

Treatment Takes Center Stage in 2001

2001 IS OFF to a roaring start following what was a year of great strides forward for CSAM in many areas:

✓ **Proposition 36** became law directing millions of additional dollars to the counties to promote treatment vs. incarceration. Other states are now following California's lead in treating substance abuse as a medical illness rather than a crime.

"Prop 36 has created a paradigm shift in the way substance abuse is viewed – it will no longer be viewed solely as a criminal justice problem but now as a medical issue." – Gary A. Jaeger, MD (primary spokesperson for CSAM on Proposition 36), Chief of Addiction Medicine, Kaiser Foundation Hospital

✓ **Coalitions** within the treatment community formed as a result of the Proposition 36 initiative and built the foundation for a presence within the legislative arena to promote our goal of passing parity legislation which means providers would be reimbursed for substance abuse treatment at the same levels as other medical illnesses.

✓ **Buprenorphine Use in the Office Setting** was planned in 2000 making CSAM one of the first organizations to offer this federally-required training. Nearly 200 took the course offered March 9-10 and evaluated the program very highly. CSAM offers the course again in October at the State of the Art Course.

✓ **CSAM's relationship with the Medical Board of California** and the California Medical Association became stronger

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Proposition 36 in the Real World

By Peter Banyas, MD, President, CSAM

Kathryn P. Jett, the newly appointed Director of the California Department of Alcohol and Drug Programs (DADP), has the unenviable task of moving Proposition 36 from a 61% to 39% voting victory to a July implementation that is capable of treating literally thousands of new case referrals from the criminal justice system. To do this, she has formed a Statewide Advisory Group that meets every three weeks and has pushed DADP into rapid implementation mode. She runs an open and transparent process and clearly wants all substantial stakeholders to be heard. I represent CSAM at these Advisory Meetings.

It is easier to vote for change than to implement it. DADP has to draft regulatory language (for an initiative they did not design), and get enough money out to the field so that the treatment system is ready to receive a flood of referrals in July. \$60 million has been distributed already, and in July an annual \$120 million will go out (less about 1% held-back for outcomes measures & other contingencies).

What does this kind of urgency mean? Well, for one thing it means that until July DADP must act as a fiscal pipeline to the counties; and, only then can it turn to matters of design, vision, true oversight, and outcomes measures.

CSAM will be encouraging DADP to take a higher profile in California standing up for scientifically sound treatments, opioid replacement as a proven intervention, and routine outcomes measurement. On the other hand, counties will, not surprisingly, welcome this initial lack of central control and appreciate being able to use "local discretion" about how to allocate funds between probation and treatment needs. County public health and probation systems are both woefully underfunded and understaffed, and these funds will make some difference, but in an understaffed system, it would be unrealistic to expect them to

If you as a CSAM physician want to influence the shape of a rapidly evolving treatment component in California, you will need to work with people at the local level. The system is receptive to input at this moment; it may be less so very soon.

develop truly innovative new programs. And, later on when DADP wants to weigh in on design and outcomes matters, the counties will have already allocated and spent the first year and a half year's of funding. In a very real sense the new systems will already be in place and less open to change. DADP is in a mousetrap not of its own making. The public raced ahead of both the politicians and the state agencies.

The key is not to lose this funding and this opportunity

for a genuine paradigm shift away from (single-tool) incarceration to (multi-tool) treatment. However, the financial black hole in the county systems is deep and in the several county based public meetings held on Prop 36 issues so far, one can literally see agencies and individuals lining up to "dial for dollars." In part because CSAM physicians are unlikely to benefit financially from this initiative, and Prop 36 will not create a wave of new physician jobs, CSAM has little conflict of interest in

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Proposition 36 in the Real World

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speaking out for quality, credentialing, and measurement.

What are the opportunities downstream? Well, for starters, the whole nation is watching how this plays out in California. A betting man would always bet on a massive county bureaucracy's capacity to defeat a good idea, and there are many just waiting to "prove" treatment a failure. This is a very important opportunity for the treatment community to get involved in order to (a) shape the face of this relatively new treatment partnership between probation and treatment, and (b) to insist on measurable quality of care.

CSAM's Public Policy Committee is monitoring and commenting on a wave of supplementary bills in the legislature, ranging from funding for urine testing to formal credentialing of counselors. This is arguably our most active committee and it could well use additional help from interested members. And, this committee will be key to the coming public discourse over parity for substance abuse insurance benefits.

CSAM has produced a working paper (available on our website, www.csam-asam.org/prop36paper.htm) defining many of the issues at stake. At a minimum, clinicians and researchers need to insist on funding only evidence-based treatments, need to emphasize the need for an array of services from simple education to residential care, and need to support the efficacy of opioid agonist treatments (methadone, LAAM, buprenorphine) for heroin addiction. It is important to call for centralized, sophisticated outcomes measures; and, after July there will be a golden opportunity for DADP to consider mandating a core database (perhaps including the Addiction Severity Index) for all publicly funded treatment programs in the State of California.

In the meantime, however, the Prop 36 game will be played at the county level. The CSAM website (www.csam-asam.org/prop36county.htm) lists each of the counties and the official responsible for implementing Prop 36. If you as

a CSAM physician want to influence the shape of a rapidly evolving treatment component in California, you will need to work with these individuals at the local level. The system is receptive to input at this moment; it will be less so very soon. Only CSAM members can work effectively at the county ground level; CSAM leadership will continue to keep you posted about continuing work at the Statewide Advisory level.

CSAM Working Paper on Proposition 36 Implementation

By Peter Banyas, MD, President, CSAM

The following is an excerpt from a document prepared by CSAM for the conference, "Exploring the Opportunities of Proposition 36," December 18, 2000 in Sacramento. The full text is available on-line at www.csam-asam.org/prop36paper.htm.

Executive Summary

The 61% majority for Proposition 36 has expressed the will of the voters to move from an incarceration strategy to a treatment strategy for simple drug possession. This will be easier said than done. Currently, both the Criminal Justice System and the Community Substance Abuse Treatment System are manifestly understaffed, under-trained, poorly funded, and overwhelmed by the caseload of clients and patients.

If the funding provision of Proposition 36 survives expected challenges, both systems will now rapidly, and competitively, seek direct funding for personnel expansion and training; and, both systems can demonstrate very real and severe needs. The legislature and agencies for both systems will need to develop additional funding mechanisms, unrelated to Proposition 36 funding, for routine, randomized urine testing and probation and parole supervision of the treatment diverted offender. It is extremely important that implementation efforts not be fragmented and competitive for the new funding.

The voters of California are clearly asking that the criminal justice system and the treatment system establish a successful and less costly set of linked interventions to support offender recovery. Voters are demanding a kind of collaboration that has occurred only sporadically in the past, but successfully so in many cases. Methods of collaboration will have to be standardized from successful, smaller efforts now in place in some jurisdictions, culled from clinical experience and prior research, and, in some cases, invented to ensure the eventual success of Proposition 36 goals.

For example, it is now well-known that existing detoxification strategies, as entrenched and reimbursed in the

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Conference on Exploring the Opportunities of Proposition 36, Sacramento, December 2000, attended by 700 people. From left: David Breithaupt, MD (CSAM Committee on Public Policy); Kerry Parker, CAE (Executive Director, CSAM); Peter Banyas, MD (President, CSAM); Kathryn Jett (new Director of the California Department of Alcohol and Drug Programs); Gary Jaeger, MD (President-elect of CSAM and Chair Committee on Public Policy); David Smith, MD, (CSAM Executive Council and Committee on Opioid Dependence); Ernest Vasti, MD (Committee on Opioid Dependence).

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current system, are weak interventions. Detox from most drugs is relatively easy, maintaining abstinence is hard. Multiple relapses in recovery are part of the natural history of any addict's life-course, and capable treatment regimens allow for a continuity of care to catch relapse early and intervene quickly. Under Proposition 36, those having decisional authority over the offender will have to determine when and whether a relapse is a *treatment failure*, as opposed to an expected event in the recovery process, and when it is also a *probation violation* requiring additional sanctions from the criminal justice system. In other words, these two actions are from different realms of discourse; yet will have to be coordinated by developing criteria to adequately define them to the satisfaction of both systems.

Urine testing is an essential component both of monitoring and outcomes evaluation; it must be provided in some fashion. There are only three ways to do so: (a) court-ordered self-pay (as is done in >70% of Arizona cases), (b) intra-agency funding transfers from the right pocket to the left pocket, or (c) enactment of additional funding legislation.

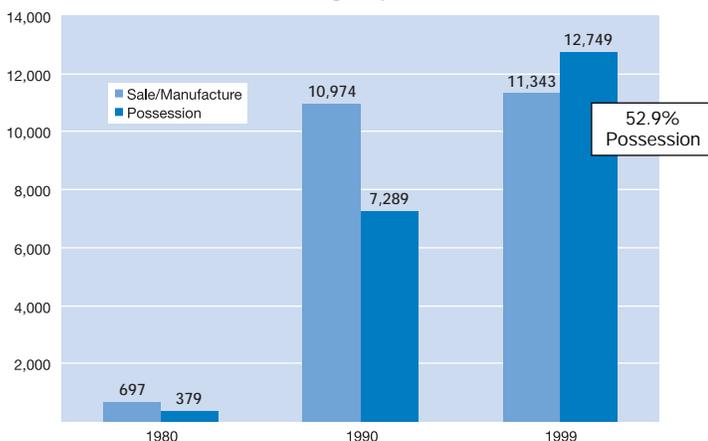
A large body of scientific evidence supports the efficacy of treatment for addiction, including offender populations. The research literature is comprehensive, clear, and convincing. However, not all treatments are effective in their basic elements, and many that are, are so poorly delivered that the potential for recovery is vastly diluted. It is essential that the State of California invest only in treatments that have demonstrated scientific efficacy, or have expert consensus panel support. This means that largely anecdotal interventions, or those in current media favor, should not be fiscally supported. Furthermore, we will recommend that the Proposition 36-mandated outcomes evaluations be built-in from the very beginning. A carefully constructed clinical and research database will permit downstream changes in program design and funding allocation.

The California Society of Addiction Medicine represents approximately 400 physicians of diverse specialties active in treatment, research, and academia. CSAM stands ready to assist in the planning, implementation, and evaluation of Proposition 36 in a manner that is collaborative, evidence-based, and practical.

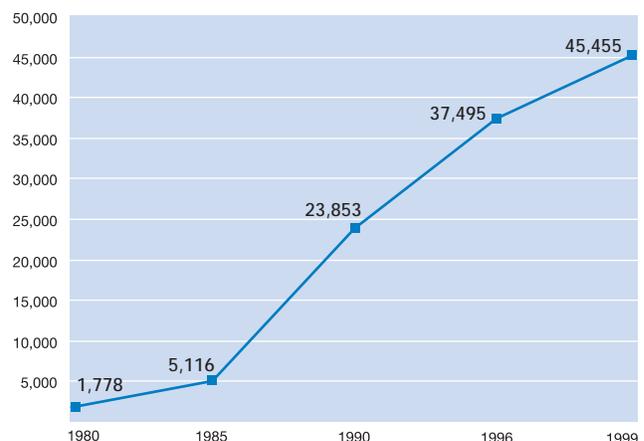
CSAM Recommendations:

- Support only Evidence-Based Treatments**
 - Rely on NIH, NIAAA, NIDA, CSAT and other specialized agencies for consensus reviews
 - Increase & legitimize opioid replacement treatments
 - Provide for multiple levels of care
 - University of California developed outcomes processes from beginning
- Develop Clinical and Outcomes Databases in Advance**
 - Common clinical and probation information
 - Program-specific data
 - Outcomes-specific data
 - Addiction Severity Index (ASI)
- Develop Funding Mechanism for Randomized Urine Screens**
 - Self-pay, or
 - Intra-agency transfer of funds, or
 - New funding legislation
- Develop Funding Methodology**
 - Consider 3-year funding cycles
 - Allocation methodology
 - Treatment providers vs Probation personnel (It is our understanding that this is a treatment funding initiative and not a solution to probation staffing problems.)
 - No reduction in existing (non-probation) treatment slots
 - Request for Proposals (RFP), selection criteria
 - Private insurance coverage and parity
- Develop Process Assessments & Funding Revocation Criteria**
- Address Public Policy and Legislative Issues**
 - Credentialing of programs and providers
 - Joint conferences with CSAM-Probation-Drug Court sponsorship
 - Additional funding legislation (testing, probation personnel, federal support)
 - Liaisons with NIH-sponsored Centers
 - Use of VA (Federal) and private insurance facilities (Kaiser, etc.)

CA New Drug Imprisonments



Number of Persons Imprisoned in CA for Drug Offenses



CSAM is Leading the Effort on New Bill Seeking Parity for Substance Abuse Treatment

State Senator Wesley Chesbro has introduced legislation with the support of the California Society of Addiction Medicine (CSAM) and the County Health Officers Association that would require health care service plans to provide coverage for substance-use disorders on the same basis as they provide coverage for any other medical care. The bill, SB 599, would require health care service plans to reimburse providers of the services and would prohibit health care service plans from seeking indemnity or otherwise transferring financial responsibility for these services onto contracting providers. Because a willful violation of this bill's requirements with respect to health care service plan requirements would be a crime, this bill would impose a state-mandated local program by creating a new crime. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Last year, CSAM worked for the passage of this bill, however at the last moment the bill was modified to require that a Legislative Analyst Office (LAO) study be conducted on the fiscal impact of such a change in the law. That report is due out in May, 2001 and is expected to substantiate the argument that treatment saves money and insurance companies/health plans would in turn save money by providing coverage for substance abuse treatment.

CSAM Members – Make Your Voice Heard!

Let your legislators know that you support parity for substance abuse treatment. Write to Senator Chesbro and send copies to your state senator or, better still, to all members of the Senate. A packet is being sent to you along with this newsletter with a sample letter, a fact sheet on parity, a set of mailing labels for all members of the senate and assembly and a copy of SB599.

This information is also available on the CSAM Home Page (www.csam-asam.org) along with e-mail links to all members of the State Senate.

Write to Senator Wesley Chesbro at 916/323-6958 (fax) or senator.chesbro@sen.ca.gov (e-mail).

EXPERTS POINT TO NEED FOR PARITY Private Sector Funding for Treatment Declines

New federal data show that overall spending on addiction treatment is shrinking as a percentage of total national health care expenditures, and that the private sector's contribution to treatment funding has dropped markedly over the past decade.

H. Westley Clark, M.D., J.D., M.P.H., who directs the federal Center for Substance Abuse Treatment (CSAT), which co-sponsored the research, added that "It is time to treat substance abuse like any other illness ... It is my hope that this data will begin to change the public perception that substance abuse treatment is too costly. In reality, not treating patients for alcohol or drug abuse is the costly alternative – in lives destroyed, promise unfulfilled and the quality of life we experience in all our communities diminished."

Dr. Clark explained that "Others of our studies have shown that treatment for substance abuse is effective and cost-effective. Today, we have the third part of the puzzle – real data on what is actually being spent on substance abuse treatment, and what the trends are. Unfortunately, it turns out that what we are spending on substance abuse treatment is not much, and trending downward." Dr. Clark pointed out that less than \$12 billion was spent on addiction treatment in 1998, even though federal data show that more than 3 million people who needed treatment in that year did not get it. He said the new study shows that private health insurance "is not filling the void." In fact, the study found that state and local governments are paying for almost two-thirds of addiction treatment, with the remaining third paid for by a combination of private insurers, philanthropy and patients and their families. He added that private funding for addiction treatment did not even keep pace with inflation, and actually fell about 0.2% per year over the study period.

The study, "National Expenditures for Mental Health and Substance Abuse Treatment, 1987-1997," was conducted by the Medstat Group, under the direction of Mady Chalk, Ph.D., Director of the CSAT Office of Managed Care, and Jeffrey Buck, Ph.D., Director of the Office of Managed Care at the Center for Mental Health Services. Key findings include:

- Addiction and mental health services represented 7.8% of U.S. health care expenditures in 1997, down from 8.8% in 1987. Real spending by private insurers for addiction treatment services fell by 0.6% annually in that 10-year period.

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- Spending on addiction and mental health treatment grew more slowly than spending for all health care. Inflation-adjusted, mental health and addiction treatment services grew by 3.7% annually between 1987 and 1997, while all health care spending grew an average of 5% each year.
- The study documented a growing trend toward outpatient treatment. Hospital expenditures as a proportion of all addiction and mental health treatment spending declined by more than 10% between 1987 and 1997.

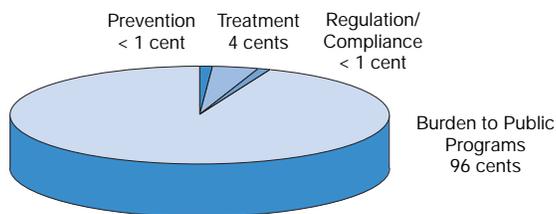
The study report is available on-line at www.samhsa.gov or can be ordered from the National Clearinghouse for Alcohol and Drug Information at 1-800/487-4889.

NEW CASA STUDY

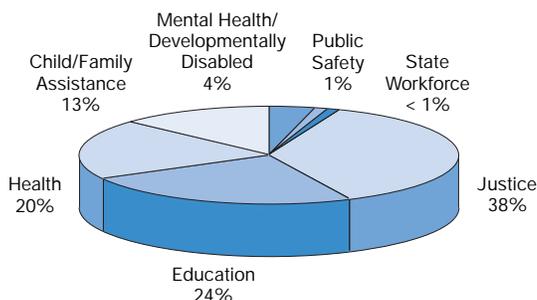
Shoveling Up: The Impact of Substance Abuse on State Budgets

The National Center on Addiction and Substance Abuse at Columbia University (CASA) has released a three-year 183-page study revealing that in 1998 states spent conservatively \$81.3 billion dollars on substance abuse and addiction – 13.1 percent of the \$620 billion in total state spending. Of each dollar spent, 96 cents went to shovel up the wreckage of substance abuse and addiction; only four cents went to prevent and treat it. These are the statistics for California:

The Substance Abuse Dollar



Shouldering the Burden of Substance Abuse



NOMINATIONS TO CSAM EXECUTIVE COUNCIL

This is Your Chance to Make a Difference

THE CSAM EXECUTIVE COUNCIL recently announced a "Call for Nominations" for individuals interested in serving on the Executive Council for terms beginning in October 2001. Dr. Gail Shultz was selected by the Council to implement a new Council structure to be approved by the members in October as a bylaws change. An election for the new Council slate will take place at the Annual Business Meeting on October 20, 2001 at the Marriott Marina del Rey during CSAM's State of the Art Conference. The Council has re-designed the governance structure and seeks to fill the following positions. If you are interested in being considered or wish to nominate another member of CSAM for one of these roles, please fax back the form below by May 30, 2001. Please submit a recent CV along with your response.

2001 CSAM EXECUTIVE COUNCIL

- President: Gary Jaeger, MD (two year term)
- Immediate Past President: Peter Banys, MD (two-year term)
- ASAM Region 2 Representative (elected through ASAM process): Lori Karan, MD
- President Elect — Open for nominations (two year term)
- Treasurer — Open for nominations (two year term)
- Two Member-at-Large Positions — (one elected to a four year term; person with second most votes elected to a two year term)
- Four Committee Chairs — to be appointed by the President
- MERF/CSAM Representative — to be appointed by MERF; must be CSAM member (two year term)

I WOULD LIKE TO BE CONSIDERED FOR A TERM ON THE CSAM EXECUTIVE COUNCIL AND HAVE ATTACHED MY CURRICULUM VITAE FOR CONSIDERATION.

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

E-MAIL _____ PHONE _____

POSITION INTERESTED IN: _____

I WOULD LIKE TO NOMINATE: _____

FOR THE POSITION OF: _____

FAX to CSAM, attention: Kerry Parker, CAE, Executive Director, 415/927-5731. Questions? Contact Ms. Parker at 415/927-5730.

New Treatment for Heroin Addiction

On March 9-10 CSAM held a 2-day training, "Buprenorphine in Office-Based Treatment of Opiate Dependence" in San Francisco. This training satisfies the training requirement of the Drug Abuse Treatment Act of 2000.

The FDA has delayed action on buprenorphine and knowledgeable observers are speculating that action will

not come until the end of this year. Meanwhile, training programs continue, with the understanding that interested physicians will need time to make preparations to begin to use this new treatment modality. Further CSAM trainings in buprenorphine are planned, including at the State of the Art conference in October in Marina del Rey.



CSAM Buprenorphine Conference planners (from left): Ernest Vasti, MD; David Pating, MD; Gail Jara; Judith Martin, MD (chair); Donald Wesson, MD; Monika Koch, MD.

The following is the text of a handout prepared by the 14th Street Clinic in Oakland to inform their staff and patients about buprenorphine:

The Drug Addiction Treatment Act of 2000 was signed by President Clinton in October. For the first time, a physician in an office setting will be able to prescribe a narcotic for treatment of addiction - following certain guidelines and restrictions. For the first time a patient who is addicted to heroin will be able to receive opioid medication for detoxification or for maintenance - again with certain restrictions - in a regular office setting. The only medication which will be allowed is buprenorphine. Methadone and LAAM still may not be prescribed in California in an office setting for the treatment of addiction.

THE NEW LAW

The Drug Addiction Treatment Act of 2000 (DATA) has the following restrictions:

- The physician has to have training in opioid addiction treatment from a designated organization. Physicians who participated as investigators in a clinical trial of buprenorphine or those who are certified in Addiction Medicine or Addiction Psychiatry are considered qualified without further training.
- The physician has to register with the Secretary of Health and Human Services and then receive a special number to add to his or her DEA license.
- The drug prescribed has to be shown in the medical literature to be useful in the treatment of addiction. (Buprenorphine has been shown to be effective for

heroin addiction and is expected to be approved by the FDA in the later half of 2001.)

- The drug prescribed may not be a schedule II narcotic, but only III, IV or V. (Buprenorphine is not schedule II. Methadone and LAAM are.)
- The physician may only have 30 patients on this treatment at one time.

THE MEDICATION: BUPRENORPHINE

Buprenorphine is an opioid medication which has been used as an injection for treatment of pain. It is a long acting medication, and binds for a long time to the "MU" endorphin receptor. This means most patients don't have to take medication every day.

Buprenorphine is not absorbed very well orally, so a sublingual tablet has been developed for treatment of addiction. One form of this sublingual tablet also contains a small amount of naloxone (Narcan) - an opioid antagonist, which will cause withdrawal if injected. Buprenorphine without naloxone has been available in other countries, and has been used illicitly by addicted persons. The combination with naloxone is intended to address the abuse potential and diversion.

Aside from the safety measure of being mixed with naloxone to discourage needle use, buprenorphine itself has a "ceiling" of narcotic effects (it is considered a "partial agonist") which makes it safer in case of overdose. By itself, even in large doses, it does not cause lethal respiratory depression. If a child swallowed a whole bottle of buprenorphine tablets (remember they are not absorbed very well by swallowing) it would probably not be lethal, whereas a single dose of methadone might be lethal to a child. These are some of the unusual qualities of this medication which make it safer to use outside of the usual strict methadone regulations at a clinic and, after stabilization, most patients would be given prescriptions for the medication to take home.

WILL IT BE USEFUL FOR OUR PATIENTS?

Our methadone maintenance patients may be interested in whether this medication might help them. Unfortunately, because of the partial agonist nature of the medication, buprenorphine is not equivalent in maintenance strength to methadone and LAAM. In order to even try buprenorphine without going into major withdrawal, a methadone-maintained patient would have to taper down to 30mg of methadone or lower. We are concerned that this medication may not be strong enough for most of our patients, and might lead to dangerous relapses if attempted. **If you decide to try it, please be aware of this danger of relapse, and keep the door open for resuming methadone immediately if necessary.**

There are also some studies which show that detoxification from buprenorphine is effective. Some of our 21-day-detoxification methadone-treated patients may want to transfer to buprenorphine to complete their tapers after the methadone dose has dropped to below 30 mg of methadone - this would usually be in the second week of 21-day detox. Whenever buprenorphine becomes available

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we will try to set up a way to expedite this transfer. So far we don't know whether buprenorphine will be "covered" under Medi-Cal the way methadone detoxification is.

Remember to inform patients of the following tips:

- If you are offered buprenorphine by a "friend" and you are taking methadone or LAAM, the buprenorphine will push the other opioids off the receptor site, and you may be in withdrawal and very uncomfortable.
- If you dissolve and inject the buprenorphine-naloxone sublingual tablet it may induce severe withdrawal because of the naloxone, which is an antagonist.
- If you are on methadone treatment and wish to transfer to buprenorphine, your dose has to be at or below 30mg.
- There have been deaths reported when buprenorphine is combined with benzodiazepines (this family of drugs includes Klonopin, Ativan, Halcion, Valium, Xanax, Librium, etc.) If you are taking any of these drugs, either by prescription or on your own, buprenorphine may not be for you.

FERGUSON V. CITY OF CHARLESTON

U.S. Supreme Court Affirms Right to Confidential Medical Care

Affirming the right to confidential medical care, the United States Supreme Court on March 21 struck down a drug testing scheme targeting pregnant women developed by local police and prosecutors in collaboration with doctors in a South Carolina hospital.

The case stemmed from a "Search and Arrest" policy was initiated in 1989 as a joint effort between the Medical University of South Carolina and local law enforcement officials. A targeted group of pregnant women was subject to secret urine searches to test for cocaine use without a warrant or consent. Results were reported to police who arrested 30 women over a 5-year period. Some of the women were handcuffed and arrested from their hospital beds immediately after giving birth; others were arrested and jailed while still pregnant.

The Center for Reproductive Law and Policy and the Women's Law Project challenged the policy arguing that it violated the constitutional rights of pregnant women. In July, 1999, the United States Court of Appeals for the Fourth Circuit found the drug testing scheme constitutional.

In its 6-3 decision in *Ferguson v. City of Charleston*, the Court overturned the lower court and found that the drug testing scheme was in direct violation of the Fourth Amendment, which provides protection from unreasonable searches.

"This decision slams the door against police searches of private medical information in your doctor's office," said Priscilla Smith, lead counsel in the Ferguson case and Deputy Director of Litigation with the Center for Reproductive Law and Policy.

The majority opinion draws on the Supreme Court's Miranda decision, which affirms that citizens should know their rights. "While state hospital employees, like other citizens, may have a duty to provide the police with evidence of criminal conduct that they inadvertently acquire in the course of routine treatment, when they undertake to obtain such evidence from their patients for the specific purpose of incriminating those patients, they have a special obligation to make sure that the patients are fully informed about their constitutional rights, as standards of knowing waiver require."

The High Court's decision was largely informed by the nation's leading medical, public health and children's groups, which opposed the use of punitive methods to address the problem of substance abuse during pregnancy. The California Society of Addiction Medicine and the American Society of Addiction Medicine joined with seventy-five groups – including the American Medical Association and the American Public Health Association – signing friend of the court briefs urging the Court to find South Carolina's policy unconstitutional. The groups argued that threatening women with arrest and jail time deters them from seeking critical prenatal care and drug treatment and could thereby actually harm their health and the health of their children. Additionally, these groups assert that those who promote prosecutions ignore the severe shortage of drug treatment programs, especially those that will accept pregnant women or provide services needed by women with young children at home.

Treatment Takes Center Stage in 2001

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through meetings of the Diversion Liaison Committee where all worked to ensure proper treatment of physicians in diversion, making California's program one of the most highly regarded in the country and a model for other states.

✓ **The Review Course** held in October drew nearly 300 attendees and those who took the exam passed in record numbers. Evaluations for this course were some of the highest ever received for a review course. This raises the standard even higher for the State of the Art Course now being planned for October 17-20 at the Marina Beach Marriott Hotel in the Los Angeles area.

✓ **CSAM launched its website (www.csam-asam.org)** and packed it with useful information, including a member directory. This resource, along with e-mail broadcasts of important notices and the newsletter, kept CSAM members informed throughout the year.

All this took place in 2000, making the outlook for 2001 very positive. CSAM is now positioned on a strong financial base as well as poised for even greater success in the year ahead. The CSAM Executive Council invites you to be part of this track-record of achievement that is expected to continue in force over the coming years to benefit CSAM members throughout California – join us as we work together! (See page five for Nominations to CSAM Executive Council.)

How Effective is Naltrexone Compared to Methadone in the Treatment of Heroin Addiction?

by James Fellows-Smith & John Edwards, Australian Medical Procedures Research Foundation & Community Based Methadone Programme, Perth, Western Australia (summarized by Dr. Bill Saunders, Clinical Psychology Consultant, Joint Services Development Unit, Shaw House, Graylands Hospital, Perth, Western Australia)

This was a two year prospective, comparative, study of heroin dependent patients who, between February 1998 and February 2000, attended either the community methadone program (total 2520) or a naltrexone induction program (total 1097).

Summary Conclusions

Overall, the evidence from this paper is consistent with the international literature and clinical experience. Methadone reduces the risk of premature mortality in heroin dependent individuals and is 'better medicine' than no treatment. Naltrexone, while of benefit to some heroin dependent persons (perhaps 10-15% of all opiate dependent patients) is associated with considerable risks. Naltrexone, as being used in Western Australia, doubles the risk of death as compared to not being treated at all and increases that risk eight-fold when compared to the outcome of being prescribed methadone.

Description of the Study

On entry to treatment all patients were assessed using a standardized intake interview. The sample were in the majority male (61% for methadone patients, 64% naltrexone) not married (71% and 87% respectively), were hepatitis C positive, (74% and 63%) and reported using heroin on a daily basis (90% and 96%). Patients attending for methadone were on average older than their naltrexone counterparts, being 28 years of age as opposed to 26. Patients in both groups reported seven-year histories of heroin use and reported having injected heroin for an average of three and half to four years. Apart from age there were, in terms of their presenting characteristics, no significant differences between the two groups.

Progress in treatment was assessed at twelve months. The average time on methadone was 6 months, naltrexone three. Forty five per cent of methadone clients were re-admitted to the program. The re-admission rate for naltrexone was 31%.

An analysis of deaths during the study period was undertaken by review of the 'deaths' register. Coronial records and toxicology reports were also reviewed. It was found that in the methadone sample there were 11 deaths (0.04%). In the naltrexone cohort there were 36 deaths (3.3%).

Calculation of the relative risks of the two treatments showed that persons attending the methadone program had a two-fold increase in mortality as compared to the general population aged 15-44. Persons receiving naltrexone had a 16 times greater risk of death than the general population and an 8-fold increased relative risk of dying than methadone patients.

The relative mortality risk of naltrexone rose to 23.3 when patients stopped taking naltrexone. However, while individuals took naltrexone their relative risk of mortality was similar to methadone (2.63 and 3.04 respectively) but termination of naltrexone results in an alarmingly rise in the risk of death. It is noted that the average length of stay on naltrexone was only three months so the protection offered by naltrexone is very time limited.

Causes of death for the two groups were examined. Of the 36 deaths in the naltrexone group, two died while on naltrexone following road traffic accidents. Of the remaining thirty four deaths in the naltrexone group, all occurred among patients who had ceased taking naltrexone. Twenty nine of the thirty four (84%) were considered as being opiate overdose deaths (respiratory depression caused by a combination of opiates and other CNS depressants) and the remainder were due to murder, medical causes (CVA and septicaemia) and road traffic accidents. For the methadone group, nine of the eleven (91%) deaths were due to overdose of CNS depressants. Of the remaining two one was deemed a suicide the other patient was murdered.

The authors also calculated mortality ratios for the two treatments and for untreated heroin users. For untreated heroin users the mortality ratio was 1 in 74 (that is a one in seventy four chance of dying). For persons prescribed naltrexone the ratio was 1 in 60, and for methadone, 1 in 458.

In effect, when compared to persons not in treatment, being placed on naltrexone increases the risk of death by a factor of 1.8 (i.e, almost two-fold). Conversely, the mortality ratio for being prescribed methadone was four times lower than being treated with naltrexone and two-fold lower than not being treated.

Additionally, it was found that persons who had attended for naltrexone treatment, but who did not carry through with the treatment, had a mortality ratio of 1 in 104, that is, they were two and a half times less at risk of dying prematurely than if they had gone onto naltrexone.

Assessing the Risks and Benefits of Benzodiazepines for Anxiety Disorders in Patients with a History of Substance Abuse or Dependence

(Posternak MA, Mueller TI, *Am J Addict* 2001; 10:48-68, 2001)

Posternak and Mueller are psychiatry faculty at Brown. They have mounted an evidence-based challenge to

Continued on page nine

Continued from page eight

decades of consensus-based positions that have cautioned providers against prescribing benzodiazepines (BZ) to patients with current or prior histories of substance abuse or dependence. This consensus has been enshrined in the American Psychiatric Association's task force report in 1990 and in most substance abuse texts.

BZ's are demonstrably effective for generalized anxiety disorder, panic disorder, and agoraphobia. They are less clearly effective for PTSD, social phobias, and OCD. The authors acknowledge data about "subacute alcohol withdrawal syndromes," marked by anxiety, insomnia, and depression, that may persist for weeks after detoxification. They ask the question if BZ's may need to be continued well past the initial detoxification period. They review evidence that alcoholics, unlike sedative-hypnotic dependent patients, do not seem to show abuse or dose escalation of prescribed BZ's. And, alcoholics reportedly have lifetime rates of any anxiety disorder at 24-44%; this overlap, however, does not distinguish primary from secondary anxiety syndromes. Approaching from the other direction, they note that 90% of BZ abusers concurrently abuse other substances. Opioid abusers are particularly prominent (2/3) co-abusers of BZ's in combination with heroin or methadone. Their review of literature concludes that drug abusers are much more likely to abuse BZ's than are alcoholics.

They believe that 20-50% of active alcoholics who are prescribed BZ's will abuse them. They found few studies examining the risks for recovering alcoholics, but no evidence supporting a higher risk of BZ abuse. Nonetheless, they note that BZ's may induce physiological dependence in as little as 2-3 weeks of high-dose treatment, and after 6 weeks at ordinary therapeutic doses. It appears that lower levels of baseline symptoms of an anxiety disorder at the time of tapering-discontinuation are the best predictor of successful taper.

Finally, they tackle the question of cross-relapse. Do BZ's increase the risk of alcohol or drug relapse? They review data from 5 large scale studies of psychiatric patients on BZ's and find no increased evidence of a turn to increased alcohol use. Do BZ's show protective effects against relapse? Few studies end up providing no support for a protective hypothesis.

The authors conclude that the evidence-base does not substantiate a highly restrictive prescribing posture for benzodiazepines when recovering alcoholics have bona fide anxiety disorders. They recommend "judicious use in patients with a history of substance abuse." The abuse potential of BZ's in the general population is remarkably low (<1%), it is not demonstrably higher in recovering alcoholics, but is higher in opioid addicts, sedative-hypnotic abusers, and in antisocial personality disorders. There are some limitations to this kind of review of the literature. They appear on firm ground when reviewing studies with addicted or recovering patients, significantly less so when extrapolating from studies on large psychiatric populations.

Insomnia, Self-Medication, and Relapse to Alcoholism

(Brower KJ, Aldrich MS, Robinson EAR, Zucker RA, Greden JF, *Am J Psychiatry* 158:3, pp399-404, March 2001)

Brower et al. at Michigan have reported on a laboratory sleep study of 172 alcoholics. Insomnia rates in the general population are 17-30%; in this population, 61% reported symptomatic insomnia in the 6 months prior to treatment. Patients with insomnia were more likely to self-medicate with alcohol for sleep (55% v 28%). Although they lost over half of the patients for follow-up, their data tend to support an increased relapse rate in insomniacs. Contrary to expectation, patients with a history of self-medicating insomnia did not seem more likely to relapse. Patients with insomnia scored significantly higher on measures of alcohol severity and on the Carroll Scale rating for depression. This group is now investigating whether treating early insomnia with gabapentin or other drugs improves outcomes.



NEEDED

Addiction Psychiatrist • 3-4 Hours / Week

Dr. Timmen L. Cermak, Psychiatric Medical Director for Ohlhoff Recovery Programs, is seeking an addiction psychiatrist to work with him to meet the evaluation, medication and disability claim/insurance needs for patients in our various treatment programs: Residential/Day Treatment, halfway houses, outpatient (adult and adolescent) and eating disorders. Please email CV at tcermak@aol.com or fax to 415-381-4009.

UPCOMING PRESENTATION

Marijuana: Why It Works and Why It Doesn't

In this Marijuana Update, Dr. Cermak expands the talk presented at last year's CSAM Review Course.

Topics include basic science findings regarding endogenous cannabinoids, especially as they relate to the amygdala and its creation of novelty, issues of use/abuse/addiction, especially as they relate to adolescents, and an addiction medicine perspective on "medical marijuana."

June 8, 2001

St. Mary's Cathedral, SF

10:00am - 12:00pm

\$40 Fee

Contact Tracy (415-626-9782, Ext. 16)
for additional information and registration.

NEW MEMBERS

CSAM welcomes the following new members:

Leslie H. Alhadeff, MD, *Palm Desert*

John G. Bors, MD, *San Francisco*

Debra Bunger, MD, *Fremont*

Brazell H. Carter, MD, *Richmond*

David S. Duncombe, MD, *Anaheim*

Otashe Nyoku Golden, MD, *Sacramento*

Howard Gurevitz, MD, *Burlingame*

Billie C. Harman, MD, *Sacramento*

James A. Hirtle, MD, *Palos Verdes Peninsula*

Rebecca Fran Keilman, MD, *Davis*

Philip J. Martin, MD, *Tustin*

Brendan Patrick Morley, MD, *Berkeley*

Kristen Colleen Ochoa, MD, *Los Angeles*

Stephen Douglas Smith, MD, *Los Angeles*

MEMBER NEWS

Monika Koch, MD and **Peter Banys, MD** had a study, *Liver Transplantation and Opioid Dependence*, published in the February 28, 2001 Journal of the American Medical Association (vol. 285, no. 8)

Lyman Boynton, MD will be retiring from Kaiser on April 30, 2001 after serving as Chief of Addiction Medicine for 10 years and Chair of the Physician Well-Being Committee. He plans to ride his motorcycle through the Redwoods, settle in Rancho Mirage area and consult to physicians in treatment. **David Pating, MD** has assumed Lyman's duties as Medical Director of the Kaiser, San Francisco Chemical Dependency Recovery Program, Chief of Addiction Medicine and Chair of the Physician Well-Being and Wellness Committee. "We will greatly miss Lyman Boynton's dedication and guiding wisdom," said Dr. Pating. "Lyman has made innumerable contributions to the health of our Kaiser patients and the personal health of our Kaiser physicians. He has miraculously rescued many alcoholic souls from oblivion."

Anne Linton, MD is the new Medical Director of the Professional Recovery Program at the Betty Ford Center.

NEW ASAM FELLOWS

The following CSAM Members were named fellows this year by the American Society of Addiction Medicine:

- Robert D. Daigle, MD, FASAM
- William Glatt, MD, FASAM
- John Harsany, Jr, MD, FASAM
- Gary A. Jaeger, MD, FASAM
- Donald J. Kurth, MD, FASAM

WEB SITES OF INTEREST

Check out what's new on the CSAM website! The following articles are available in the "News You Can Use" section at www.csam-asam.org/newsitem.htm

- *Assessing Nicotine Dependence*
(from American Family Physician)

These tools can assist family physicians in guiding patients to quit smoking—the single most important thing smokers can do to improve their health.

- *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*
(U.S. Public Health Service)

This guideline, released in June of 2000, summarizes strategies for smokers in three treatment categories: Smokers willing to quit, smokers unwilling to quit, and patients who have recently quit.

- *Practice Guideline for the Treatment of Patients with Nicotine Dependence*
(American Psychiatric Association)

The guideline addresses disease definition, treatment principles, and formulation and implementation of a treatment plan.

- *Alcohol and Tobacco* (NIAAA)

Between 80 and 95 percent of alcoholics smoke cigarettes, a rate that is three times higher than among the population as a whole

- *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America*
(National Center on Addiction and Substance Abuse)

American's substance abuse epidemic has come to rural America. This paper discusses trends, prevention, education, and treatment in smaller communities.

- *Substance Abuse Treatment for Women Offenders*
(Center for Substance Abuse Treatment)

This guide offers a planning framework for those in the corrections and treatment fields who want to design comprehensive services for women offenders. (Adobe Reader is needed.)

- *Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities* (SAMHSA)

People with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability.

UCLA Drug Abuse Research Center

www.medsch.ucla.edu/som/mpi/darc

DARC is a diverse research organization that investigates psychosocial and epidemiological issues pertaining to drug use and conducts evaluations of interventions for drug dependence. Their web site includes a listing of research projects, research training, publications as well as a section on ethnic issues and a news center.

YOU CAN WRITE FOR

Drug Abuse "Toolbox"

The National Institute on Drug Abuse (NIDA) had compiled a comprehensive science-based "Toolbox" to be distributed to 12,000 drug treatment programs in the U.S.

The toolbox contains 3 therapy manuals on treatment of cocaine addiction, which highlight approaches in cognitive-behavioral, community reinforcement plus vouchers, and individual counseling. Also included are publications on Approaches to Drug Abuse Counseling, Principles of Drug Addiction Treatment: A Research-based Guide, NIDA Research Reports, a chart of commonly abused drugs, and NIDA's Publications Catalogue.

Copies of the toolbox are available from NIDA for a small shipping fee. To order call the National Clearinghouse for Drug and Alcohol Information at 800/729-6686. Most of the manuals also are available online in the publications sections at www.drugabuse.gov.

Substance Abuse Chartbook / Robert Wood Johnson Foundation

This 133-page book is full of useful charts and graphs on substance abuse that are very useful in presentations and other education. Sections include "The Context of Substance Abuse," "Patterns of Use," "Consequences of Use," and "Combatting the Problem." The booklet can be downloaded from the Robert Wood Johnson Website (www.rwjf.org/app/rw_substance_abuse/rw_res_sa_chartbook.html) hard copies of the book can also be ordered through the website.

Addiction Medicine State of the Art 2001: The Emerging Role of the Clinician

October 17-20, 2001
Marina Beach Marriott
Marina del Rey



TOPICS INCLUDE:

- Buprenorphine Training
- Policy Updates: Parity, Proposition 36, Office-Based Opiate Treatment
- Neuroscience Update
- Pain and Addiction
- One-Day Course on Addiction for Family Physicians
- Spirituality
- State of the Art Treatment: Adolescents, Women, Homeless, Jails
- The Science of 12-Step Programs
- Ecstasy
- Substance Abuse and the Media

CONTINUING MEDICAL EDUCATION

63rd Annual CPDD Meeting

College on Problems of Drug Dependence

June 16-21 • Fairmont Scottsdale Princess

Info: Call 215/707-3242 or send an e-mail to rdavis04@unix.temple.edu

Training Course for Medical Review Officers

June 1-3 • Hilton, St Louis Airport Hotel, St Louis

Sponsored by: American Society of Addiction Medicine

Credit: 20 Hours of Category 1 CME

Info: Contact ASAM, 310/656-3920 or www.asam.org

Haight Ashbury 34th Anniversary Conference

Therapeutic Jurisprudence:

Integration of Prevention Treatment and Research

June 8-9, 2001

UCSF Laurel Hights Conference Center, San Francisco

Sponsored by: Haight Ashbury Free Clinics

Credit: Up to 12 hours of Category 1 CME

Fees: \$150 plus \$20 CME fee

Info: Contact Haight Ashbury Free Clinics, 415-565-1904

International Doctors in Alcoholics Anonymous

IDAA 2001: A Spiritual Odyssey

August 8-12, 2001 • Oklahoma City, OK

Credit: CME will be given for the scientific portions of the program

Scholarship information: Contact Jim Wells, MD at 405/272-4028 (fax)

Info: Contact David Blackshaw, MD at 405/728-3668

Conference on Tobacco Dependence

September, 2001 • Date & Location TBD

Sponsored by: American Society of Addiction Medicine

Credit: 16.5 hours of Category 1 Credit plus up to 6 additional hours for preconference workshops

Info: Contact ASAM, 310/656-3920 or www.asam.org

CSAM news

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Certification Exam Results

Congratulations to the following California Physicians who passed the ASAM Certification/Recertification Exam in 2000.

Davar Aram, MD, Internal Medicine, Chino Hills, Certified
Ralph H. Armstrong, MD, Psychiatry, Ventura, Certified
Patricia Louise Ashley, MD, Psychiatry, Granada Hills, Recertified
Clifford A. Bernstein, MD, Anesthesiology, Newport Beach, Certified
Bharat Bhushan, MD, Psychiatry, Redwood City, Certified
Milton M. Birnbaum, MD, Addiction Medicine, Los Angeles, Recertified
Edgar Hugo Castellanos, MD, Family Practice, Salinas, Certified
Dale C. Dallas, MD, Addiction Medicine, Walnut Creek, Recertified
Evelyn R. Edelmuth, MD, Psychiatry, Indian Wells, Certified
Daniel Jay Glatt, MD, Internal Medicine, South San Francisco, Certified
Lester Sherwin Goldstein, MD, Psychiatry, Huntington Beach, Recertified
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Allan H. Rabin, MD, Child Psychiatry, San Diego, Recertified
James S. Robbins, MD, Psychiatry, Los Angeles, Certified
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Nicholas Z. Rosenlicht, MD, Psychiatry, San Francisco, Recertified
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Stephanie Shaner, MD, Psychiatry, Los Angeles, Certified
Scott Brian Smolar, MD, Psychiatry, San Francisco, Certified
C. Lee Sturgeon, Jr., MD, Addiction Medicine, Redwood City, Certified
George Peter Tardelli, MD, Internal Medicine, San Francisco, Recertified
Edward R. Verde, MD, Psychiatry, Loma Linda, Certified
Robert William Watrous, MD, Family Practice, Riverside, Certified
James Gregory White, MD, Addiction Medicine, Redding, Certified

Physicians who took the California Society's Review Course in San Francisco did especially well on the Certification Exam. California Review Course attendees had a 100% pass rate on the exam and scored over 70 points above the average score.



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