CSAM NEWS

Newsletter of the California Society of Addiction Medicine Winter 1999 Vol. 26, No. 2/3

Substance Abuse Parity: Numbers and Politics

By David Pating, MD

Substance abuse treatment once again remained roped to the pier while mental health benefits steamed forward.

On September 27, Governor Gray Davis signed AB88 requiring full parity benefits for severe mental illness equal to treatment benefits for medical conditions. This bill, which affects policies renewed after July 1, 2000, stems the current limitations in insurance coverage which have "resulted in inadequate treatment for persons with (mental illnesses)."

Unfortunately, substance abuse did not make the priority list of severe mental illnesses protected by this bill. Instead, the treatments for nine diagnoses including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic, obsessive-compulsive disorder, pervasive developmental disorder, anorexia and bulimia, stand to make significant gains while substance abuse treatment continues to lag.

The problem facing parity for substance abuse treatment has been national in scope. In 1997, following the Federal Mental Health Parity Act of 1996, which insured mental health parity—but no substance abuse parity—for some federal workers, 12 states enacted parity laws but only 5 covered substance abuse treatment. In 1999, 70 proposed parity plans in 34 states were considered,

Inside:

Fundamental Changes for CSAM

By Peter Banys, MD, President, CSAM

CSAM came of age in the concluding years of the prior millennium. In the 1970s if a physician made the perplexing choice of working with addicted patients, he or she was assumed to be deeply mediocre and incapable of working with "good" patients. Over the last 27 years, things have changed. The national certification examination developed first by CSAM, the move of ASAM to the Washington beltway, the development of evidence-based conferences, recognition in the AMA, and the growing alliances with NIDA and NIAAA have all contributed to very real respectability within the family of physicians. More remains to accomplish in this new millennium. As a field, addiction medicine must continue to struggle for parity on behalf of patients. As an organization, CSAM must develop a new and fiscally sound organizational structure. As addiction medicine physicians, we must be prepared to have a voice in matters as important and diverse as physician diversion, insurance inequalities, legalization of drugs, and, above all, a humane and respectful approach to the addicted patient.

Kerry G. Parker, CAE our incoming Executive Director

Gail B. Jara, our retiring Executive Director

Our retiring executive director, Gail Jara, developed this newsletter into one of the most highly valued services of our Society. Our incoming executive director, Kerry Parker, has committed to continue this publication and, in addition, to move us rapidly onto the worldwide web. So, fire up your computers. In this new year we have some challenges, but nothing as difficult as what our founders experienced (among them Jess Bromley who died last year) standing alone in those early years. Stay together, speak clearly, and do good work.

See page 4 for more on the changes at CSAM

and like California, many did not include a substance abuse parity benefit.

Parity requires health insurers to cover medically necessary treatment for mental illness under the same terms and conditions as medical disorders. Not all parity plans, however, are equal. Some plans provide equal co-pays, while others may provide equal day and dollar limits, or annual and lifetime limits. Making comparisons among parity plans is difficult.

Early figures on the cost of full substance abuse parity had been based on poor data from the early 80s.

Adding insult, from 1988-98, according to the recent HAY Group Report commissioned by the American Society of Addiction Medicine, value-adjusted dollars spent on substance abuse treatment had declined by 74.5%. This compares with an 11.5% decline in funding for medical benefits and a 52.3% decline for mental health.[1]

Part of the decline in funding for substance abuse treatment has been due to cost containment by shifting care to HMOs and carve-out insurers. Another part has been the direct impact of day and dollar limits on inpatient treatment.

This dollar decrease in substance abuse treatment services has had a noticeable effect. In a 1998 survey of ASAM members on the impact of managed care on substance abuse treatment, 67% of the physicians interviewed said that inpatient detox was negatively impacted. 86% noted declines in inpatient rehabilitation, 65% in outpatient rehabilitation, 79% in quality of care, 79% in ethical practice and 56% in income. Physician dissatisfaction has been high.

The historical problem facing advocates for substance abuse parity legislation has been twofold. First, the costs of substance abuse treatment have greatly exaggerated the real costs of full substance abuse parity. Second, the political climate surrounding substance treatment remains infertile despite pronouncements in Washington by drug czar, General Barry McCaffrey, that substance abuse treatment actually works.

Early federal legislative discussion on the cost of full substance abuse parity had been based on poor data from the early 80s. These studies estimated insurance premium increases of 9-30% for parity. Recent studies by SAMHSA and the RAND Corporation have recently put that estimate as low as 0.3-1.3%.

In 1998, SAMHSA compared 5 states with existing Mental Health and Substance Abuse Parity.[2] They modeled an "artificial" full parity plan that combined assumptions observed in the actual programs from each of the 5 states. They projected that full parity for substance abuse treatment increased premiums only 0.2%. This compares to a 3.4% increase from mental health parity.

The RAND Corporation in 1999[3] examined 25 "carved-out" managed care plans with unlimited substance abuse benefits. They calculated backward "what-ifs", e.g. what if substance abuse benefits were reduced by $10,000. They found that the incremental savings from limiting substance abuse treatment benefits were only $5.11 PMPY, or 0.3% premium. Moreover, the "what-if" benefit limits had great impact. A dollar limit of $5000 would adversely affect 11.3% of plan members and the save only 78 cents. They also noted benefit limits subjected insurers to many hidden unrecoverable expenses.

Despite better cost estimates, politics presents another roadblock to substance abuse treatment parity. Although overwhelming evidence suggests that cost savings for substance abuse treatment are substantial—every dollar spent on treatment results in 7-dollar savings in medical, occupational and social services—state and federal legislatures have found substance abuse treatment parity unpalatable.

Business, especially small businesses and chambers of commerce, are vocal critics saying that increases in the amount that they have to pay for health insurance for their employees are significant to their cost of doing business no matter how small they appear to others. The California Manufacturers Association opposed AB88. The California Association of Health Plans (CAHP) opposed AB88 because of the increased cost to employers. CAHP testified that for every 1% increase in premium cost 40,000 workers loose health coverage.

Lawmakers are not wholly unaware of the relevant issues. According to Nancy Chavez, legislative consultant to California Assemblywoman Helen Thomson, in early discussions on AB88, "substance abuse and dual diagnosis came up, but we needed to proceed one step at a time...to pass the broadest bill possible." Furthermore, "it took 3 years to bring (the legislature) up to speed, that mental health (disorders) are brain illnesses and treatment is effective."

Critics say that increases in the amount that they have to pay for health insurance for their employees are significant to their cost of doing business no matter how small they appear to others.

Chavez noted that substance abuse parity was heavily opposed by the insurance industry that used outdated fee-for-service cost estimates. Including substance abuse parity provisions in AB88 would have alienated support for mental health parity that already had a reasonable chance of passage. Chavez was not aware of any substance abuse parity bills in this session of the California legislature.

In Washington, Sen. Paul Wellstone (D-Minn.) has been one tireless advocate for substance abuse parity coverage. In July 1999 he introduced the Drug and Alcohol Addiction Recovery Act of 1999[4], noting that even if treatment is available and accessible, it is often unaffordable.

Of course, this was only Sen. Wellstone's fourth attempt since 1996 to pass a substance abuse parity bill through Congress. Perhaps his ongoing efforts will receive assistance from President Clinton who announced his intention to expand substance abuse treatment benefits to federal employees by executive order.

No substance abuse parity bills in this session of the California legislature

So, the question remains, while some feel the federal War on Drugs has swept aside the national substance abuse treatment agenda, is funding for substance abuse treatment moving forward? Or will it be left permanently dry-docked.

The local and national currents encircling parity are complex. Anyone willing to wade through the numbers and politics might wander into deeper uncharted waters before reaching the other shore.

References:

1. "The Impact of managed care on Substance Abuse Treatment," ASAM Position Paper prepared by the Working Group of the ASAM Managed Care Initiative, Internet version, April 28, 1999.

2. Sing, M, et al., "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, " DHHS Pub 98-3205. Rockville, MD: CMHS, SAMHSA, 1998.

3. Sturm, Roland, "How Expensive are Unlimited Substance Abuse Benefits Under Managed Care?," J. Behav. Health Svc and Res., Vol. 26, No. 2, May 1999.

4. "Wellstone's Latest Parity Bill Addresses Substance Abuse Treatment," Psychiatric News, Vol. XXXIV, No. 16, August 20, 1999.

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

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

PARITY FOR MENTAL HEALTH TREATMENT BUT NOT FOR SUBSTANCE ABUSE TREATMENT

Surgeon General's Report on Mental Health Touches on Co-occurring Addiction Only

Surgeon General David Satcher's Report on Mental Health, released by the National Institute on Health in December, 1999, calls for parity – equality between mental health and other health coverage. However, the addictive disorders are not discussed except in passing in the report.

In a section describing the scope of coverage of the report, it is noted that alcohol and drug use disorders "co-occur with such frequency with the other mental disorders, which are the focus of this report, that the co-occurrence is discussed throughout. The report covers the epidemiology of addictive disorders and their co-occurrence with other mental disorders as well as the treatment of co-occurring conditions. Brief sections on substance abuse in adolescence and late life also are included in the report."

The full report has been posted to three websites:

Surgeon General's Web Site:
www.surgeongeneral.gov/library/mentalhealth/home.html

National Institutes of Health:
www.nih.gov/mhsgrpt/home.html

National Institute of Mental Health:
www.nimh.nih.gov/mhsgrpt/home.html

CSAM IS MOVING!

NEW ADDRESS FOR CSAM BEGINNING JANUARY 1, 2000

California Society of Addiction Medicine
74 New Montgomery Street
Suite 230
San Francisco, CA 94105

Phone: 415/243-3322

Fax: 415/243-3321

E-mail will remain csam@compuserve.com

More on the Changes at CSAM

Fundamental changes are underway within CSAM. Our founding Executive Director, Gail Jara, is retiring, and CSAM will move into an association management group in San Francisco where Kerry Parker will be our new Executive.

The other fundamental change for us is related to our finances. We will be doing the same work with less money. During the 1999 retreat, Executive Council members committed to keeping a strictly balanced budget, something that CSAM has not been able to achieve in three of the last four years.

New Executive Director

Kerry G. Parker brings an impressive educational background and a wealth of experience in making organizations productive. She has worked in Association Management since 1985 when she finished graduate school with an MPA in Public Administration. She graduated in 1981 from the University of Iowa, Iowa City with a BS in Journalism and from Iowa State University in 1985 with a MPA in Public Administration. In 1991 she became a Certified Association Executive (CAE), a credential awarded by the American Society of Association Executives. She is Executive Vice President of the Northern California Society of Association Executives, a position she has held for the last ten years.

She and her partner, Kirk Lindeman, CMP, are co-owners and principals of Holland-Parlette Associates, Inc., a firm with 15 employees. Their clients include the Western Occupational and Environmental Medical Association (WOEMA), the California Society of Internal Medicine, the Oxygen Society, the Medical Marketing Association and nine other associations.

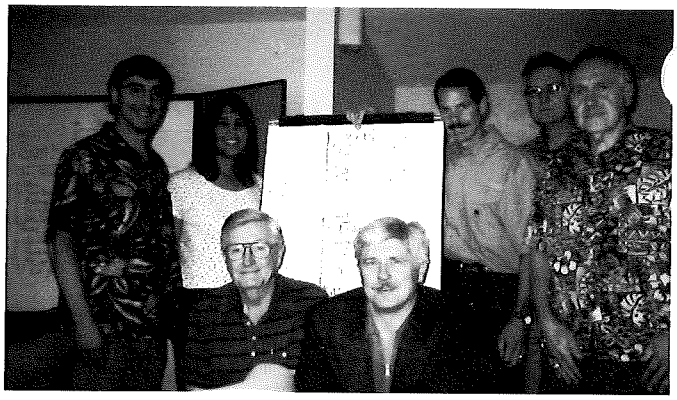
She lives in marin with her husband Jim and their nine-year old son, Reid. Jim Parker is Assistant Hospital Administrator at Alameda County Medical Centers – the County hospital system. Kerry is a tennis player; Jim is a runner. He completed the Portland marathon and will be in Boston for the marathon this year. They are transplanted Californians, from Iowa as are Kerry's two sisters and her brother, who also live in California now.

CSAM Executive Council

During the year 2000, the Executive Council will restructure itself to put more emphasis on Committee activity. Each person on the Executive Council will have a specific portfolio of accountable work assignments. Some seats will become *ex officio* and be filled by the appointed chairpersons of CSAM's major committees – Education, Fund Raising, Public Policy, Publications, Treatment of Opioid Dependence. The officers and two members-at-large will be filled by election. Nominees for the at-large seats will be solicited from all members, for the election at the annual meeting in October 2000.

The transition will begin with changes to the by laws. Members will be kept informed of the proposed changes by notices in the newsletter and on CSAM's new website when it "goes up" in February. Stay tuned.

– Peter Banys, MD



The Executive Council held a 2-day retreat meeting in August to wrestle with all the issues of organizational change and came away with a plan.

Standing (from left): William Brostoff, Lori Karan, Steven Eickelberg, Gary Jaeger, John Harsany, Jr. Seated: Gail Shultz, Peter Banys

Executive Council 2000

Peter Banys, MD	President
Gary Jaeger, MD	President-elect; Chair, Committee on Public Policy
Lyman Boynton, MD	Secretary-Treasurer
Gail Shultz, MD	Immediate Past President; ASAM Regional Director from CA (Region II)
Steven Eickelberg, MD	Member-at-Large; Chair, Committee on Fundraising
Walter Ling, MD	Member-at-Large; Chair, Committee on Opioid Dependence
Donald Wesson, MD	Member-at-Large; Chair, Publications Committee
David Pating, MD	Member-at-Large; Chair, Committee on Education
John Harsany, MD	Member-at-Large
Lori Karan, MD	Member-at-Large
David Smith, MD	Member-at-Large
Margaret Yates, MD	Member-at-Large

LETTER TO THE EDITOR

CSAM Should Oppose Prop. 21

There is an initiative on the March 2000 ballot, Proposition 21, that CSAM should take an active stance in opposing. Though it is a rather technical legal proposition, proposing changes to the Penal Code and Welfare and Institutions Code, the gist of the Proposition would be to increase the number of juveniles who are sent to adult state prisons, and decrease ft number who are eligible for local county programs. CSAM's concern should come from the pervasive lack of drug treatment programs in the adult prisons, as opposed to the availability of drug treatment programs funded by many counties for their young people in general, and juvenile offenders in particular. At present the California Department of Corrections (the agency that administers the adult state prisons) has fewer than 10,000 treatment "slots" per year for an inmate population of over 160,000 men and women, most of whom have significant chemical dependencies. Some institutions do not even have more dm very minimal volunteer 12-Step programs because of their remote locations. CSAM should also oppose the Proposition because it is completely anti-rehabilitation in its orientation. There is no money proposed for either prevention of juvenile crime or treatment of juvenile offenders. CSAM should be promoting the message that successful rehabilitation and change can occur for many people who have made bad choices in their lives.

CSAM might also consider a standing subcommittee on chemical dependency and treatment in correctional settings.

Sincerely,

Alan A. Abrams, MD, JD

Editor's note: The California Secretary of State's official description and preliminary analysis of Proposition 21, plus other information, is available on the internet at www.noprop21.org. Interested readers can also find out more by joining the discussion group at www.egroups.com/list/defeat_juvenile_crime/info.html.

New Members

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

Marshall David Bedder is National Medical Director of NEURAAD, Inc., a program for opioid addiction utilizing rapid anesthesia-assisted detoxification and emphasizing neuro-behavioral and neuropharmacologic adjunctive treatments.

Charles J. Burstin is an internist and renal specialist in Beverly Hills.

Thomas Leverone is Medical Director of the Department of Anesthesiolgy and of the Opiate Detoxofication Unit at Centinela Hospital in Inglewood.

Edward A. Moore is Medical Director of San Diego Health Alliance, a narcotic treatment program, and San Diego Reference Lab.

Steven F. Ruh is an anesthesiologist in West Covina with Aegis Medical Systems, which operates narcotic treatment programs throughout the state.

Stephanie Shaner is a psychiatrist and physician-in-charge of the Department of Addiction Medicine with the Southern California Permanente Medical Group.

News About Members

Steve Batki is now Director of Research in the Department of Psychiatry at the School of Medicine, State University of New York at Syracuse. He left his position as Director of Substance Abuse and Addiction Medicine at San Francisco General Hospital. **David Hersh, MD** has taken that position.

Tim Cermak now serves as the Medical Director for Ohlhoff Programs, in addition to his private practice of psychiatry in San Francisco and Marin.

Dan Ferrigno has moved to Winton after a series of surgeries that gave him two new hips. He reports he is walking with a cane.

Howard Kornfeld has been given an affiliate membership in the American Academy of Addiction Pstchiatry.

Matilda Mengis and **Scott Smolar** are now at San Francisco General Hospital Hospital in the Department of Substance Abuse

Michael Meyers is now an addiction medicine physician with Kaiser in Harbor City.

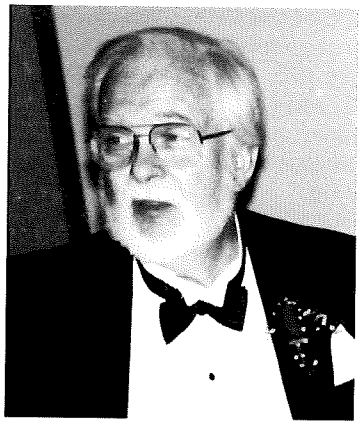
Cheryl Paizis is now Medical Director of Sacramento County Jail Psychiatric Services.

Michael Shwayder is now Medical Director of the Chemical Dependency Unit at Daniel Freeman Hospital in Marina del Rey

Don Wesson is now Vice President, Clinical Development for Drug Abuse Sciences, Inc., a pharmaceutical company dedicated to addiction care, based in Meno Park and Paris.

Jess W. Bromley, MD 1931-1999

Jess W. Bromley, MD, one of the founders of the specialty of addiction medicine, passed away September 17, 1999 at the age of 68. Jess was born on January 31, 1931 in American Fork, Utah. After receiving his bachelor's degree and MD degree from the University of Utah, he completed his internship and residency at the US Naval Hospital in Oakland and served at the US Naval Hospital in Yokosuka, Japan. He achieved the rank of Lieutenant. Commander and was cited for establishing the first coronary care unit.



Jess's early professional focus was on critical and coronary care. In 1966, he established a private practice in internal medicine in San Leandro. He served as medical director of the intensive and coronary care units at several hospitals and was president of the Alameda County Heart Association.

In the late 1960s Jess recognized the need for more humane treatment of drug addicts and for the professionalization of drug abuse treatment, and he worked tirelessly toward these goals for the rest of his life. He once said that addiction to drugs and alcohol was the most pressing problem facing the medical profession.

He served on many California Medical Association Committees. He founded the California Society of Addiction Medicine and served as its president. He was instrumental in unifying the American Society of Addiction Medicine and served as its first delegate to the American Medical Association House of Delegates, where he enjoyed his greatest achievement -- the recognition of addiction medicine by the AMA as a practice specialty.

A colleague in the AMA House of delegates said of Jess, "With his staff-like cane and his flowing beard, he reminded me of a prophet of yore, but the sermon he preached was as modern and relevant as any other issue being voiced in the House."

Jess also launched many alcohol and drug dependency programs, including Starting Point at the Hayward Hospital, Step One at Physicians' Community Hospital in San Leandro, the detoxification unit at the Alameda County Health Department, Brothers United to Combat Addiction, Caucus of San Leandro, and Desiderata House.

In 1994, after suffering a stroke the previous year, Doctor Bromley retired from his busy medical practice and from medical politics.

Jess is survived by his wife, Jane; his children, Robin and Benjamin Bromley of Castro Valley; David Bromley of Arlington Heights, IL; Lynne Bromley Kite of Park Ridge, IL; Richard Bromley of Los Angeles; and Susan Bromley of Pacifica; six grandchildren, as well as a sister and two brothers.

Donations in his memory can be made to:

Jess Bromley Education Fund
California Society of Addiction Medicine
74 New Montgomery Street
San Francisco, CA 94105

or

Jess Bromley Memorial Fund
American Society of Addiction Medicine
c/o Claire Osman
12 W. 21st Street
New York, NY 10010

Memories of CSAM's Founder

Jess Bromley was always a "global thinking" person. My memories of Jess go back to the 1960s during the time when substance abuse was exploding particularly in the Bay Area. Jess and I were both involved in starting community substance treatment programs and we would frequently get together to exchange ideas and to work at problem solving.

We felt that the treaters and treatment had to be professionalized. Jess envisioned a national organization with professional standards for those who treat alcohol and drug abuse.

It was at that time that Jess and I were concerned regarding the quality of alcohol and substance abuse treatment. We felt that the treaters and treatment had to be professionalized. Jess envisioned a national organization with professional standards for those who treat alcohol and drug abuse.

With this in mind we got together with Gail Jara and began discussions as to how to implement this concept. We were able to enlist the aid of the California Medical Association through the Committees on Alcoholism and Drug Abuse. Jess was able to enlist the support of the leaders in the field of treatment. Jess was always able to convince people of the wisdom of his ideas.

Out of all this came the first organization in California called the California Society for the Treatment of Alcoholism and other Chemical Dependencies, generally shortened to the California Society. Through Jess's ability to not only think globally but to act globally the California Society eventually connected with the American Medical Society on Alcoholism and eventually the national organization that Jess envisioned was formed – ASAM!!

I am sure that without Jess's vision and energy we would not be as far along in the professionalizing of alcohol and substance abuse treatment.

Jess and I remained close friends during all of this. We used to refer patients to each other. He would see the adults involved and I would take care of the adolescents. He will be greatly missed and I will always fee the absence of a good friend and colleague.

Arthur Bolter, MD

Announcing the CSAM Founder's Lecture

The Jess W. Bromley Memorial Lecture

To continue the memory of the founder of the Society, CSAM has established a Founder's Lecture to be given regularly in association with our major conference, the Review Course in Addiction Medicine or the State of the Art Conference in Addiction Medicine. CSAM will invite lecturers on topics related to the professional identity of the specialty of addiction medicine and introduce them with a brief history of Society's formation. Doctor Bromley's intention in establishing the Society in 1972 was to provide the traditional specialty society structure for physicians who treated alcoholics and other drug dependent patients through which they could come together for education, peer interaction and development of professional standards.

The first lecture will be given at the Review Course in the year 2000.

Donations to the CSAM Education Fund marked for The Jess W. Bromley Education Fund or the Founder's Lecture will be used to support the lecture. Each donation will be acknowledged to Doctor Bromley's family and in the lecture program at the time of the presentation.

Jess W. Bromley, MD 1931-1999

CSAM

The California Society of Addiction Medicine

presents its

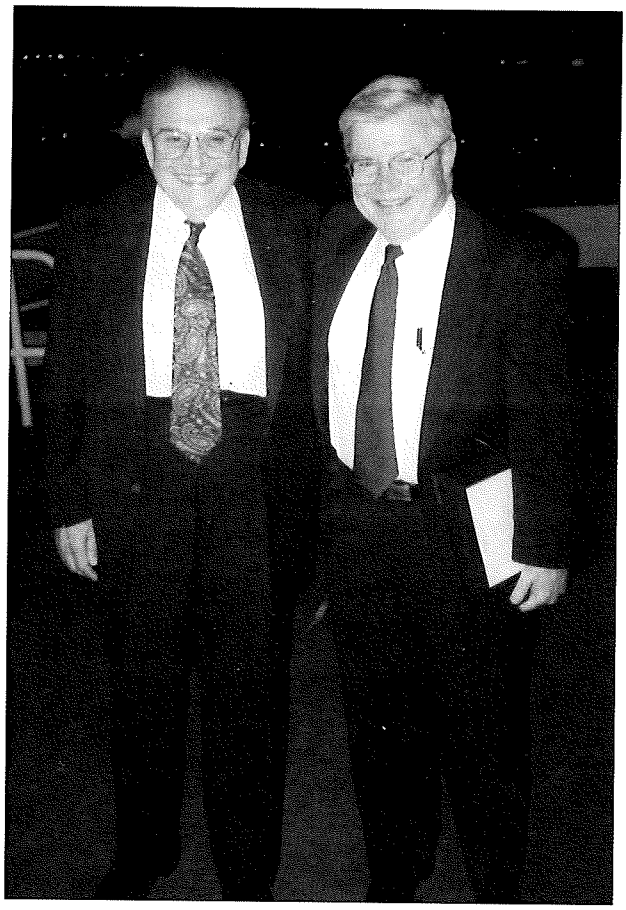
Community Service Award

to

Jack Sanow

in grateful recognition of
his tireless dedication
and his loving contributions
over the years
to the health and well-being of
the physicians of California

Presented in Los Angeles
on the eighth day of October, 1999



Jack Sanow and Donald Wesson

Community Service Award recipient Jack Sanow surrounded by well-wishers.

CSAM Awards

The Community Service Award

Alcohol and other drug use, abuse and addiction are public health problems. The California Society wishes to recognize persons who have made a positive impact on the public health of our communities in California.

The Community Service Award is given in recognition of activities which have made a significant positive impact on the public health and have beneficially influenced the quality of life for the citizens of a California community.

The Vernelle Fox Award

The California Society wishes to recognize physicians who have made noteworthy and lasting contributions in line with the mission of the Society: contributions which improve the quality of health care services, increase communication and education among providers of care and add to the research on which the understanding of the field is based and on which the health care services are built.

Because the Society has designated Vernelle Fox, MD, as the model against which future recipients will be measured, the criteria for selection will reflect the contributions and qualities for which she was honored at the Society's Tenth Annual Meeting: an inquiring mind (contributions to the understanding of the field), courage (resolution, tenacity), and enthusiasm (energy for the positive).

Vernelle Fox Award recipient Donald Wesson and his wife, Eileen, with Gail Jara (far left) and Peter Banys (for right).

CSAM

The California Society of Addiction Medicine

presents the

Vernelle Fox Award

to

Donald R. Wesson, MD

in appreciation
of his many contributions
to the field of addiction medicine
as a scientist,
a critical thinker
and
a clinician

Presented in Los Angeles
on the eighth day of October, 1999

From NIDA

Principles of Effective Treatment

A Review by Peter Banys, MD

NIDA has just published an excellent booklet which makes helpful reading for addiction medicine specialists, for our colleagues and our patients. It is the first ever science-based guide to drug treatment, in clear, straightforward language – for all readers. The 54-page booklet does not mince words. It states principles succinctly and candidly:

- Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning.
- Medications are an important element of treatment for many patients, especially when combined with counceling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabalize their lives and reduce their illicit drug use.
- Treatment does not need to be voluntary to be effective.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

It gives clear descriptions of 12 different approaches to treatment and gives the 2-3 central references which support their efficacy. It is well worth reading from cover to cover for good information and an overview of current treatment models.

Copies are available from NIDA's website, www.nida.nih.gov, or from the National Clearinghouse for Alcohol and Drug Information (1-800-729-6686).

NIDA lists Scientifically-Based Approaches to Drug Addiction Treatment

- Relapse prevention
- Supportive-expressive psychotherapy
- Individualized drug counseling
- Motivational enhancement therapy (MET)
- Behavioral therapy for adolescents: stimulus control, urge control, social control
- Multidimensional family therapy (MDFT) for adolescents
- Multisystemic therapy (MST) for serious anitsocial behavior in children and adolescents
- Combined behavioral and nicotine replacement therapy for nicotine addiction
- Community reinforcement approach (CRA) plus vouchers
- Voucher-based reinforcement therapy in methadone maintenance treatment
- Day treatment with abstinence contingencies and vouchers
- The Matrix model

Office-Based Buprenorphine Trials Have Begun in California

The NIDA-funded multicenter safety trial is under way, making buprenorphine available for physicians to prescribe in routine office practice for the treatment of opioid dependence.

In California, the trials are being conducted by Walter Ling, MD. In addition to his office in Los Angeles, five other private offices or clinic settings throughout the state are participating:

- In Santa Barbara, P. Joseph Frawley, MD, in his office practice of general internal medicine.
- In Stockton, Ernest Vasti, MD, in his office practice of family medicine.
- In Berkeley, Donald Wesson, MD, in his office practice of psychiatry.
- In Clovis, Richard Guzzetta, MD, in his office practice of family medicine.
- In the VA Medical Center in Loma Linda, Mickey Ask, MD, in the substance abuse clinic.

To be eligible for the study, a patient must be 18 years or older, able to give informed consent, able to comply with the requirements of the study, and able to participate for 12 weeks or longer. The patient must meet the DSM-IV criteria for the diagnosis of opiate dependence and must be seeking opiate substitution treatment.

Persons who have an acute medical condition that would make participation hazardous, or who need inpatient treatment for any condition, cannot be accepted into the study. Pregnant or nursing women are not eligible. Persons who are dependent on, or need immediate medical attention for dependence on, a drug other than an opiate, caffeine or nicotine, cannot be accepted. Persons who have stopped their participation in a narcotic treatment program within the last 30 days are not eligible. Anyone who expects to leave the area before completing the study or a person with pending legal action that could prohibit completion of the study cannot be accepted.

Patients will be accepted for a minimum of 12 weeks and may participate up to one year. The first six weeks will be devoted to stabilization on buprenorphine. At the end of the period of stabilization, the patient and the treatment staff will determine the appropriate course of treatment: detoxification or on-going substitution therapy for a period of up to one year.

Patient retention rates will be the primary outcome measure, with emphasis also given to urine toxicological screen results, patient self-reports of drug use and the clinician's rating of improvement.

For more information about the trials, or to refer patients to one of them, contact Walter Ling, MD at 310/479-9330 or Susan Camber at 510/704-8119.

Drug Abuse Treatment in the US at the Millennium

BY DONALD R. WESSON, MD

As addiction medicine has matured and been increasingly recognized as a subspecialty, the growth process has been both painful and inspiring. While great leaps have been made in the basic science of addiction and evidence for treatment effectiveness has been steadily accumulating, patient access to drug abuse treatment has decreased. Politically, it is fashionable to assert that drug addicts don't want treatment, but a wealth of clinical experience tells a different story.

While great leaps have been made in the basic science of addiction and evidence for treatment effectiveness has been steadily accumulating, patient access to drug abuse treatment has decreased.

The addiction medicine field has been divided into two ideological camps – those who believe that the primary goal of drug abuse treatment is abstinence from all mind-altering drugs and those who believe that the primary goal is for patients to be free of health-impairing drug use and able to function as members of society. In the US, and particularly within ASAM, the ideological split is not as acrimonious as it once was, but the laying down of arms has been slow.

In the US, we like to view ourselves as progressive and at the forefront of addiction treatment. NIDA funds 85 percent of the drug abuse research in the world, and most of the leading addiction journals are published in the US. The annual meeting of the College on Problems of Drug Dependence is clearly the world's premier scientific meeting devoted to drugs of abuse. One might think, or at least hope, that this advantage of resources and expertise would translate into a leadership position in front line treatment of drug abuse. However, there is considerable evidence that other countries are ahead of the US in terms of access to treatment and in the application of treatment technology. Take France, for example, where the treatment for heroin addiction until 1996 was limited to detoxification, with or without medication support. In 1996, methadone maintenance was introduced, and in 1997, buprenorphine. Now, methadone and buprenorphine are dispensed in both drug treatment clinics and the offices of private physicians. The public health consequences have been positive, contrary to what some in the US would predict.

Other countries are ahead of the US in terms of access to treatment and in the application of treatment technology.

In the US, one of the symbols of the ideological polarization is the concept of "harm reduction." As applied to drug abuse, "harm reduction" can have very different meanings depending on the speaker and the context in which it is used. In the libertarian view, drug abuse is seen as a life-style choice and, in and of itself, not a disease or disorder. Harm reduction advocates say that clean needles and drug education are the appropriate interventions. They would not insist that drug abuse treatment was needed.

In the drug abuse treatment community, harm reduction advocates support opiate substitution or replacement therapy and do not insist on abstinence as the only appropriate goal of treatment. Experience has demonstrated that some heroin addicts have an ongoing physiological need for opiates and will function well within the bounds of society when stabilized on an effective maintenance dose.

The current efforts for providing opiate maintenance in office-based practice represent a gradual movement in the right direction.

Despite a large body of research supporting the efficacy of maintenance treatment in reducing crime and reducing high-risk behavior for acquiring of spreading HIV infection, treatment opportunities are minuscule compared to the need. The current efforts for providing opiate maintenance in office-based practice represent a gradual movement in the right direction.

Despite our superior research resources, we are behind most of the industrialized countries in health care delivery and drug abuse treatment not because we lack knowledge, but because our public policy is driven by a greater passion for finding evil than for advancing the public health. □

1980-2000

California's Diversion Program for Physicians is 20 Years Old

A Comprehensive Review of Diversion

The Medical Board of California's Diversion Program begins its 20th year with a system-wide review of the Program's efficacy and the $800,000 per year current cost. The review is being conducted by staff of the Medical Board and the Diversion Program and by a MBC Task Force on Diversion chaired by MBC member Karen McElliott from San Diego. The Task Force was appointed by MBC in 1997 "to make a deliberate and long-term evaluation of the Program," said Ms. McElliott. Three meetings have been held so far: on June 3, 1998, November 5, 1998 and January 20, 1999. Previous reports appeared in *CSAM NEWS* in the Fall and Spring issues of 1998.

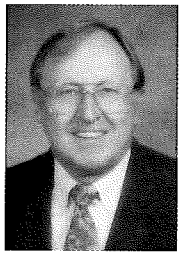
The staff review of the Diversion Program compares it to the elements described in a draft document entitled "Guideline for the Regulatory Management of Chemically Dependent Health Care Practitioners" from the Citizen Advocacy Center in Washington, DC – A Training, Research, and Support Network for Public Members of Health Care Regulatory and Governing Boards.

The 4th meeting of the Task Force was expected in January, 2000, but no date had been set when this newsletter went to the printer. Information about the progress and the outcome of the review and evaluation of the Diversion Program will be reported in future issues. □

Diversion Program Managers

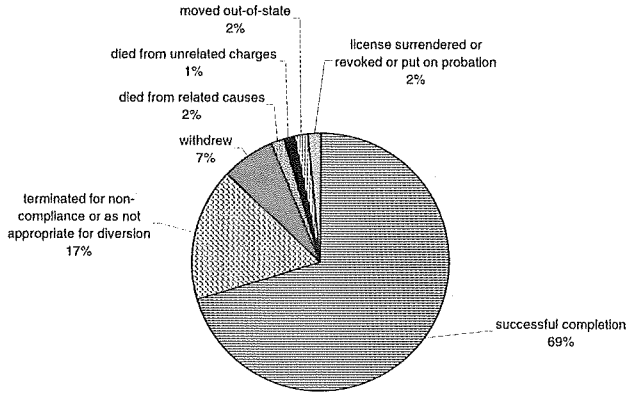
Jerome Becker – 1980–1985
The founding Program Manager

Chet Pelton
1985–1998



Janice Thibault
1999

955 participants since 1980



A total of 955 physicians have completed or left the Diversion Program between January 1980 and June 1999. Six hindred fifty completed the program successfully.

Physicians May Have to Choose Between an 805 Report and Mandatory Diversion

Pending changes in the law (SB1045) may require hospital medical staffs to make an 821.5 report to the Diversion Program when the medical staff takes action resulting in a physician taking a leave to enter treatment for chemical dependence. The same change may also require that the physician enter the Diversion Program. If the physician is not willing to enter the Diversion Program, the Medical Staff would be required to submit an 805 report, instead of an 821.5 report.

Information in 821.5 reports is kept by the Manager of the Diversion Program. If she determines that appropriate action has *not* been taken by the hospital medical staff or other peer review body to resolve the matter within 75 days, she reports the information to Enforcement. If she receives a follow-up report from the medical staff and determines that appropriate action *was* taken, all records are destroyed.

Section 805 report information is kept by the Enforcement Division of the Medical Board and reported to the National Practitioner Data Bank. The 805 information about the physician is reported to all health care service plans or medical staffs at the time of an application for privileges or renewal of privileges. □

CONTINUING MEDICAL EDUCATION

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

ASAM Certification Examination
November 18, 2000
Los Angeles, New York, Chicago
Sponsored by American Society of Addiction Medicine
Credit: 5 hours of Category 1 credit
For information: ASAM 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920.

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

CONTINUING MEDICAL EDUCATION

AMTA

American Methadone Treatment Association

April 9-12, 2000
Hyatt Regency, Embarcadero Center, San Francisco
Sponsored by American Methadone Treatment Association, Inc. and American Society of Addiction Medicine
For information: AMTA, 217 Broadway, Suite 304, New York, NY 10007. Phone: 212/566-5555. Fax: 212/349-2944

31st Annual

ASAM's Medical Scientific Conference

April 14-16, 2000
Chicago Downtown Marriott, Chicago, IL
Sponsored by American Society of Addiction Medicine
Credit: 21 hours of Category 1 credit
For information: ASAM 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920.

62nd Annual Scientific Meeting

College on Problems of Drug Dependence

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

ASAM MRO Course

Medical Review Officer Training Course

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

CSAM Review Course in Addiction Medicine

October 11-14, 2000
Radisson-Miyako Hotel, San Francisco
Sponsored by California Society of Addiction Medicine
For information: CSAM, 74 New Montgomery Street, Suite 230, San Francisco, CA 94105. Phone: 415/243-3322. Fax: 415/243-3321.

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California Society of Addiction Medicine
3803 Broadway, Oakland CA 94611

CSAM IS MOVING!
NEW ADDRESS FOR CSAM BEGINNING JANUARY 2000
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San Francisco, CA 94105
Phone: 415/243-3322; Fax: 415/243-3321
E-mail will remain csam@compuserve.com