, it's not acceptable to charge for a longer visit than is needed to examine the patient and document the session, and then use part of the visit for insurance authorization.

Although the steps outlined above may appear daunting, practice makes perfect and most healthcare providers fairly rapidly develop a pattern of success in Utilization Reviews with Managed Care companies. A rapport and mutual respect develops as in most relationships where the ground rules are transparent, and accepted, albeit reluctantly. Subsequent reviews become easier and less time consuming. It's not uncommon for a Managed Care Care Manager or Medical Director to say "If this authorization request is coming from Dr. Smith, let's approve it as she has always been fair and reasonable."

Managed Care Utilization Review is a realistic necessity for many of our patients and becoming a healthcare provider who is expert at it has, like it or not, become an important aspect of patient care. ■

Dr. Brady is a psychiatrist and Vice President and Chief Medical Officer at CRC Health Group, based in Cupertino, California.

¹ERISA, the Employee Retirement Investment Security Act of 1974, pertains to an employer's self-insured retirement and healthcare insurance employee benefit plan. As a Federal Act, ERISA regulation trumps individual state insurance regulation. In this case, a patient who has an ERISA healthcare insurance plan, also termed an ASO (Administrative Services Only) healthcare plan, administered by a Managed Care company, is not eligible for an external IMR, otherwise required by California's Dept. of Managed Health Care. As a final level of appeal, the ERISA healthcare insurance patient is instead eligible for an internal IMR, conducted by a Managed Care medical director who is different from and does not report to the original medical director who denied the treatment authorization request. If the authorization request is denied at this level, an employee can approach his/her employer directly and ask that the treatment be covered, and the employer's decision is final.

Wilkins Named Endowed Chair

Jeffery N. Wilkins, MD, a member of the CSAM Executive Council, was named an Endowed Chair in Addiction Medicine at Cedars-Sinai Medical Center in a ceremony held there on January 25, 2007. At the ceremony, Dr. Wilkins was described as a scholar, a teacher, a community leader, a physician leader, and the doctor's doctor:



JEFFERY N. WILKINS, MD

A SCHOLAR

- An investigator or co-investigator on over 19 grants or contracts
- An author of 69 peer-reviewed publications
- An author of over 68 abstracts for state, national and international meetings
- The founding Director of the VAMC WLA Clinical Psycho pharmacology Unit

A TEACHER

- Graduates annually between 5-10% of all ACGME- approved fellows in addiction psychiatry in the United States
- Established the alcohol and drug treatment training programs for residents at the Greater LA VAHS, MLK, and Cedars-Sinai for UCLA medical students at the Greater LA VAHS and Cedars-Sinai Medical Center

A COMMUNITY LEADER

- Medical Director, the Comprehensive Homeless Center of Excellence for the Greater LA VAHS
- Research Director, US VETS (a national program providing shelter and care for homeless veterans)
- Course Coordinator, "Biological Perspectives on Dual Diagnosis" a 10-week course for LA County Department of Mental Health and Division of Drug and Alcohol Counselors

A CEDARS-SINAI PHYSICIAN LEADER

- Led the development and implementation of 3 innovative screening and treatment interventions for:
 - Alcohol and sedatives misuse in a major medical center
 - Patients on suboxone/subutex who require surgery
 - Surgical trauma cases

THE DOCTOR'S DOCTOR

- Available to his patients in times of crisis
- Available to his colleagues in time of need

THE MAN

- Modest, caring, highly ethical, generous
- A father and husband
- A son
- A brother
- A musician
- A member of the CSAM Executive Council
- A friend

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Addiction Treatment Belongs in the Community

continued from page 1

already repealed the UPPL regulations that discourage physicians from diagnosing drug and alcohol abuse problems and that shield insurers, but not citizens. Assembly Member Paul Krekorian has introduced AB 1461 in an effort to carry out this recommendation.

Youth Treatment Initiative: Managed care has pretty much dismantled inpatient psychiatric services for teenagers. Yet, as many parents realize all too well, behavior problems, failing school performance, psychiatric symptoms, and drug abuse travel together in today's youth. Teens need treatment programs that are highly structured but not hospital-based, and at much lower costs. CSAM is preparing comprehensive recommendations for improved addiction and dual-diagnosis treatment for California youth.

Insurance Fairness for Addiction Treatment: Federal employee insurance plans have granted parity for over 5 years, and careful studies have demonstrated no increased costs overall. CSAM believes that CalPers, our state employee insurance, needs a wholesale revision of its antiquated addiction benefits.

The benefits profile is incorrectly tilted towards (expensive) inpatient care and shorts outpatient care to 20 visits a year. This needs to be re-balanced in accord with more modern ideas that show greater effectiveness from outpatient services. And, we believe that it is time to require insurance companies to provide coverage for substance abuse treatment at the same levels as they insure for other medical illnesses. The bill, AB 423, is authored by Assembly Member Jim Beall, Jr.

Proposition 36, Treatment Rather Than Incarceration

Initiative: I used to say that a year in a California prison cost somewhere between UC Berkeley and Stanford. Recently, I learned that at over \$43,000 per year the cost of incarceration has just surpassed a year at Stanford. Recently, many of us read the devastating report from the Inspector General on the dismal state of so-called "in-custody treatment," a billion-dollar boondoggle.

It reminds us that the rhetoric of treatment is not the same as real treatment. The report found that the California Department of Corrections and Rehabilitation has provided such poor drug treatment services behind bars that the services had no positive impact whatsoever, despite a \$1-billion price tag. As doctors specializing in substance abuse problems, we recommend that treatment be provided within the community whenever possible. Community-based treat-



ASSEMBLY MEMBER JIM BEALL, JR. (D-SANTA CLARA) ANNOUNCING THAT HE HAS DECIDED TO ADD SUBSTANCE ABUSE TREATMENT TO HIS MENTAL HEALTH PARITY BILL (AB 423). HE RECEIVED A STANDING OVATION AT CSAM LEGISLATIVE DAY.

ment is not only effective at reducing drug abuse behavior but also costs far less than incarceration.

Each year through Prop. 36, over 36,000 people convicted of a non-violent drug offense access treatment, half of them for the first time. UCLA research showed that Prop. 36 has saved California at least \$800 million over five years—between \$2.50 and \$4 per \$1 invested. And, by July 1, the program will have graduated over 72,000 people. According to UCLA, those who complete Prop. 36 treatment are twice as likely to be employed.

CSAM has opposed bogus improvements to Prop. 36, such as incarcerating participants for relapse. For some constructive improvement recommendations, visit our website.

No Good Deed Goes Unpunished: We are acutely aware of California's budget crisis, but the Governor's proposal to cut funding to Prop. 36 this year is unfortunate. Not only is he cutting \$25 million off the top, he plans another hidden cut, by requiring county matching funds before any state spending on Prop. 36 can be dispersed. (Does anyone really believe that counties will increase sales taxes to make this happen?)

CSAM hopes that the legislature will not permit cutting off the oxygen from Prop 36. It saves money, it rescues squandered lives, and it can help us avoid building more prisons to house non-violent offenders.

Peter Banys, MD, MSc, is a member of the Executive Board of the California Society of Addiction Medicine and the American Society of Addiction Medicine. He is a Health Sciences Clinical Professor of Psychiatry at UCSF and is listed in Best Doctors in America.

Visit the CSAM website at www.csam-asam.org for links to the legislation and reports mentioned in this article. ■



New Director of the CA Department of Alcohol and Drug Programs Renee Zito spoke at CSAM Legislative Day. Zito replaced Kathy Jett who was appointed to the newly re-organized Division of Addiction and Recovery Services within the California Department of Corrections and Rehabilitation (CDCR).

CSAM State of the Art Course in Addiction Medicine

October 17-20, 2007
Sheraton Universal Studios, Los Angeles

Conference Chair: *Lori Karan, MD*
Vice Chair: *Stephanie Shaner, MD*

To find out about newly scheduled regional meetings and other courses offered by CSAM,
visit: www.csam-asam.org where registration is available on-line.



CSAM

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