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RESPONSE TO INFLAMMATORY HEADLINES

CSAM Defends Methadone Maintenance

by Judith Martin, MD, Chair, CSAM Committee on the Treatment of Opiate Dependence


JUDITH MARTIN, MD

EFFECTIVE TREATMENT for opiate addiction is crucial in California where heroin is readily available. According to the national Drug Abuse Warning Network, which examines medical records related to drug abuse, in San Francisco emergency-room records, heroin is mentioned four times more frequently than the national average for big cities. [1]

In its Consensus Statement of 1997, the NIH called opiate addiction a 'brain disease' and recommended expanded access to medical treatment, including methadone maintenance. [2] The same report characterized methadone maintenance treatment as over-regulated. Diversion of methadone from opioid treatment programs was a marker for lack of treatment. Diverted methadone was being used by addicted persons in withdrawal. [2]

Concern about diverted methadone has resurfaced lately, and may be focused on methadone use outside of methadone maintenance. In January of this year, a DAWN report about "narcotic analgesics" – among them methadone – was issued. [3] Abuse of these prescription medications has increased nationwide by

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Little Hoover Commission Takes a Stand for Addiction Treatment

by Gary Jaeger, MD, FASAM and Donald J. Kurth, MD, FASAM

The Facts

"One in nine Californians suffers from an addiction to alcohol or other drugs. But few addicts suffer alone. Drug addiction underlies the abuse and neglect of more than 100,000 children in California and is a factor in a majority of domestic assaults."

"Eight in 10 felons who are sent to prison abuse drugs or alcohol. But the costs are not limited to the criminal justice system. Some $11 billion is spent from the state General Fund responding to problems created by abuse of addiction. The expenditures and economic losses to individuals, corporations and public agencies that result from abuse and addiction in California are estimated to top $32 billion."

So begins the cover letter to Governor Gray Davis of the Little Hoover Commission report entitled, **FOR OUR HEALTH & SAFETY: Joining Forces to Defeat Addiction**. The Little Hoover Commission is an independent state oversight agency entrusted with "making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives..." The Commission is a bipartisan board composed of five public members appointed by the Governor, four public members appointed by the Legislature, two Senators and two Assemblymembers. Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the commission supports through the legislative process. This report is likely to shape public policy on addiction treatment in California over the next decade.

Over the course of the past year the Little Hoover Commission has accepted testimony, organized workgroups, and hosted subcommittee meetings throughout California in an effort to understand the role that the state plays in combating drug and alcohol addiction. The result of this Promethean effort was published March 2003 and is available for order or download at **www.lhc.ca.gov**. CSAM President Gary Jaeger, M.D., Past President David Smith, M.D., CSAM Member Charles Moore, M.D., Kathryn Jett, Director, California Department of Alcohol and Drug Programs, Joan Ellen Zweben, Ph.D. and many other experts in the field of addiction treatment contributed to the report by providing expert testimony.

The Commission notes that "because of its earlier work on criminal justice, mental health and child abuse, the Commission began this study with the understanding that alcohol and other drug treatment could change lives and is essential to safe, healthy and productive communities."

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The report begins:

> *Alcohol and drug abuse underlie many of our greatest concerns: Persistent poverty and homelessness. Violence in living rooms and in neighborhoods. The neglect by parents and the squandering of youth. Carnage on highways. Overcrowded jails, prisons, emergency rooms, and foster care systems. In many neighborhoods, the addiction and abuse of alcohol and other drugs are nothing less than a scourge, the plague of our day that is stripping communities of potential, ambition, and hope.*
>
> *Recovery, however, is possible. Treatment works. Managed correctly, alcohol and drug treatment is a cost-effective response to these expensive maladies – saving $7 for every dollar spent, by two analyses. As part of a larger effort to reduce drug and alcohol abuse, treatment can restore lives, revive communities, and reduce the growing demand on public programs.*

The Commission noted that they were "impressed by the dedication and professionalism of the people working to help the addicted recover." "But ultimately," the report continues, "the Commission was struck by the evidence that we could do much more to coordinate drug control efforts, target our resources, improve the quality of treatment, integrate necessary interventions to improve effectiveness, and make the most of available funding."

The report goes on to cite specific findings and make equally specific recommendations to correct these problems. Each item is then further defined and the resources or course of events required to implement each specific recommendation is described in detail *(see sidebar on page three)*.

Specific Recommendations

Among the specific findings and recommendations of importance to addiction medicine physicians are the following:

1. While recognizing a role for prevention, treatment and enforcement, the Commission is critical of the current federal policy of putting enforcement first. The report notes that, "the emphasis on enforcement has meant that those involved in the drug trade, as well as the addicted, have largely been dealt with through arrest and incarceration. Nationwide the number of state prisoners serving time for drug offenses has soared from 19,000 in 1980 to nearly 237,000 in 1998...There is a growing doubt that America can incarcerate its way out of its drug problem." The Commission cites a 1995 RAND study which identified treatment as the most cost-effective of the three drug control strategies (prevention, enforcement and treatment) by a margin of 7 to 1 for reducing cocaine consumption.

2. The report argues for the State to adopt a strategic approach to allocate and coordinate its drug control resources. It calls for the creation of a "Coordinating Council on Alcohol and Drug Abuse Policy" to create and guide a strategic plan. The Committee recommends that the 16-member Coordinating Council include "a representative from a California addiction medicine association."

3. Noting that the trend in substance abuse benefits is downward[1] the report calls for increased private sector participation. "Providing treatment to substance-abusing employees reduces absenteeism, raises productivity and improves workplace safety. A Price-Waterhouse-Coopers study estimated the cost at 50 cents per insured person. The State could shift part of the burden of treatment to employers, who would see improved attendance productivity and safety. The Commission also found that the State's own health plan, the Public Employees Retirement System provides a lower level of coverage than research shows is clinically effective.

4. Finding that quality control in drug treatment programs often falls short, the Commission put forward a number of measures to raise the quality of personnel, programs and facilities, including certification and raising wages for drug treatment counselors, specifying staff to client ratio in treatment programs, and instituting outcome-based performance measures. These measures will require increased authority for the state's Director of Alcohol and Drug Programs.

A Useful Resource

In addition to the specific recommendations, the report is chock full of valuable data, graphs, and charts presented in a form that would be easily understandable by educators or legislators as well as the general public. Addiction is clearly defined, the extent of the problem is identified, and statistical comparisons are provided between California and the United States as a whole. Unfortunately, California leads the nation in all the areas of drug and alcohol use presented except binge drinking.

The history of addiction treatment public policy is outlined, not just for California, but also nationally. Treatment availability is reviewed and funding sources

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FOOTNOTE

1. Between 1988 and 1998 the value of addiction treatment benefits has declined 74.5 percent compared to a 14.2 percent decline for all employer-provided health care benefits.

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are discussed. Special population, Proposition 36, treatment instead of incarceration, private participation in addiction treatment, and addiction treatment parity are all covered in this omnibus report.

The signature of CSAM and ASAM are threaded throughout the report. Many of the concepts and ideas are the same as those we have been discussing and promoting for years in our public policy statements, and our conferences across the state and across the country. Perhaps this should not be surprising since CSAM and ASAM have struggled to bring an evidence-based understanding of addiction and treatment into public policy. However in the political arena, where metaphors of war rather than medicine are more often applied to drug policy, it is a breath of fresh air to see a major policy document guided by scientific evidence.

Send for a copy of this report today. But beware: this is not bedside reading. This is a living, breathing document that lays the foundation for saving the lives of thousands or even millions of people who suffer from the disease of addiction.

FINDINGS AND RECOMMENDATIONS OF THE LITTLE HOOVER REPORT

1. The State's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California.

Recommendation: The State should establish a council to develop a unified strategy to cost-effectively reduce the expense, injury and misery of alcohol and drug abuse. The council should advise policy-makers, coordinate programs and assess the effectiveness of statewide efforts to reduce the consequences of addiction. The Council should:
- Involve prevention, treatment, and law enforcement leaders
- Institutionalize a planning and coordination process.
- Guide the allocation of resources
- Advance evaluation and accountability
- Focus on youth

2. The State does not make the most of available resources by prioritizing treatment to serve those whose drug and alcohol abuse imposes the greatest consequences on Californians and their communities.

Recommendation: Working with counties, the State should set broad goals for treatment programs and help counties to ensure that treatment is available to those whose substance abuse imposes the greatest harm on their communities. Specifically, the State should:
- Establish State goals
- Require counties to assess community needs and concerns
- Shift resources to intervene earlier with substance abusers
- Establish accountability for outcomes

3. The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement.

Recommendation: The State should implement outcome-based quality control standards for treatment personnel, programs, and facilities and encourage continuous quality improvement. Specifically the State needs to:
- Define and enhance the Director's authority
- Develop management tools
- Establish a strategy to develop a well-qualified workforce
- Develop, promulgate and enforce treatment quality standards
- Tie provider reimbursement to outcomes
- Ensure safe and suitable treatment facilities

4. To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse.

Recommendation: The State should facilitate the integration of alcohol and drug treatment with other social services to effectively reduce abuse and related public costs. Ways to promote integration include:
- Replicate and reinforce success
- Develop leaders
- Create a process and a venue to facilitate change

5. Even if the State integrated its drug control efforts and improved alcohol and drug treatment services, as presently funded, available treatment would be inadequate to respond to the costs and misery inflicted on California communities by substance abuse.

Recommendation: The State should immediately maximize available resources that can be applied to treatment. As the treatment system improves, the State also should consider new funding sources to provide more stable funding.
- Make the most of available federal funds
- Seek reimbursement from clients
- Reinvest in treatment
- Expand private sector participation
- Identify new sources of revenue

CSAM Responds; Defends Methadone Maintenance

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117 percent between 1994 and 2001. The highest percent of these emergency room visits with mention of narcotic analgesic abuse was for patients with a diagnosis of dependence. The specific medications most responsible for the increase were oxycodone, methadone, morphine and hydrocodone, in that order. [3]

With this nationwide increase in problematic abuse of prescription opioids as a backdrop, publicity has surrounded an increase in reported methadone-related deaths along the East Coast. [4] (See page five for CSAM's letter to the *New York Times* editor). Maine and Florida are specifically mentioned. The Center for Substance Abuse Treatment (CSAT) has been collecting and analyzing information about these deaths, and preliminary data were shared at the recent meeting of the American Association of the Treatment of Opioid Dependence in Washington, DC. (Clinician Roundtable, led by Dr. Alan Trachtenberg) Not all of the deaths were in opioid dependent individuals. Some were in abusers who were not dependent, and are presumed to have had low tolerance, and some may have been in patients with poorly managed chronic pain. The methadone was in pills (most methadone clinics dispense liquid methadone). Many of the victims had medical co-morbidity, including cardiac histories.

Why certain East Coast States should have an increase in deaths with methadone is not a fully answered question, but pathologists from the University of Florida (in Florida, methadone deaths increased 71 percent in one year) believe that the source of the diverted methadone is prescriptions originally written for pain syndromes. [5, 6]

DAWN reports of drug-related deaths show that deaths in Miami from narcotic analgesics also had four or more other drugs involved in 85 percent of cases. [7] This poly-drug abuse highlights one of the perennial problems in analyzing "methadone deaths." Because tolerance varies so much in addiction, there is no standard lethal blood level of methadone that can be used as a diagnostic tool in post-mortem evaluation. And even relatively low blood levels of methadone may be lethal when sedative effects are potentiated with CNS depressants such as benzodiazepines.

Although it is important for West Coast CSAM members to know about this publicity related to methadone, the same DAWN report on drug-related deaths shows a decrease in narcotic-analgesic-related deaths in San Francisco and in San Diego from 1999 to 2001. Still, methadone is among the top ten drugs mentioned in drug-related deaths in San Francisco. [7]

Patients in methadone maintenance should be reassured that these deaths were not patients in treatment. The methadone maintenance literature clearly shows that methadone treatment is life-saving. Methadone maintenance is not just a medication, and includes counseling, testing and structured supervised dose administration early in treatment. Methadone maintenance has been shown to reduce mortality [8] [9], and discharge from methadone maintenance treatment is associated with an increase in death rates. [10] [11] Addiction physicians who are familiar with the beneficial effects of methadone maintenance treatment, and with the literature showing effectiveness at average doses of 80 to 120mg per day [12] [13] may be puzzled about these reports of lethal effects. Training of methadone maintenance physicians in the United States has emphasized the gradual accumulation of tissue stores that leads to the therapeutic 'steady state' and long action of the daily dose to control withdrawal. [14] [15] In the United States, initial doses of methadone are strictly regulated. By Federal Regulation, the first dose is no more than 30mg, and the first day total dose is no more than 40mg. [16]

In countries where methadone maintenance is less regulated, there have been reports of in-treatment deaths in the first ten days of treatment. [17] [18] [19] [20] These are generally associated with induction doses of more than 50 mg, and rapid buildup of the dose. These deaths are also mostly poly-drug deaths. Deaths in the first few days of methadone treatment highlight the difficulty of quantifying tolerance at intake. History of heavy heroin use, severity of withdrawal, previous treatment with high doses of opiates all may suggest tolerance, but the patient still needs to be monitored closely during the induction period.

Methadone in multiple daily doses is the norm when used in chronic pain treatment. [21] Use of opiates in treatment of chronic pain syndromes may include rotation of opiates to enhance pain control, and over-reliance on an equivalency table can be a problem in the case of methadone treatment. [22] These tables are usually based on analgesic strength with a single dose of medication, and do not take tissue buildup into account. Frequent monitoring of the patient as the dose is adjusted is recommended. In order to minimize diversion and abuse of prescription opioids, specific structure and documentation is helpful for chronic pain treatment of patients who also have the disease of addiction. [23] [24]

In summary, informed CSAM members may be in a position to balance inflammatory headlines by giving patients and colleagues reassurance that methadone maintenance is indeed life-saving, and continues to be indicated in the treatment of chronic intractable opioid addiction. In addition, addiction physicians may be in a position to advise and support colleagues who use opioids to manage chronic pain, encouraging them to have diversion control measures in place in their practice, and to clearly address the disease of addiction should it be a co-morbidity.

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CSAM LETTER TO THE NEW YORK TIMES

Re: Methadone, Once the Way Out, Suddenly Grows as a Killer Drug, on Feb 9, 2003.

YOUR HEADLINE demonizing methadone as a killer drug is misleading and erroneous. The culprit here is not methadone, but untreated opiate addiction. When a drug of abuse such as heroin is not available, addicted men and women who are not in treatment will turn to any opiate, including methadone to stave off withdrawal symptoms. Methadone is a clinically useful medication prescribed for the treatment of opiate addiction and for management of severe pain. Blaming methadone for the ravages of untreated opiate addiction can do much harm to patients.

Methadone maintenance is a treatment for opiate addiction that includes counseling, drug testing and prescribed doses of methadone. Forty years of research show that this treatment decreases abuse of heroin and other drugs, decreases transmission rates of HIV, decreases criminal activity, reduces heroin overdose deaths, and improves patients' ability to function as productive members of society. Like any opiate medication for treatment of pain, methadone can be lethal in overdose particularly when taken in combination with alcohol or sedative drugs.

Opiate abuse in the U.S. is a severe medical and public health problem that has resisted simplistic solutions. In San Francisco treatment of soft tissue infections from injection drug use are the number one non-psychiatric reason for hospital admissions at San Francisco General Hospital, accounting for about 3,000 emergency department visits, 2,400 hospital admissions, and 1,000 cases in the operating room each year. Costs to the hospital are estimated to be in excess of $20 million per year.

Physicians who are providing effective medical treatment of drug addiction and/or management of chronic pain already face many barriers. These areas of health care are over-regulated, there is limited public funding or insurance coverage for treatment, and patients are stigmatized. Articles such as this may serve to further prejudice public opinion against an important medication, and against the patients who need it.

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Physicians Begin Using Buprenorphine in Office Practice

by Donald R. Wesson, MD

This update builds on the "FDA Approves Buprenorphine" article that appeared in the last edition of NEWS: Volume 28/No. 3 Winter 2003. A PDF version of that issue is available on the CSAM website www.csam-asam.org.

Physicians have begun to treat opioid dependence patients with Suboxone®within their office-based practice, and some report receiving referrals from the Substance Abuse and Mental Health Services Administration physician locator website.[1] Although Suboxone is still not widely available in pharmacies, any pharmacy can now order it from their normal drug wholesaler and some pharmacies are beginning to stock it. The manufacturer of Suboxone®and Subutex®, Reckitt and Benckiser Pharmaceuticals, has "launched" the products with a sales force of about 30 regional representatives.

Forums on CSAM and ASAM websites

Moderated Internet forums are now available where physicians can post questions and share experiences with prescribing Suboxone. Accessing the CSAM website is straightforward: go to the home page at www.csam-asam.org, click on "discussion board." Accessing the ASAM website log-on at www.asam.org is a bit more complex. After connecting to the site, scroll down to "ASAM Discussion Bulletin Board" on the left hand side of the screen below "ASAM Membership." Clicking the "ASAM Discussion Bulletin Board" will bring up a pop-up screen asking for a "user-ID" and a password. Type "asam" in the user ID box and "asam" in the password box. Then click the "push to log-in" button." It is necessary to click the "push to log-in" button; hitting the "enter" (or "return") key after entering the user ID and password does not work. After getting by this log-on, there is a second log-on requiring a personal log-on name and password. If you don't have one, contact the webmaster.

Provision of DATA 2000 Extended

The Drug Abuse Treatment Act of 2000,[2] (DATA 2000) allows *qualified* physicians to dispense or prescribe Schedule III, IV, or V *narcotic* medications approved by FDA for treatment of opioid dependence.[3] It also contains a three-year provision prohibiting states from precluding physicians by regulation from prescribing or dispensing the medications (see box 1). The effect of the three-year provision in DATA 2000 is to put into abeyance current *state law* prohibiting physicians from prescribing "narcotics" for treatment of addiction, and to prevent state regulatory agencies from prohibiting prescribing by regulation.

At the time DATA 2000 became law, the Food and Drug Administration's approval of the medications seemed imminent. Congress, the manufacturer of buprenorphine and sponsor of the New Drug Application, the National Institute of Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT) all believed that the Food and Drug Administration's approval of the manufacturer's New Drug Application would be issued "shortly." FDA did not, however, approve Subutex®and Suboxone® until October 8, 2002. By that time, the legislative clock had already been running for two years and the preemption of State laws provision in DATA 2000 would expire in October 2003. A paragraph embedded in a 2002 appropriations bill[4] amended the DATA 2000 three-year provision to start on the date that the FDA approved Subutex/Suboxone. Thus, the protections from State restrictions in DATA 2000 run until October 8, 2005.

Use of Suboxone/Subutex for Pain Management

It is clear from some of the physician buprenorphine training conferences that physicians involved in pain management have a keen interest in sublingual buprenorphine. They are interested in prescribing it for patients (1) who have become opioid addicted during treatment of chronic pain, and (2) as an alternative to full opioid agonists for management of chronic pain. Since the FDA labeled approved indication for Suboxone and Subutex is treatment of opioid dependence, treatment of pain would be an off-label use but it is not specifically prohibited. Physicians who chose to prescribe Suboxone or Subutex for pain control could be supported by the published medical literature about using sublingual buprenorphine for pain management (e.g., Heel, Brogden et al. 1979; Adriaensen, Mattelaer et al. 1985) and on using sublingual buprenorphine for management of pain in patients with addiction (Hughes, Bickel et al. 1991). Sublingual buprenorphine in dosage forms of 0.3-0.4 mg is available in many countries for treatment of pain under trade names of Temgesic®and others (see table 1).

Physicians in the US, however, should be leery of using Subutex or Suboxone for treatment of pain, for several reasons. First, the dosage formulations of Suboxone and Subutex (2 mg or 8 mg) will be too high for initial opioid agonist treatment of pain in patients unless they have significant tolerance to opioids. Two milligrams of buprenorphine will make some patients extremely nauseated. Subutex or Suboxone tablets are not scored for breaking; however, the tablets can be cut with a pill cutter because the tablets contain a uniform matrix of buprenorphine. The usual sublingual buprenorphine dose for initial treatment of pain is 0.3 to- 0.4 milligrams.

Second, if a patient is opioid dependent by *DSM-IV-TR* (American Psychiatric Association 2000) criteria, the DEA would probably view the patient as being treated for addiction and therefore falling under the DATA 2000 provisions and within the limit of 30 patients per physician or group. To be safe, physicians should treat patients where there is any suggestion of addiction (as opposed to only physical dependence on opioids) under the DATA 2000 provisions even if they have an uncontroversial pain syndrome. Prescriptions for Suboxone/Subutex for these patients should use the physician's DEA number beginning with "X".

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Federation of State Medical Boards Publish Guidelines for Office-based Opiate Agonist Treatment

The Federation of State Medical Boards has published guidelines for "Opioid Addiction Treatment in the Medical Office." These guidelines are intended to assist State Medical Boards investigating allegations of improper practice by physicians and are available on the Federation of State Medical Boards website at www.fsmb.org. The documents can be accessed by going to the website and clicking "Policy Documents" on the left-hand panel.

These include six key elements which the Medical Boards look for if a case comes up for review. First, the patient must have been properly evaluated, including a history and physical examination supportive of the diagnosis for which the narcotic is indicated. Secondly, a treatment plan must be specified, with clear goals for this treatment. Third, the patient must be monitored to see if the treatment is working. Fourth, informed consent and agreement for treatment must be in writing. Fifth, proper use of consultation must be shown, such as use of psychosocial treatment for addiction, or neurologist consultation for intractable pain. Sixth, clear and legible medical records must be easily available for review.

These guidelines are the standard by which a State Medical Board will investigate a complaint against a physicians prescribing Subutex or Suboxone in treatment of opioid addiction. Physicians who follow the guidelines receive considerable reassurance against overzealous or inappropriate disciplinary action by a medical board:

> *Qualified physicians need not fear disciplinary action from the Board or other state regulatory or enforcement agency for appropriate prescribing, dispensing or administering approved opioid drugs in Schedules III, IV, or V, or combinations thereof, for a legitimate medical purpose in the usual course of opioid addiction treatment. The Board will consider appropriate prescribing, ordering, administering, or dispensing of these medications for opioid addiction to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of opioid addiction and in compliance with applicable state and federal law.*
>
> *The Board will determine the appropriateness of prescribing based on the physician's overall treatment of the patient and on available documentation of treatment plans and outcomes. The goal is to document and treat the patient's addiction while effectively addressing other aspects of the patient's functioning, including physical, psychological, medical, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of accepted professional practice.*[5]

The long anticipated dream of office-based buprenorphine to treat opioid dependence is finally becoming a reality.

FOOTNOTES

1 http://buprenorphine.samhsa.gov/bwns_locator/
2 Section 3502 of The Children's Heath Act of 2000 (HR 4365)
3 The Controlled Substances Act prohibits physicians from using "narcotics" for treatment of opioid addiction. DATA 2000 created a waiver of that provision for qualified physicians. DATA 2000 also included definitions of qualified physicians and mechanisms for qualifying and notifying the Secretary of Health and Human Services of their intention to treat patients with these products.
4 Section 2501, Public Law 107-273. *21st Century Department of Justice Appropriations Authorization Act.*
5 Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office. www.fsmb.org accessed 4/23/2003.

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BOX 1. Text of Original DATA 2000 Provision

During the 3-year period beginning on the date of the enactment of the Drug Addiction Treatment Act of 2000, a State may not preclude a practitioner from dispensing or prescribing drugs in schedule III, IV, of V, or combinations of such drugs, to patients for maintenance or detoxification treatment in accordance with this paragraph unless, before the expiration of the 3-year period, the State enacts a law prohibiting a practitioner from dispensing such drugs or combinations of drug.

TABLE 1. Buprenorphine Brand Names in addition to Suboxone, Subutex, and Temgesic

BRAND NAME/ FORMULATION	DOSAGE	PACKAGE/ AMPOULE SIZE	PHARAMCEUTICAL COMPANY/COUNTRY
Buprigesic			
FOR INJECTION	0.3mg/ml	10x2ml	Neon
FOR INJECTION	0.3mg/ml	10x1ml	Neon
Norphin			
FOR INJECTION	0.3mg/ml	2ml	Unichem
FOR INJECTION	0.3mg/ml	1ml	Unichem
FOR INJECTION	200mcg	10	Unichem
Pentorel			
FOR INJECTION	0.3mg	1ml	Khandelwal
FOR INJECTION	0.3mg/ml	2ml	Khandelwal
Tidigesic			
SL-TAB	0.2mg	10	Sun Pharma, India
FOR INJECTION	0.3mg/ml	1ml	Sun Pharma
FOR INJECTION	0.3mg/ml	2ml	Sun Pharma

CSAM Positions on Pending Legislation

This year CSAM's Committee on Public Policy has reviewed over 20 bills on substance abuse issues pending before the California Legislature and has taken a position on 13. CSAM requests your support and asks you to advocate on behalf of your patients regarding several urgent legislative matters (see below).

It only takes *five* (5) phone calls in one day to a legislator's office to get their attention. It takes less than five minutes to relay your message to your legislator or their aide. As always, be sure to leave your name, address, and phone number.

A personal visit with a legislator or their staff is best – call to request a brief appointment. Write letters or send emails if you can't make a visit or a call – they matter. As a constituent you have power ... USE IT!

To find out who your representative is, visit **http://www.leginfo.ca.gov/yourleg.html**. From this website you can enter your zip code to get your representative's contact information.

BILLS CSAM SUPPORTS

SB 101 (Chesbro)
Health care coverage: substance related disorders.
• **Analysis:** This bill would require these health care service plans and disability insurance policies to provide coverage for the treatment of medically necessary substance related disorders, excluding caffeine-related disorders, on the same basis as they provide coverage for any other medical condition. Additionally, the bill would require these plans and insurers to reimburse providers of the services and would prohibit a health care service plan that directly contracts with an individual provider or organization from delegating the risk-adjusted treatment cost of providing these services, unless certain requirements are met. The bill would authorize these plans and insurance policies to limit non-hospital residential care, as defined, to 60 days per calendar year.
• **Status:** Bill is currently being studied by UCLA (as is required of all health insurance mandates). There is discussion of amending bill to specify minimum levels of coverage rather than strict parity, which may be difficult to pass in current economic climate. CSAM is working to insure that specified levels of coverage are adequate and evidence-based.

AB 216 (Chan)
Alcohol fee: youth alcohol recovery and prevention.
• **Analysis:** This bill would require the Department of Alcoholic Beverage Control to collect a fee, as specified, from any beer manufacturer, distilled spirits manufacturer, beer importer, and distilled spirits importer, with specified exemptions. This bill would require the State Department of Alcohol and Drug Programs to establish 68 youth alcohol recovery and prevention centers in this state to perform various functions in connection with youth alcohol recovery and prevention.

AB 1308 (Goldberg)
Drug treatment: local correctional facilities: indigent addicts.
• **Analysis:** This bill would require jails to adhere to practice treatment standards for substance abuse. Initially the bill referred specifically to ASAM's Public Policy Statement on jail treatment.
• **Status:** Passed Assembly. Referred to Senate Committee on Public Safety

SB 774 (Vasconcellos)
Hypodermic needles and syringes.
• **Analysis:** This bill would authorize a licensed pharmacist to sell hypodermic needles or syringes to a person without a prescription under specified conditions.
• **Status:** Passed Senate. Referred to Assembly.

AB 946 (Berg) *previously AB 1363*
AIDS: clean needle and syringe exchange program.
• **Analysis:** Allows counties to authorize needle exchange programs without declaring a state of emergency every 30 days. This bill would authorize cities, counties, or cities and counties to develop clean needle and syringe exchange projects that contain prescribed components, and would authorize pharmacists, physicians, and certain persons authorized under those projects to furnish hypodermic needles and syringes without a prescription or permit.
• **Status:** Passed Assembly. Referred to Senate.

SB 295 (Vasconcellos)
California Marijuana Research Program.
• **Analysis:** This law eliminates a three-year limit (current law) for the California Marijuana Research Program, the purpose of which is to develop and conduct studies intended to ascertain the general medical safety and efficacy of marijuana, and if found valuable, to develop medical guidelines for the appropriate administration and use of marijuana. CSAM supports evidence based study to ascertain the safety and efficacy of marijuana and develop evidence – based guidelines.
• **Status:** Passed Senate; referred to Assembly

SB 519 (Vasconcellos)
Nonviolent drug possession: parole.
• **Analysis:** This bill would let People jailed pre-36 let out on parole on with treatment – which they would have received if they had been convicted after the passage of Prop. 36.

AB 1100 (Longville)
Alcohol and drug abuse counselors.
• **Analysis:** This bill would enact the Alcohol and Drug Abuse Counselors Licensing Law to be administered by the Board of Behavioral Sciences in the Department of Consumer Affairs. The bill would require that one of the

Continued on page nine

Continued from page eight
two licensed clinical social workers on the board also have a license as an alcohol and drug abuse counselor. The bill would require the board to adopt rules and regulations regarding alcohol and drug abuse counselors, administer a semiannual licensing examination to applicants, discipline licensees, and establish a program for alcohol and drug abuse interns. The bill would require the board to issue a license to an applicant meeting specified qualifications. The bill would require the board to complete an occupational analysis on alcohol and drug abuse counseling and report its findings to the Legislature on or before January 1, 2005.

SB 151 (Burton)
Controlled substances: Schedule II.
• **Analysis:** This bill would eliminate the triplicate prescription requirement for Schedule II controlled substances. The bill would require prescribers of Schedule II controlled substances to meet the same prescription requirements imposed with respect to other prescribable controlled substances.
• **Status:** Passed Senate Committees on Health and Human Services and Public Safety

SB 340 (Florez)
Substance abuse: adult recovery maintenance facilities.
• **Analysis:** Existing law provides for the licensure and regulation of alcoholism or drug abuse recovery or treatment facilities serving adults, administered by the State Department of Alcohol and Drug Programs. This bill would also require the department to administer the licensure and regulation of adult recovery maintenance facilities.

CSAM's position is that state licensing and regulation of these facilities which are now completely unregulated would be in line with supporting evidence-based treatment.

SB 995 (Aanstad)
Pain management: county review board.
• **Analysis:** This bill would require a county to establish a review board to address allegations of misconduct by physicians and surgeons specializing in pain management practice. The bill would require a district attorney to submit these matters to a review board prior to taking any action to require a physician to cease providing pain management services to a patient.

CSAM's position is that decisions concerning the practice of medicine should be determined by qualified professionals and not by law enforcement. However, CSAM has concerns that some counties may lack qualified physicians to conduct a review. CSAM is working with Senator Aanstad and the CMA to address these concerns.

SB 599 (Perata)
Drug diversion: sealed records.
• **Analysis:** This bill would provide that whenever a person is diverted pursuant to a drug diversion program administered by a superior court, regardless of whether the program is statutorily established, and the person successfully completes the program, and it appears to the judge presiding at the hearing where the diverted charges are dismissed that the interests of justice would be served by sealing the arrest record of the diverted person, the judge may order the records in the case be sealed, as specified.

BILLS CSAM OPPOSES

AB 1067 (Shirley Horton) / SB 762 (Brulte)
Nonviolent drug possession: GHB, rohypnol, and ketamine.
• **Analysis:** This bill is sponsored by the narcotic officers association. It amends Prop 36 making people ineligible for treatment if arrested for GHB or ecstasy. CSAM opposes because 1) it sets a bad precedent in amending Prop. 36 2) lumps ecstasy together with GHB 3) studies show most arrested for GHB a re not using it as a "date rape" drug.
• **Status:** Failed to make it out of Committee.

Impact of Treatment Cuts in Massachusetts: Crime and Despair

ON APRIL 1, Massachusetts cut funds for treatment services to address a $3-billion budget deficit. The budget cuts, which took effect April 1, included reducing beds at detox facilities by nearly 50 percent, leaving just 500. Addicted individuals undergoing treatment also lost their MassHealth insurance on April 1. Without the state insurance, many are unable to afford the cost of rehab programs at local clinics. State funding for methadone treatments is being eliminated July 1.

Only one month after the cuts, neighborhoods are seeing a rise in crime, the *New Bedford Standard-Times* reported April 27. In New Bedford and Fairhaven, neighborhood activists say prostitution and burglary are on the rise.

"In the past few weeks, crazy things started happening," said Suzanne Braga, chairwoman of Neighborhoods United. "We're starting to see prostitution, breaking into homes is on the rise. The last time I heard of so many cars broken into was in the '70s."

In addition, people are flooding emergency rooms seeking help. Ludy Young hears the pleas from people every day as an emergency-room counselor at Boston Medical Center. According to Young, **there has been a 25-percent increase in addicted individuals seeking help at the emergency room.**

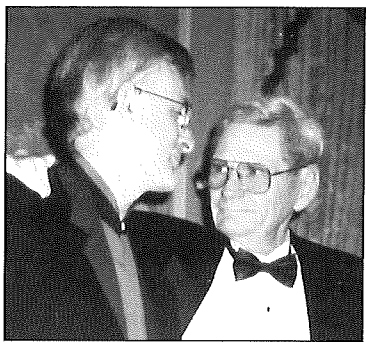
"This is the end of the line for a lot of people," Young said. "You know there's nowhere else for them to go, and it makes you feel helpless, like your hands are tied."

The situation could become even worse next year if a Massachusetts House of Representatives bill is approved that cuts 10 percent of the $37 million the state now provides for addiction programs. The bill would also prohibit the state from awarding contracts to any social-services agency that provides methadone treatment.

Source: Boston Globe, April 28; Bedford Standard-Times; April 27

Remembering John Lanier

by Anthony Radcliffe, MD



JOHN LANIER (RIGHT) PRESENTS VERNELLE FOX AWARD TO ANTHONY RADCLIFFE

DR. JOHN LANIER started his medical career in 1949, four years after he started his "husband" career with soulmate Betty. He graduated from Bowman-Grey School of Medicine in 1953 and moved West with Betty to begin a residency in family medicine at Riverside General Hospital from 1953-55. He practiced as a family practitioner for about 30 years, gradually seeing more and more CD patients. By 1987 he started working full time in ADM or as he was fond of saying "my [practice] years of passion." John had several other passions, Betty being number one and then his family. But he also loved coaching kids in baseball and boating/fishing.

John started on his journey in ADM by befriending a young alcoholic early in his FM practice. He did such a good job of engaging this person, the man referred several of his family and friends to John for help. And though the outcomes were not always as positive, few chemically dependent patients were not touched by him. His penetrating stare and direct questions belied an intense interest in people. Dr Vikki Fox spoke of the need to develop a keen interest in patients' complaints and problems and if you did, you would be successful as a practitioner. John showed us daily how prophetic these words were.

John had developed great respect for working with chemically dependent patients in the Riverside area, serving on Well Being Committees, and on various boards of residential facilities before we at Kaiser had the privilege of working with him over the last seven years of his practice. John was meant to work full time in ADM. He could calm angry, demanding people with simple, direct advice. He was tolerant and rarely displayed anger, but when he did, people knew that they had crossed a boundary that they shouldn't have. He was excellent at setting appropriate boundaries. His passion allowed all of our work to have greater meaning. One simply could not work with John without learning and laughing.

John however never sought to be a saint. He suffered pompous, holier than thou, and long-winded people poorly. Once after a workshop on improving communication, he told me that he was going to try and refrain from saying "bullshit" after listening to certain long-winded explanations from people. Luckily he never did. John had a wicked sense of humor which he often displayed at our staff meetings. "You people gonna talk this person into sobriety or give him a chance?" No world or medical problems kept his work, humor or wit silent.

When someone dies we often talk about what they leave behind. For John Lanier foremost would be Betty, his two sons and grandchildren. But for all those kids in baseball, all those fellow fishermen, all those members on the Boards he was on, all those patients he helped and all those who worked with him, John Lanier left a lasting footprint on our souls as good teachers do. The lessons he taught were humility, compassion, and competence.

NEWS BRIEFS

Even as Blood-Alcohol Declines, Impairment Remains

NEW RESEARCH SUGGESTS that alcohol could impair brain functions for a longer period of time than originally believed.

For the study, researchers examined the impact of alcohol on complex brain functions such as abstract reasoning, planning, and the ability to monitor behavior in response to external feedback. One group of volunteers was given a mix of alcohol and orange juice, while a control group was given a non-alcoholic placebo.

The study found that the participants who drank alcohol had impaired complex brain functions even after their blood-alcohol level had dropped. The effect was more pronounced as blood-alcohol concentration began to decline.

"People who think they've waited their two hours before driving home may need to actually wait six hours," said lead researcher Professor Robert Pihl of McGill University in Montreal, Canada. "Or else, maybe at the time when you least expect it, you're the most vulnerable. The drinker in the process of re-attaining sobriety is likely to be more dangerous, for example, than the drinker who is still imbibing."

The study's findings are published in the May issue of the journal *Alcoholism: Clinical & Experimental Research.*

—Source: BBC, May 14, 2003

Bipolar People at Increased Risk for Alcohol Addiction

A UNIVERSITY OF CALIFORNIA at Los Angeles study shows that women with manic depression are seven times more likely to have alcohol problems, the Health and Age newsletter, sponsored by the Novartis Foundation for Gerontology, reported May 14.

The study analyzed men and women with bipolar disorder. The researchers found that men with manic depression were three times more likely than men without the disorder to have alcohol problems.

In addition, men with bipolar disorder and alcohol problems were more likely to have a family history of the conditions.

For women with bipolar disorder, the risk increased sevenfold. The study further found that these women were more likely to drink to forget their problems.

The report was published in the May 2003 issue of the *American Journal of Psychology.*

—Source: Join Together May 15, 2003

CSAM NEWS

CSAM in Pilot Program to Train Primary Care Providers

CSAM IS WORKING with the San Francisco Department of Public Health to train personnel at four community primary care clinics in "screening and brief intervention for substance abuse." The program is funded by a $30,000 grant from the Robert Wood Johnson Foundation through the San Francisco Department of Public Health, Department of Substance Abuse Services. David Pating, MD and Diana Sylvestre, MD designed the curriculum for the course.

San Francisco has developed a substance abuse screening tool to be used in its primary care clinics and the training is part of introducing the new tool to clinic physicians and staff. CSAM is conducting 6 hours of training at each clinic covering the basics of addiction as a medical disease, an overview of drugs of abuse, screening for substance abuse, states of change, and brief interventions. In addition, the trainings have a cultural component geared specifically to the population served by a particular clinic.

So far the response to the trainings has been enthusiastic and CSAM is seeking to expand the program statewide. Many of the participants have said that even though they have attended previous trainings on substance abuse, the CSAM training really opened up their eyes to looking at addiction as a medical disease. The Department of Public Health plans to do follow up to examine whether more patients are being referred to substance abuse counselors as a result of the trainings.

Discussion Boards Added to CSAM Web Site

CSAM HAS ADDED a new feature to its website that we hope you will use. We now have a message board where people can post messages in any of four areas (public policy, buprenorphine, physician well being, and general addiction medicine). Anyone can browse these boards but you have to "register" – a simple 2 minute process – to be able to post. Please check out this new feature and help to make it into a lively center of discussion.

To access the discussion board go to the website www.csam-asam.org and click on the discussion board link.

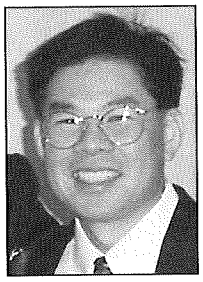
CSAM Seeks Nominations for Executive Council

CSAM IS SEEKING nominations for its Executive Council. Nominations, including self-nominations, are welcome and should be sent via e-mail to csam@compuserve.com. Please include the reasons for your nomination and a CV of the candidate, if possible. Executive Council members will be selected by mail ballot. Ballots will be mailed out by September 10 – one month prior to the annual meeting of members, which takes place on October 10 at the State of the Art Conference in San Francisco.

CSAM Receives Samuel Sherman Award

CSAM HAS BEEN HONORED with the 2003 Samuel R. Sherman Award for Meritorious Achievement in Continuing Medical Education in the Category of Specialty Society. The award, presented by the California Medical Association, is considered the most prestigious recognition for continuing medical education providers in the state.

In presenting the award the CMA said: "This organization was honored for its conferences which are characterized by the highest quality of each of the different elements of a CME program, including educational content and teaching methods – demonstrating respect for the learner. Conferences are carefully crafted and monitored by the organization's Executive Council and Education Committee to assure continuity in program planning standards from one conference to the next."


David Pating, MD

Carol Havens, MD, Chair of the CMA Institute for Medical Quality's CME Committee will present the award to **David Pating, MD**, *Chair of CSAM's Committee on Education* at the CSAM Awards Banquet on Friday, October 10 at the State of the Art Conference in San Francisco.

NEW MEMBERS

Anthony Albanese, MD *Mather*
G. Wayman Blakeley, MD *Los Angeles*
Miguel Casillas, MD *Little Rock, AR*
Michael Crookston, MD *Salt Lake City, UT*
Grace Downing, MD *Antelope*
William Huang, MD *Los Angeles*
Tim Kelly, MD *Portland, ORled out*
Jack Kuo, MD *Los Angeles*
Larry Lawrence, MD *Upland*
David Mathis, DO *Stockton*
Edward McCluskey, MD *Portland, OR*
Rajneesh Nath, MD *San Francisco*
Vincent Perez, MD *San Jose*
Larry Snyder, MD *Laguna Niguel*
Roger Stephens, MD, PhD *Sacramento*
Philip Zaret, DO *Buena Park*

CSAM news CSAM NEWS is published quarterly 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: 415/927-5730; Fax: 415/927-5731; 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.

CONTINUING MEDICAL EDUCATION

August 13-17, 2003
International Doctors in Alcoholics Anonymous
Adams Mark Hotel, Mobile, Alabama
For information: Contact IDAA Central Office at 859-277-9379

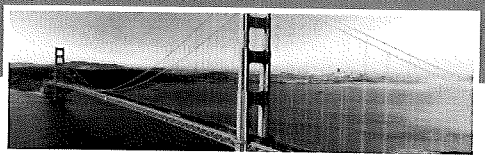
September 12-13, 2003 in Santa Clara
and January 9-10, 2004 at LAX
Pain Management and End of Life Care
Sponsored by California Medical Association
Endorsed by CSAM
Meets the requirements of AB 487 for 12 hours of CME
(The 12 hours may come from one or more courses and from any distribution of topics that includes both pain and end of life care.)
Topics include palliative medicine, hospice and
end of life care, as well as pain topics.
Full program information at www.csam-asam.org or CMANET.org
For information call 415-882-3375

October 30-November 1, 2003
ASAM State of the Art in Addiction Medicine
Hyatt Regency Washington Capitol Hill, Washington DC
Credit: Up to 20 hours of Category 1 CME
For information: Call the ASAM Office at 301-656-3920

November 6-8, 2003
Association for Medical Education and Research on Substance Abuse
Wyndham Baltimore – Inner Harbor, Baltimore, MD
For further information: Contact AMERSA at 401-349-0000

November 20, 2003
ASAM Forensic Issues in Addiction Medicine Workshop
The Loews L'Enfant Plaza, Washington, DC
Credit: Up to 7 hours of Category 1 CME
For information: Call the ASAM Office at 301-656-3920

November 21-23, 2003
ASAM Medical Review Officer Course
The Loews L'Enfant Plaza, Washington, DC
Credit: Up to 18 hours of Category 1 CME
For information: Call the ASAM Office at 301-656-3920



October 8-11, 2003

California Society of Addiction Medicine's Addiction Medicine: State of the Art Conference

Radisson-Miyako Hotel • San Francisco

CREDIT: Up to 25 hours of Category 1 CME

KEYNOTE SPEAKERS
- Nora Volkow, MD, Director, National Institute on Drug Abuse
- Andrea Barthwell, MD, Deputy Director, Office of National Drug Control Policy

PRECONFERENCE WORKSHOPS
- Spirituality and Addiction Medicine
- The Challenge of Pain and Addiction
- Dialectical Behavioral Therapy
- Addiction Medicine for the Primary Care Physician
- Streamlining Office-Based Opiate Treatment with Buprenorphine (Subutex/Suboxone)

FULL DAY PLENARY AND WORKSHOPS ON DIAGNOSIS AND MANAGEMENT OF CO-EXISTING DISORDERS
with Douglas Ziedonis, MD, Richard Reis, MD, Mark Frye, MD, Stephanie Brown, MD, Garrett O'Connor, MD, Douglas Sears, MD, Elissa Triffleman, MD, Joan Zweben, PhD

OTHER TOPICS
- Neuroimaging, Genetics, Medication Development
- Ibogaine
- Culture and Substance Abuse

DESSERT RECEPTION
With Lonny Shavelson, author of Hooked: Five Addicts Challenge our Misguided Drug Rehab System.

CSAM

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