

## Update on Medical Board's Diversion Program

*[Editors Note: The Medical Board of CA Physician Diversion Program is undergoing extensive restructuring brought on by a recent unfavorable external audit that uncovered a number of deficiencies in the Program. The audit, entitled the Enforcement Monitor's Report, is available on the Medical Board of CA's web-site. Many of the weaknesses identified within the audit were related to understaffing brought on by the hiring freeze of the past two years, and the shortage of resources dedicated to the Program.*

*The environment is now changing. A new Program Administrator is now on board, administrative staff has been augmented, case manager vacancies have been filled and it has been determined that, despite the monitor's assessment to the contrary, an accurate count of participants who need monitoring reveals there are sufficient case managers (5) to handle the caseload (1 per 50 cases) within the norm for appropriate monitoring.*

*In addition, CSAM has been working with the CA Medical Association (CMA) and the CA Psychiatric Association (CPA) in an advisory role to support the Program's re-design and ensure that the Program continues to serve the physician community, as it strives to protect the public. The Medical Board has asked CSAM to give a presentation on the Diversion Program at its May meeting.*

*In an effort to strengthen the Program, a proposal was initiated by the Santa Clara County Medical Association's Physician Well-Being Committee earlier this year, that seeks to integrate a medical model in which Addiction Medicine physicians would be involved in the assessment and monitoring of program participants. CSAM, CPA, and CMA are*

*Continued on page five*

## Proposition 36 Revisited

**T**he Substance Abuse and Crime Prevention Act, also known as Proposition 36, was passed by 61% of California voters on November 7, 2000. This initiative allows first and second time non-violent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. Proposition 36 allocated \$120 million annually for five and one half years to pay for treatment services. However, due to the large disparity between incarceration and treatment costs, it was estimated that the initiative will save California taxpayers \$1.5 billion over the five-year period.

The allocation of funds for treatment expires in fiscal 2005-2006. A number of bills have been introduced in the legislature to refund Proposition 36. However, not all of the bills so far introduced are driven by a desire to further the mission of Proposition 36. Some legislation, backed by law enforcement, aim to turn back Proposition 36 and to move back toward a crime and punishment mentality in dealing with substance abuse.

CSAM has been very vocal in support of Proposition 36. CSAM's President (at the time of the initiative) Peter Banyas, MD wrote a statement on behalf of CSAM that appeared in the voters' handbook. Gary Jaeger, MD, Chair of CSAM's Committee on Public Policy appeared on television spots for the initiative.

In approving Proposition 36, the majority of California voters defined drug abuse as a medical and public health problem deserving of medical responses. As physicians we cannot agree to restore the failed criminal justice approaches inherent in the three decade long "War on Drugs."

"Jail is a blunt and expensive

instrument. If you are a hammer, everything looks like a nail. Clinicians have a broader range of tools in their toolboxes," Dr. Banyas recently wrote in a letter to the Chair of the Senate Committee on Health.

### Proposition 36 is Working

According to a study of Proposition 36 by UCLA, about half of clients in the program's first two years were entering treatment for the first time in their lives. In the most recent year, first-time clients were more commonly Hispanics, men, younger drug users (over half were 35 years of age or younger) and methamphetamine users. Many first-time clients have a drug use history of 10 years or more.

Nearly three out of four clients entering Prop. 36 treatment make substantial progress and reach positive outcomes. Just over a third (34.4%) complete their treatment. Another 8% are discharged from treatment with a rating of "satisfactory progress." Almost a third more (29.8%) receive what UCLA researchers call a "standard dose" of treatment, in this case meaning they spend the same amount of time in treatment as people who complete treatment. This is a respectable mix of outcomes that shows treatment dollars are being well-spent. Remember, a month of incarceration is far more expensive to California than a month of even the most intensive treatment.

Proposition 36 compares well with other systems linking treatment and criminal justice. The Proposition's 34.4 percent completion rate is virtually the same as the rate for all other criminal-justice referrals. Drug courts had a 41.8 percent completion rate statewide — albeit with a much smaller, handpicked group of drug offenders.

*Continued on page six*

# CSAM Public Policy Advocacy Day III

## Taking the Voice of Addiction Treatment to the State Capitol

BY DONALD J. KURTH, MD, FASAM  
PRESIDENT, CSAM

On February 2, 2005 one hundred and thirty five Legislative Day III physicians and health care professional assailed the hallowed halls of the California state legislature to press for better addiction treatment public policy. Organized by CSAM Past President and Public Policy Committee Chair, Gary Jaeger, MD, FASAM, CSAM joined co-sponsors O.A.S.I.S. and Drug Policy Alliance to bring addiction issues to the forefront of Sacramento discussion. Many thanks to Kerry Parker, Michael Barack, and all the volunteers for helping to organize and coordinate the massive event.

CSAM Public Policy Committee members met the night before for a dinner meeting and last minute planning session. Legislative Day began with a press conference and television interviews which included Senator Wes Chesbro, CSAM President Don Kurth, MD, O.A.S.I.S. founder and CSAM member Diana Sylvestre, MD, Drug Policy Alliance Sacramento Director Glenn Backes, and an O.A.S.I.S. member-in-recovery.

"I challenge our Terminator Governor to terminate drug and alcohol dependency in California!" said Don Kurth, MD "A thousand Californians a month die from this treatable disease and the time has come to stop these needless deaths." Television reporters asked Senator Chesbro if he would take these issues to the people in ballot initiatives if the governor failed to act and improve addiction treatment public policy in California.

KQED (San Francisco), KFBK (Sacramento), and Channel 3 NBC-TV, UC Berkeley, and the Democratic Caucus film crew all covered our Advocacy Day at the capitol and KFBK ran the story three times throughout the day. The event was also covered by PAC SAT/ Capital New Service, which then followed a volunteer and recovering person through the state capitol for the entire day.

Public policy talks followed at the Sheridan Grand Hotel and national speakers included Eric Goplerud from the Center for Health Services Research and Policy at

George Washington University who flew to Sacramento specifically to join our Legislative Conference to speak on the repeal of the UPPL in California.

Several talks focused on the stunning success of CSAM initiative Prop 36 which has been widely acclaimed by legislators and press alike, not just for saving millions of dollars for budget strapped California, but saving many thousands of lives as well. "Building prisons to solve addiction is like building graveyards to solve AIDS," said D.P.L. spokesman Glenn Backes in his appeal to refund and expand this revolutionary treatment in lieu of incarceration program enacted with strong CSAM support by the people of California three years ago by a 61% majority.

Of the 135 CSAM members and other health care professionals in attendance, 85 were able to attend from southern California as a result of a Tides Foundation travel grant secured by CSAM's 2004 Vernelle Fox, MD



CSAM PRESIDENT DONALD KURTH, MD (AT PODIUM) ADDRESSES PRESS CONFERENCE. FROM LEFT: SIMEON GANT, SENATOR WESLEY CHESBRO, GLENN BACKES (DRUG POLICY ALLIANCE), DIANA SYLVESTRE, AND MARY LUTE.

Award Recipient Diana Sylvestre, MD and D.P.L. leader Glenn Backes.

Issues discussed included support for addiction treatment parity, repeal of the UPPL, continued support and expansion of the very successful Proposition 36 treatment in lieu of incarceration initiative, education for expansion of the needle sales/exchange laws, and our voice against combining the Department of Substance Abuse Programs with the Department of Mental Health Programs. Generally, our points were well received. But,

*Continued on page three*

## Advocacy Day III

Continued from page one

it was clear that a great deal more education of our policy makers would be necessary for all of them to really understand the magnitude of the issue at hand.

CSAM members and health care professionals attended scheduled visits with over 30 newly elected legislators to educate them about a variety of topics. Another 15 plus unscheduled impromptu visits were attended as well and many participants were able to establish or reinforce ties with their own hometown legislators.

A group of CSAM physicians also met with David Link, Chief of Staff of Senator Liz Figueroa's Joint Committee on Boards, Commissions, and Consumer Protections, the committee reviewing the Medical Board of California and the Physician Diversion Program. The meeting went very well and many misconceptions appeared to have been corrected.

CSAM Legislative Day, the very first state addiction medicine grassroots lobbying effort of its kind in the country, has once again brought your addiction treatment issues to the forefront of our legislators' minds. CSAM is working to find practical, science-based solutions for California's greatest single public health problem today—the disease of addiction and alcoholism. We will be back next year to again bring your issues to the Governor's desk. Think about joining us then. You will have fun, contribute to the lives of millions of Californians, and enjoy an experience that you will remember for the rest of your life.

*Donald J. Kurth, MD, FASAM currently serves as President of the California Society of Addiction Medicine and well as Chairman of the Legislative Advocacy Committee and Treasurer Elect of the American Society of Addiction Medicine. He serves as Chief of Addiction Medicine at the Loma Linda University Behavioral Medicine Center and holds a facul-*

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OVER 100 ADDICTION TREATMENT PROFESSIONALS ATTEND TREATMENT ADVOCACY DAY. FEBRUARY 2, 2005



PATIENT ADVOCATES FROM THE OASIS CLINIC IN OAKLAND LOBBY LEGISLATORS (FROM LEFT TO RIGHT ARE MIKE BALDWIN, KENNETH SCHNELLE (REAR), KATHY ARATA, AND GUY MOTOR).

# Meet Frank Valine: New Program Administrator of California Physician Diversion Program

BY DONALD J. KURTH, MD, FASAM  
PRESIDENT, CSAM

**F**loundering and adrift without a permanent program director for almost a year and rocked by the scathing report of the Enforcement Monitor released in November 2004, the California Diversion Program finally has a captain to man the ship. And Frank Valine is just the man to do the job.

Who is the man, unknown to most of us around the state, who is willing to take the helm in these stormy seas? What qualifies him for this unique position —halfway between enforcement and not quite treatment — charged with protecting the California public but also with salvaging the lives of once productive and even revered physicians who have fallen from this fatal malady we call alcoholism and addiction?

Frank Valine was born and raised in Sacramento. His mother, Myrtle Valine, founded and operated the very first recovery home in Sacramento in 1956 when Frank was only twelve years old. His mom had gotten sober in 1953 and jumped into Alcoholics Anonymous with both feet, perhaps partly to find a way to help her husband get sober as well.

“I would come home from school and find the garage filled with newly sober guys my mother had brought home from AA because they didn’t have a place to stay,” says Frank with a recollecting smile. “My dad drank for another three years after she founded “Myrtle’s House” recovery home,” explains Frank, “But he finally got sober after his porta-caval shunt in 1959 and he stayed sober until he died many years later.”

“I have been around alcoholism all my life and I have seen what it can do to people’s lives,” explains Frank, “but I have also seen the process of recovery work in peoples lives as well.” After graduating from Citrus Heights High School, Frank joined the Army and served in Okinawa, Japan through the beginning of the Viet Nam war. When he returned stateside, he attended American River College in Sacramento, then went on to graduate from Sacramento State in 1969 with a BA in Correctional Work and Administration.

He worked for the California Youth Authority at the



**“I have been watching the process of recovery work in people’s lives since I was twelve years old.”  
— Frank Valine**

Perkins Reception Center as a group counselor for a couple of years, then on to a career at the San Joaquin County Department of Probation. Always dedicated to education, Frank first earned his CADAC II and NCAC II, then went on to do graduate work Chapman University during this time. He rose through the ranks and became Supervisor for Juvenile Intake for the County during his last four years and retired in 1999 at age 55 and began to look around for something interesting to do.

He worked briefly with the PC 1000 program and worked with the DUI program for a while. The San Joaquin County Superior Court Judge then appointed him as a Traffic Hearing Commissioner for adolescents, where he served for several years.

Always looking for a yet greater challenge, Frank then saw the need and took on the task for writing the successful proposal for the Adolescent Juvenile Drug Court Program for San Joaquin County. He put together a consortium including the Departments of Education, Substance Abuse, and

Probation and developed a model program that is still in place today. As an outshoot from this, he began working in drug testing and actually learned how to do the drug testing himself during this time, becoming expert in this area.

Frank’s career has been dedicated to helping people who are caught up in the criminal justice system get into recovery and straighten out their lives. Late last fall Frank read a copy of the Enforcement Monitors report. Did he throw his hands up in despair? No, not a chance!

“Hey, this can be fixed!” Frank said to himself and he put in a call to Medical Board Executive Director David Thornton to find out how to apply. “Sometimes it just takes somebody from outside with a fresh perspective to cut to the chase. I see Diversion becoming a viable program throughout California, and even expanding in the future.” In time, “we need to make some changes to the Action Report to be more open and encouraging to self-referrals” and to the program as well. Throughout his career, Frank has always found ways to work within the system to incorporate innovation without rocking the boat. He is just the captain Diversion needs at this point in time.

Frank Valine has never met a challenge he didn’t like. His tough-as-nails approach to personal accountability will go a long way toward satisfying the concerns of the Enforcement Monitor. However, his compassion for those who suffer from this fatal disease shines through from deep within his soul.

## Diversion Program Update

*Continued from page one*

currently reviewing the proposal. CMA's House of Delegates recently supported its principle concepts.

A final report from the Enforcement Monitor will be available in November. Following is an excerpt from a response prepared by CSAM's President Donald Kurth, MD to the Enforcement Monitor's preliminary report. The full text of the response can be viewed on CSAM's website at [www.csam-asam.org](http://www.csam-asam.org).

## California Physician Diversion Program Sets Standard for the Nation

The California Physician Diversion Program has been the standard by which some other state physician diversion programs have been modeled and its philosophy of supervision, monitoring, and treatment has been adopted by more than 400 drug courts across the United States. As noted in a respected journal early in the Diversion Program's history:

"Since January 1980, following a change in California law, impaired physicians have been given the opportunity to be diverted from possible medical board discipline into a statewide treatment program financed by the Board of Medical Quality Assurance (BMQA). The success of the program has depended on a rapid response mechanism, an individualized treatment program, an ironclad confidentiality, and a multilevel

monitoring program. This non-disciplinary approach has made it easier for physicians to encourage their sick colleagues to volunteer for treatment. The experience after 24 years indicates that impaired physicians are found and treated more quickly when legal restrictions against one's license are avoided."

Throughout the Program's 24-year history, there have been no reported cases of harm to patients by physicians participating in the Diversion Program. However, patients could be endangered when the Program's staffing and resources are too low to ensure proper implementation of participant monitoring. By removing the impaired physician's fear of legal discipline and its attendant publicity, the California Diversion Program for Impaired Physicians has fostered a speedier recognition and treatment of the sick doctor.

The 24-year experience with the program has more than justified its cost and effort. Physicians who have been diverted from the possible BMQA discipline have not required an extensive investigation or an expensive legal hearing. This has resulted in substantial budgetary savings for the BMQA.

The most surprising result from the program's experience is the negation of the prevailing idea that impaired physicians cannot safely practice medicine while undergoing treatment. When a physician's outpatient rehabilitation treatment is individually tailored to meet his needs, and an appropriate supportive monitoring system is in place, "impaired" physicians are

*Continued on page seven*

## Summary of Response to Enforcement Monitor Report

**The Physician Diversion Program is an essential option and must be maintained.** The idea of having no such alternative for physicians suffering this illness, would create enormous public safety issues, sending physicians needing treatment to go into hiding in order to protect their licensure and their livelihood. California law, in addition, supports the rehabilitation of physicians consistent with public protection.

**The Program has literally been starved** – the root cause of the problems identified. The EM's report identifies program deficiencies caused by insufficient staffing and resources that are required in order for the program to operate effectively to protect the public.

**Maintain the focus of the Program** – the one for which it was initially created – to monitor physicians who seek treatment for substance abuse. Inclusion of participants who have mental health illnesses is beyond the intended scope of the Program and should be halted unless there is proper funding and appropriate staffing to address the needs of this unique population.

**Confidentiality of voluntary participants is an essential element of the program and can draw participants who might not otherwise admit their illness.** We strongly urge separation of enforcement staff from diversion program staff in order to ensure confidentiality.

**That case managers caseloads must be held to manageable and appropriate levels.** Internal quality controls can be ensured when case managers workloads are held to appropriate levels.

**Random Drug and Alcohol Screening is an essential part of ensuring the quality of the program and protecting the public.** It must be properly implemented in order for the program to function as intended.

**We support a licensing fee increase.** However, any fee increase must be tied to the continuation and proper funding of the Diversion Program.

# Proposition 36 Success Stories

**Mary (Sacramento):** During the years Mary was using she didn't even show up at her family's home for the holidays. This year, Mary is caring for her two sick parents during the day, and at night she will be celebrating and cooking a holiday meal for the women in the residential treatment house where she now works. Mary started using drugs at age 38 and was arrested for the first time in her life at age 45. With the option of entering treatment through Proposition 36, Mary went into recovery. This February Mary celebrated three years clean and sober. Mary went back to school in the field of recovery, got her certification, and has been working in a recovery house for the last two years.

**De Andre (Los Angeles):** As a user of crack cocaine, De Andre was well known to police officers in Los Angeles— he had begun using at the age of 20. He's now 28, and since being offered treatment through Proposition 36 in April 2004, he has been getting his life back on track. He now has a job and is going to school, and says he is grateful for receiving treatment because he can now spend more time with his two daughters. De Andre admits that if it weren't for Prop 36 he would "probably be running the streets or dead."

**Gary (Riverside):** Gary used drugs for 30 years before he was able to turn his life around. He had lost job after job, as well as his home, and was living in a tent in a canyon when he was picked up on possession charges and offered the choice between years in prison and treatment through Prop 36. Gary was 47 when he entered treatment. After completing a residential program, he was able to move in with his daughter and meet his grandchildren for the first time. He graduated from Prop 36 in February of 2003, and he now has his driver's license, owns two vehicles, has a job and rents an apartment.

**Sam (Oakland):** In January Sam completed his 12 month residential program and became a Proposition 36 graduate. During the program he obtained his GED, went to trade school, graduated and is now part of the carpenter's union. He specializes in installing fireproofing insulation. His counselor beams as he describes Sam's successes, "He is receiving a pension and benefits and making good money. He saved enough money to buy his own vehicle and is now saving to move into his own apartment." Before entering Prop 36, Sam lived on the streets. When he was brought in on a possession charge and his public defender offered him Prop 36, he decided to enter treatment. Sam will celebrate the holidays with his family this year. After not having seen his seventeen-year-old brother for seven years, he now regularly takes him to the movies on the weekends.

## Proposition 36 Revisted

*Continued from page one*

Data show that Proposition 36 clients are more severely addicted than those in drug court.

Most importantly, Proposition 36 has saved the lives of many people. "Before I entered Prop 36 I never saw my family during the holidays," said Gary, 47, a Prop 36 graduate who had used drugs for 30 years. "Yesterday I bought toys for my grandchildren. I am now a productive member of society." (For more Proposition 36 success stories see sidebar.)

## CSAM Opposes SB 803

CSAM is strongly opposing SB 803 (Ducheny) as presently drafted, because it seeks to roll back the defining 'treatment rather than incarceration' component of Proposition 36.

Some in law enforcement have argued that SB 803 will simply modify Prop 36 to follow the drug court model. However, returning incarceration options to regular judges will in no way make them into the more complex and more expensive drug courts. The drug court model has many interventions and sanctions available beyond 'flash incarceration.'

Drug Courts, because of their expense, never accounted for a significant part of the criminal justice system. Prior to Prop 36, drug courts were processing only about 3% of eligible cases in California.

SB 803 overrides the current law's clear ban on incarceration early in the treatment and recovery process, allowing courts to jail defendants for up to 21 days for early signs of relapse. There is no evidence for the efficacy of jail sanctions. Although there is research evidence supportive of drug courts in general, the use of jail time as a 'sanction' to enforce treatment compliance is not supported. Drug courts around the nation have been using this tool for over 15 years, yet not a single study isolates the impact of jail sanctions in generating improved treatment outcomes.

There is clearly a role for incarceration in drug policy. However, incarceration is not treatment. As CSAM member Diana Sylvestre, MD wrote, "I went through 4 years of medical school, 2 years of residency, and 5 years of fellowship, all at top locations. In all those years, and with all of those lectures, I did not receive a single lecture on jail. That is because jail is not treatment, it is PUNISHMENT. I could get my fat patients to lose weight if I locked them in a cage. Would you call that a treatment for obesity?"

CSAM objects to a number of other aspects of SB 803 which would undermine the intent of Proposition 36 by:

- Excluding a large number of nonviolent drug offenders now eligible for treatment, sending them to jail or prison. People who are currently eligible for treatment under Proposition 36 could face three-strikes 25-to-life sentences if SB 803 becomes law.
- Making dismissal of charges more difficult. The language adds a new standard for total abstinence after treatment discharge. Though an idealistic goal, this deprives judges of the ability to respond to relapse, a common occurrence in all chronic disorders, and still offer dismissal later.
- Impeding access to employment for people who

*Continued on page seven*

## Proposition 36 Revisted

Continued from page one

successfully complete treatment, using vague language requiring disclosure of a conviction even after successful treatment completion and dismissal by the court

- Allowing courts to order up to 10 days in confinement for detoxification. There is no requirement for medical recommendations or guidance to be heard or heeded; medical input is, quite offensively, treated as an afterthought.

## CSAM Supports SB 556

CSAM is strongly in support of SB 556 authored by Senator Carole Migden. SB 556 is in the spirit of the original proposition while strengthening it by correcting some of its problems.

For example SB 556 would authorize a court to impose treatment beyond 12 months (as provided in the current law) to a period of treatment and aftercare to not

exceed 24 months.

Under Proposition 36 some courts were refusing to set aside the conviction of a defendant who completed treatment but was in narcotic replacement treatment. Migden's bill clearly specifies the conditions under which a defendant undergoing narcotics replacement treatment would be deemed to have successfully completed treatment.

A problem with Proposition 36 was that no funds were set aside for drug testing, which CSAM believes is an essential component of treatment. This bill would allow a county to spend up to 12% of its allocated funds for those provisions on costs or services other than drug treatment, training, counseling, or housing for defendants.

CSAM members John J. McCarthy, MD, Christy Waters, MD and Gary Jaeger, MD have testified in recent days on the Proposition 36 bills. CSAM will continue to keep you informed on these bills which will have a big impact on the future of substance abuse treatment in the state.

## Defending Diversion Program

Continued from page five

not impaired, and can safely practice.

"Voluntary" coercion by the BMQA does not turn off physicians who are potential self-referrals. Also, hospital executive committees and department chairmen are now more inclined to urge an impaired colleague to voluntarily apply to the program in lieu of suspending his or her hospital privileges. The existence of a confidential Diversion Program has permitted many concerned physicians to encourage their sick colleagues to self-refer. Finally, the program has brought the medical profession one step closer to the goal of healing itself (Gualtieri, et al., *Journal of the American Medical Association*, v. No., January 1983.)

## Situational Analysis

### Budgetary and Staffing Crises

Over the past few years, the Diversion Program has been faced with tremendous budgetary pressures and staffing shortages. As a result, some policies were modified to adapt to the availability of limited resources. For example, the Program Manager served as a Case Manager for a period of six months, due to a staffing shortage in one region. During this time, the Deputy Executive Director of the Medical Board of CA, took over the responsibilities of the Program Manager. This caused a "blurring of the lines" between the Diversion Program and the Enforcement side of the Medical Board and raised concerns about protection of confidentiality of physicians voluntarily involved in the program.

### Physicians with Mental Illness Added to Program

In addition, pressure was placed on the Program's staffing and resources in 2003 with the passage of legislation that required it to accept referrals from the

Enforcement Division of physicians who had been diagnosed with mental illness. A representative of the CA Psychiatric Association was invited to join the Liaison Committee, however, no additional funding was provided in order to increase Diversion Program staffing levels or to recruit the clinical experts to serve this new group of participants. The addition of this group of participants added greater responsibility to the already overburdened Program that continued to operate with a staffing and resource shortage.

### Selection of Biased Enforcement Monitor

Previous to her position as the Enforcement Monitor, Julie D'Angelo Fellmeth has been a public interest advocate who has been publicly critical of the Diversion Program for almost a decade. She has taken a long-standing role of questioning the Program's ability to protect the public from impaired physicians. She was often quoted in newspaper articles attacking the Program and its effectiveness with regard to recidivism and recovery. Her well-known bias opposing the Program has raised many concerns about her ability to fairly evaluate the Program and issue a well-balanced report to the CA Legislature.

### Program Manager Resignation

During the course of the review by the Enforcement Monitor, the Program Manager, Laura Choate, tendered her resignation. Prior to her departure, she speculated that the Enforcement Monitor would raise issues such as: insufficient number of drug screenings, higher relapse rates, etc. Her resignation has resulted in an administrative loss to the Program. While deficiencies may have existed prior to her departure, often related to budgetary and staffing shortfalls as previously described, the management void created by Ms. Choate's untimely departure certainly contributed to the negative statistics quoted by the Enforcement Monitor's report.

## California Colleague Writes Novel



### REVIEW

BY JUDITH MARTIN, MD

In the exact center of this novel a thinly disguised famous Stanford researcher named Gavril Bernstein sits down with a frantically concerned young man and explains the neurophysiology of opiate addiction. Not surprisingly, he does a pretty good job of it, and few CSAM members would find fault with the medical data presented here, although novel readers might object to the presence of “data” in the middle of their story.

Descent is a tale based on the legend of Orpheus and Eurydice, where Eurydice (Erin) is a young college student who falls hard for a musician (Chris) whose day job is immunology research. We watch Erin as she sinks ever deeper into her addiction, and later as she surfaces during various treatment episodes. The development of loving and supportive relationships is shown clearly. There are explicitly sexual moments, there are dinners with family, and chats over coffee with friends. These are things we might do with our own friends or parents, there is a familiar quality to the situations. As befits a story that includes an ‘Orpheus’ character, the love of music is vividly conveyed. And as in other artistic renderings of opiate addiction, there are graphic descriptions of injecting heroin and of getting high.

Avoy’s most luminous portrayals are of daily experience in the methadone clinic. The dispensing nurse calls Erin ‘honey’. Closely held secrets leak out little by little in the women’s support group. Patients get irritated while waiting in line to take their daily methadone dose. The stigma attached to methadone and the brutal limits of regulations and clinic rules are felt. The sections of the novel that provide inside glimpses into this little-known area of addiction treatment are quite moving.

The protagonists live in a California that will be familiar to CSAM members. CSAM members will professionally ‘know’ the characters in this novel: the supportive parents, the recovering professional who runs a group, the concerned lover, the caring physician who will always go the extra mile, and the well-meaning one who rigidly sticks to the rules. They may also know the author, Don Avoy, a hematologist who trained at Stanford and who now lives in San Jose and works at a methadone clinic run by the county of Santa Clara.

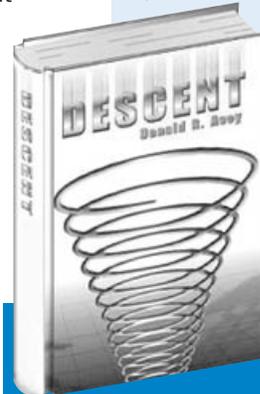
In summary, this short novel, written by one of our colleagues, depicts opiate addiction, and the treatment of opiate addiction. It includes some – perhaps too many – didactic conversations that cover lots of addiction-related information. Most interestingly, it gives us a rare glimpse into methadone clinics, the professionals who work there and the patients who are treated there. Caveats: there are some vivid descriptions of injecting heroin and getting high, and those who notice typos will find a light sprinkling of them.

## Interview with Dan Avoy

Following are responses by Don Avoy to questions submitted to him by Judith Martin.

**Martin:** I think CSAM members would be interested to know why you wrote this book, and how did you come up with using the Orpheus and Eurydice legend as inspiration?

**Avoy:** When I began this journey into the world of addiction medicine, I was almost completely ignorant about the neurobiology and the molecular biology/pharmacology. As I learned more I was really surprised at how little the patients, and their families knew about the



### Donald R. Avoy, Descent.

Denver: Outskirts Press, 2004., 260 pages, \$15.95 paper, \$23.95 hardcover.

process. I was appalled at how my medical colleagues were willing to substitute negative stereotypes for that indispensable core of the physician/patient relationship—understanding and compassion. So, having done some other fictional attempts, I decided to try to write something that would contribute to better understanding of this incredibly complex field, and maybe to moving the system a bit closer to what it might be. With regard to my use of the wonderful legend of Orpheus and Eurydice, I have always been fascinated that literature could survive through the cen-

turies and still be so relevant and compelling. So, I thought I’d see if there was one that could be adapted, I hope not mal-adapted, to what I wanted to achieve.

**Martin:** I wasn’t sure I liked the conversations that were a bit didactic, they seem to interrupt the story, and I wanted to know what happens next, but on the other hand, a lot of patient education type of material is covered. How do you see this fitting into the novel? Do you see using this book with patients? Have you done so with your own patients?

**Avoy:** That’s one of the most difficult parts about this effort. The two goals are a) to educate/inform and b) to capture the imagination and the emotions of the reader and to do so in such a way that they don’t hinder each other. What I attempted to do was to make the didactic parts as conversational as possible and to present them in an appropriate realistic context. Whether I have succeeded or not is really up to the reader. I have to count on there being some intrinsic motivation to want to learn more about

Continued on page nine

## Interview with Dan Avoy

*Continued from page eight*

addiction. That can be from patients, families, and others new to the profession who want to begin their intellectual adventure. I also hope it can be informative to those working in the criminal/justice part of our world.

**Martin:** *Tell us a bit about your work, your own career, and what you are excited about doing in our field.*

**Avoy:** As I revealed above, I have always been drawn to those parts of our profession in which you can take the majesty of molecular biology to the bedside and have a positive impact on your patient's lives. That initially drew me to hematology and oncology. Later, I turned away from the bedside and spent some years in the public sector, in blood transfusion, and still later, in clinical research in the pharmaceutical/ diagnostic world. One of the things I most enjoy about my present work, in addition to the molecular biology, is being back with patients on a one to one basis. It was really wonderful to find that I still had the same reverence for the doctor/patient relationship, and the great privilege I feel it is to be someone's physician.

**Martin:** *As you can see from the review I wrote, I appreciated reading such a vivid description of the ins and outs of methadone maintenance. Even some CSAM members might not know what goes on in a methadone clinic. What kind of reception have you had to this part of the story so far?*

**Avoy:** It has been gratifying to receive positive responses from my professional colleagues which validates that dimension of the effort. But, also very gratifying has been the response from people with no scientific background who found themselves engrossed in what addiction is on a day to day basis, not merely as a sociological, statistical, demographic phenomenon.

**Martin:** *Is there anything you would say to CSAM members that I haven't asked you?*

**Avoy:** Just this. One of the burdens our patients carry, is the stigma of not only their addiction, but also, in many cases, of their treatment with methadone. We, in the field, are the repositories of the knowledge and information that can erode the prejudices that wound our patients. I think we must all look for opportunities to educate our colleagues and the public about the realities of addiction. Thanks for asking. And thanks, most sincerely for your interest in my project.

*Judith Martin, MD is Medical Director of the 14th Street Clinic and East Bay Recovery Project in Oakland. She is the Chair of CSAM's Committee on the Treatment of Opioid Dependence.*

## CSAM Guideline Published

The 2005 edition of the CSAM Guideline for Physicians Working in California Opioid Treatment Programs is now available from the publications section of CSAM's website. The 85-page document is the work of CSAM's Committee on Treatment of Opioid Dependence and of Deborah Stephenson, MD, MPH, the project editor. The guideline was developed with review and comment by all interested parties, including the California Department of Alcohol and Drug Programs and the Center for Substance Abuse Treatment (CSAT).

J. Thomas Payte, MD, of ASAM's Subworkgroup on Opioid Agonist Treatment, said, "Congratulations on what I feel will be the single most significant clinical contribution to OAT that I am aware of. Overall, it is excellent and like a breath of fresh air in contrast to much of what has gone before."

The guideline covers all aspects of methadone maintenance treatment, including treatment of concurrent medical and psychiatric conditions and co-morbid poly-substance use, treatment of pregnant women, and treatment with buprenorphine in an opioid treatment program (methadone maintenance treatment program.)

The full document can be downloaded from the publications section of the CSAM website ([www.csam-asam.org](http://www.csam-asam.org)). Copies in booklet format are available at cost from the CSAM office.

### WELCOME NEW MEMBERS

**Laja Ibraheem, MD,** Palos Verdes Peninsula

**Blake Berman, DO** San Bernardino

**Suzie Schuder, MD,** Newport Beach

**Roderick Pettis, MD,** San Francisco

**Mary Idso MD,** San Jose

**Edward Eaton, MD,** Mather

**Jason Stone, MD,** Los Angeles

**W. Emory,** Thousand Oaks

## LETTER TO THE EDITOR

Dear Sirs:

I am writing in response to Dr. Timmen Cermak's piece on the Narconon drug education program. I am a member of CSAM. I am board certified occupational medicine specialist, and over the last two decades I have treated thousands of addicted individuals at my practice. I am also chairman of Narconon's Science Advisory Board.

Dr. Cermak mentions at the outset that he is unfamiliar with Narconon. I'm sorry that he did not have the opportunity to consult with me or others who do know the organization before writing his article. I can only assume that Ms. Asimov is responsible for the various misperceptions and untruths that Dr. Cermak reports.

Based on more than 20 years of experience with Narconon, I would like to offer the following clarifications in the interest of accuracy and for the benefit of your readers.

Narconon drug education is funded by public donations. Details are filed each year in the Form 990 which all non-profit organizations must submit to the IRS. Narconon International, which provides guidance regarding this work, is funded entirely by licensing fees received from more than 120 Narconon rehabilitation and prevention centers in 40 countries. These centers generate revenue through fee for service delivery or government grants.

The Narconon materials do not include religious content, a fact recently confirmed by Charles Haynes, PhD, senior scholar for the First Amendment Center. After fully reviewing the Narconon materials (an advantage Dr. Cermak did not enjoy), he wrote: "Simply put, I see no First Amendment issue here. These materials do not, in my view, promote the religion of Scientology."

The content of the presentations was also mischaracterized. The suggestion that they are based on promoting fear, the basis of several paragraphs of editorializing and a pull quote, is entirely untrue. Narconon has rejected this approach for more than three decades – in fact, it was one of the first groups to do so.

Narconon assumes that what students need is information. Although Dr. Cermak makes a blanket challenge to the information Narconon presents, he offers little that is specific. As he has not personally seen a Narconon presentation, this is not surprising.

The anecdote he recounts regarding "colored sweat" has nothing to do with Narconon presentations regarding drug taking. No such claims are made.

It is true that the sauna-based detoxification program that is part of the Narconon rehabilitation protocol is also used to treat occupational and environmental chemical

exposures. These patients do sometimes experience such phenomena—I have frequently seen them in the nearly 4,000 patients who have completed the program at my clinic. Ms. Asimov seems to have confused these applications.

Body retention of residues and metabolites from street drugs and pharmaceuticals is well established. It would be most honest to say that the duration of storage has not been adequately investigated. Ongoing revelations regarding the biological fate and effects of environmental chemicals seem to indicate that this subject deserves further study.

As CSAM members are well aware, untreated addiction is America's greatest public health problem. There is little evidence that addiction professionals have this epidemic under control. What is unknown dwarfs what is known.

I share Dr. Cermak's distaste for pseudoscience and politicization. I would hope that future discussion of Narconon is fact-based and free of prejudice. What is called for is humility before the medical, social and humanitarian challenges that addiction presents and a determination to work together to face them.

I encourage any interested CSAM members to contact me for further information, or help in arranging a visit to a Narconon facility. I can see no other way for them to gain an objective understanding of what this organization has to offer.

Yours sincerely,

**David E. Root, MD, MPH, FACOEM**

## CSAM Mission Statement

The specific purpose of the California Society of Addiction Medicine is to advance the treatment of alcoholism and other addictions through education of physicians, physicians-in-training, and other health professionals. Additionally, the Society promotes research, prevention, and implementation of evidence-based treatment.

### CSAM news

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## IN MEMORIAM

BY DONALD J. KURTH, M.D., FASAM  
PRESIDENT, CSAM

On Friday evening at the 1996 ASAM Med Sci in Atlanta I attended the Pain and Addiction Committee Workshop. The topic was pseudo addiction. The room was packed — every seat was filled and interested physicians were even sitting on the tables set up across the back of the room. Most of us had not heard much of pseudo addiction at that time and there were lots of questions from the audience.

I was doing community based addiction medicine at the time. My addiction practice had grown up right out of my Urgent Care/Family Practice almost without willful direction from me and I was in Atlanta trying to learn more about the science of addiction. But, knowing almost nobody in CSAM or ASAM at the time and feeling like I had nothing to lose, I got up to the microphone and asked, “I think I understand what you mean by pseudo addiction. My question is, ‘When the pseudo addicted patients come to my office asking for help, are there Pseudo Twelve Step programs that I can send them to?’”

Apparently, the panel did not appreciate my sense of humor and they looked at me grim-faced while the table-sitters along the back wall chuckled audibly under their collective breath. Although my question had been tongue-in-cheek, I had not meant to be disrespectful of the panel and I took my seat feeling like I was not winning a lot of friends at the meeting. I sat down wondering if maybe I should have just kept my mouth shut.

After the workshop, though, a group of CSAM doctors came up to me to introduce themselves and shake my hand. One of those doctors was Joe Galletta, whom I had never met. After I told him that I lived in southern California, and still standing outside the doorway of the workshop, he said, “Loma Linda needs somebody like you to work with our chronic pain patients. Why don’t you come work at our Pain and Addiction Program at the Behavioral Medicine Center?” Joe was Medical Director of the program at that time and one of the founders of Loma Linda’s Pain Track — an abstinence based chronic pain and addiction program in southern California.

I thought to myself, “I think this guy is recruiting me right here on the spot!” I explained that I already had a



**Joseph Leo  
Galletta, M.D.**  
December 21, 1935 –  
December 8, 2004



DR. JOE GALLETTA AND FORMER CSAM EXECUTIVE DIRECTOR GAIL JARA

practice and was not looking for a job but he insisted that I at least come by to visit and see the program. That was the start of a long and warm friendship with Joe.

He was successful in his recruitment efforts and a year later I came to work at Loma Linda University. Joe had moved on to bigger and better things and I soon took over his role as Medical Director of the Chronic Pain and Addiction Program, where I am today. Joe Galletta’s shoes, however have been very big shoes to try to fill.

Joe Galletta was one of those rock solid CSAM physicians who worked tirelessly for the benefit of our patients and our Society. In 1983, Dr. Galletta had become one of the first 160 physicians in the nation to become certified in Addiction Medicine. Between 1983 and 1986, he served as Medical Director for Hemet Valley Medical Center’s Outpatient Chemical Dependency Center. From 1993 to 1996 he served as Medical Director of the Chemical Dependency Unit at Loma Linda

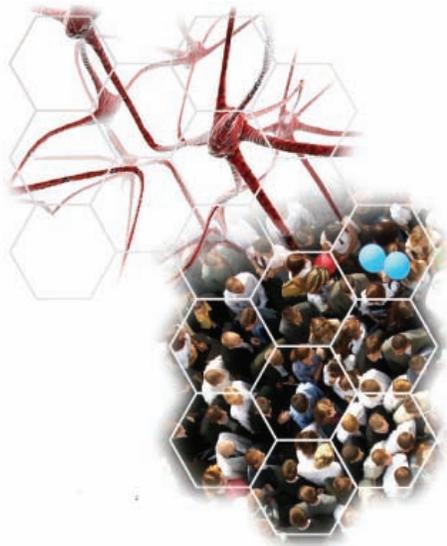
University’s Behavioral Medicine Center. He later served as Medical Director of the Hemet Valley Recovery Center until his passing.

Dr. Galletta also served for many years as Chairman of CSAM’s Membership Committee servicing our members’ needs and keeping our membership numbers high. In addition, while Dr. Rick Beach and I are often given credit for the highly successful SMSS Program (State Medical Specialty Societies), it was actually Dr. Galletta who came up with the idea for the innovative program. On other fronts, he was author of the “ABC’s of Addictive Behaviors” and the inventor of the Flexisplint Flexed Armboard for IV therapy.

Dr. Galletta was a member of the Riverside County Medical Association since 1979 and Chairman of the Riverside County Medical Association Physician’s Well Being Committee. In 1997, he assumed Chairmanship of that committee’s nationally recognized Western States Regional Conference on Physicians’ Well-being, which is Co-sponsored by the California Society of Addiction Medicine.

Joe Galletta was a dear friend and mentor to many of us who are now stepping into leadership roles in addiction medicine, both in California and at ASAM nationally. His commitment to all those who suffer from this disease will live on in all of us whose lives he touched.

Dr. Galletta is survived by his wife of 43 years, Teresita Soler Galletta, and by his six children, three siblings, and five grandchildren.



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STRATEGIES:** John Tsuang, MD; Jeffrey Wilkins, MD; Romana  
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**CHRONIC PAIN: CLINICAL TOOLS FOR THE ADDICTION MEDICINE  
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