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New Systems of Care for Substance Use Disorders: Impact of Health Care Reform

By David Pating, MD


David Pating, MD

Health care reform is around the corner. On January 1, 2014, five million previously uninsured Californians will become newly eligible for enrollment in expanded Medi-Cal or subsidized health insurance coverage under the Affordable Care Act (ACA, 2010). The health status of the newly insured is expected to be subpar — suffering higher rates of chronic disease, mental disorders, and substance abuse. While substance abuse and dependence affect about 15 percent of the general public, rates among the newly insured are anticipated to be two to three times higher. This poses potential concerns, since nationally, only 10.4 percent of those needing substance abuse treatment receive necessary services.

The Affordable Care Act assures parity in mental health and addiction treatment benefits.

By conservative estimates, if substance abuse remained untreated in this newly enrolled population, the impact of untreated substance abuse could cost California 2.5 million days of lost employment and $2.6 billion in total health care costs. Obviously, things must change.

Fortunately, health care reform provides opportunities to improve treatment for substance abuse and dependence. First, the Affordable Care Act assures parity in mental health and addiction treatment benefits. Parity in coverage means that co-pays, deductibles, and day or dollar limits for substance abuse treatment must be on par with those for medical disorders. Currently, persons with substance use disorders suffer systemic discrimination on the basis of their health condition — being an addict or alcoholic. In California, many health insurance plans, including Medi-Cal,

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Editor's Note

By C.Y. Angie Chen, MD, FACP


Angie Chen, MD, FACP

The modern history of alcoholism and by association the understanding of drug addictions has followed the arc of a pendulum swinging from the concept of moral vice to that of disease process. Dr. Benjamin Rush, known as the father of temperance, had the foresight as early as the mid-18th century to call for a public policy reform to combat the ravages of drunkenness. In 1951 the World Health Organization officially called alcoholism a disease process, and later in 1973 the American College of Physicians, the American Medical Association, and the

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State of the Art Conference to Address Health Care Reform

A major focus of the **Addiction Medicine State of the Art Conference (October 16-19, 2013 in San Diego)** is to prepare addiction medicine physicians for the changes that will be taking place with the implementation of the Affordable Care Act. The conference kicks off on Thursday morning with a session, "Improving the Dialogue Between Addiction Medicine and Primary Care." Richard Saitz, MD, MPH, and Daniel Alford, MD, MPH, will review the evidence base and share practical clinical experience helping us meet the challenges of primary care and addiction medicine integration and collaborative practice. H. Westley Clark, MD, JD, MPH, Director, Center for Substance Abuse Treatment (CSAT) will speak on how the ACA will impact addiction medicine practice and what physicians need to do to be prepared.

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Editor's Note

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American Psychiatric Association all joined in the acceptance of a medical framework for addictive disorders; and yet, the practical application of such an understanding has been a long embattled road to parity, still waiting to materialize unconditionally, free of stigma, with treatment having been limited to incarceration, sanatoriums, or complete abstinence through the 12-Step model for decades until the advent of a handful of pharmaceuticals available only in recent years.

Treatment of addictive disorders hopefully will have wider acceptance under a medical model as the Affordable Care Act mandates parity; slowly, it is gaining respect and value as more Addiction Medicine Fellowships are being created to fulfill the need that has always been there — to train physicians adequately and according to evidence-based approaches. This past February in *The New York Times*, the specialty of treating addictions was called into question regarding the efficacy of substance use disorder treatments and those who deliver such care. The scrutiny may sting for those who have dedicated their lives to treating addicts, but the time has come to re-evaluate what works and what doesn't, and rise to the challenge of bridging exponentially growing technological, neurobiological and genetic advancements with clinical treatment.

Although the field of addiction is gaining legitimacy in medicine, with more physicians than before becoming trained and certified in Addiction Medicine, the real work of integrating general medicine with mental health and substance use disorder treatments is only just beginning. It will be a challenging paradigm shift for everyone. We will need to work with our colleagues in educating them about the dependency risks of overprescribing opioids, benzodiazepines and stimulants within the primary care setting; alcohol use needs to be sufficiently considered in many differential diagnoses where it is often overlooked; cannabis use needs to be discussed knowledgeably and frankly; and while the 12-Step model has saved countless lives and is often misunderstood with nuances that take time and participation to understand, we need to have a broader inclusion of other mutual help groups — or accept that some patients don't want group support at all. The wonderful thing about addiction medicine is that it attracts practitioners from all specialties and this is an advantage that can help with that integration.

Whatever we are called to do, remaining open minded is key, curiosity and striving for evidence-based approaches is part of that willingness to bring the best and most compassionate care for those who need it.

In this issue and at our upcoming State of the Art Conference, the ramifications of the Affordable Care Act on Primary Care and Substance Use Disorders treatment will be addressed. There is an article announcing the inception of a new Addiction Medicine Fellowship at Stanford University and as always CSAM News is here to keep our membership and community at large up to date with how we are shaping public policy in our advocacy work. Enjoy, and see you in October in San Diego! ■

President's Message: CSAM's Mission and Milestones

By Jeffery Wilkins, MD, CSAM President

Jeffery Wilkins, MD

The California Society of Addiction Medicine (CSAM) is one of the largest and most active chapters of the American Society of Addiction Medicine (ASAM). A physician-dedicated organization, CSAM is committed to improving the treatment of substance use disorders (SUD). CSAM members engage in a wide spectrum of public policy activities in California: advocating for patients, producing large scale and local educational programs, and actively promoting the leadership development of physicians who work in the field of SUD.

CSAM's educational programs seek to define the important leadership roles of physicians in the prevention and treatment of SUD — while also clarifying for the consumer the expected role of the physician. CSAM recognizes that proper training and reimbursement is essential to attract physicians into this field and to keep physicians in practice. Therefore, CSAM is dedicated to advancing insurance coverage parity for SUD with that of other medical conditions, providing training and examination preparation courses, and advocating for the development of new addiction medicine fellowship programs.

CSAM also leverages the vast knowledge of its physician members in the area of evidence-based SUD treatment to advocate for a shift from a criminal focus of drug abuse and addiction to a community and public health focus. In addition, CSAM's leadership and members frequently educate policy makers and the public on substance abuse policy that is anchored to evidence-based epidemiological, sociocultural and biological sciences.

Recent CSAM milestones:

- More than 800 people attended CSAM's Addiction Medicine Review Course held in San Francisco. Participants of the 2012 course achieved the highest pass rate (83%) on the certification exam of the American Board of Addiction Medicine (ABAM);
- CSAM launched AddictionMedicineCME.org to provide continuing medical education on topics related to the treatment of substance use disorders;
- Over the past year, CSAM researched and took positions on over 40 California legislative bills and initiatives, in addition to sponsoring three pieces of legislation in 2013; physicians also testified frequently, and supported various treatment-related bills. With active CSAM support, legislation was passed to provide limited immunity from arrest or prosecution for minor drug law violations for people who summon help at the

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New Addiction Medicine Fellowship at Stanford

By Anna Lembke, MD

Anna Lembke, MD

The Stanford University School of Medicine is pleased to announce that on July 1, 2013, we opened our doors to our inaugural fellowship in Addiction Medicine. Kudos to Stanford Graduate Medical Education for recognizing the need for such a program and providing fellowship funding despite the broad fiscal uncertainties facing academic medical centers across the country; thanks also go to Kaiser Permanente Santa Clara and Santa Clara Valley Medical Center for partnering with Stanford in this endeavor.

The Stanford Addiction Medicine Program (SAMP) is a one-year, advanced fellowship opportunity open to any physician who has completed an ACGME-accredited residency in any clinical specialty. The SAMP provides state-of-the-art training in the treatment of patients with addiction, including detoxification, pharmacotherapy for addiction, abstinence-based recovery models, harm-reduction recovery models, motivational interviewing, 12-Step facilitation, consultation for medical and psychiatric hospital services, and psychosocial approaches to the treatment of patients with addiction and pain. The program is tailored to the individual background and interests of the applicant, and includes but is not limited to experiences in the following settings: Stanford Inpatient Psychiatry, Stanford Outpatient Dual Diagnosis/Addiction Medicine Clinic, Stanford Consult-Liaison Psychiatry, Stanford Pain Clinic, Stanford Family Medicine Clinic, Kaiser Santa Clara Chemical Dependency and Rehabilitation Program, Santa Clara Valley Medical Center Primary Care and Addiction Clinics, and scholarly/research collaborations. Our goal is to train physicians in all aspects of treating patients with substance use disorders, behavioral addictions, and co-occurring psychiatric and medical disorders. We hope to promote future leaders in the field of Addiction Medicine.

By the end of the training year, our fellow will be eligible to sit for the Addiction Medicine Board exam, next scheduled for November 8, 2014. Physicians who wish to qualify to sit for the exam currently need not complete a Fellowship (this may soon change), but the Fellowship does meet the rigorous requirements for certification in Addiction Medicine, namely one year's full-time equivalent (1,950 hours) over the last 10 years in teaching, research, administration, and clinical care in the prevention and treatment of individuals who are at risk for or have a substance use disorder, with at least 400 of these hours spent in direct clinical care of patients.

As Program Director for SAMP, I am responsible for leading the team that chooses our fellows from among the many applicants who apply. In this first application cycle, I was impressed by the quality and breadth of experience of the applicants, and touched by the willingness of some applicants to share their own journeys of recovery from addiction in their personal statements. Stanford is particularly motivated to train individuals who will provide leadership, innovation, and advocacy in addiction medicine in the future.

The concept of addiction as a disease dates back to the writings of Herodotus (5th century BC) and Aristotle (384-322BC)[1], but it wasn't until the mid-19th century that addiction as a bona fide medical specialty came into its own. The disease-model of addiction was sidelined in the 20th century by the 'self-medication' hypothesis and the 'war on drugs'; but despite these stutter-steps, addiction medicine has today gained traction as a legitimate branch of clinical medicine and scientific research.

The inception of the Addiction Medicine Fellowship in 2007 under the auspices of the American Board of Addiction Medicine (ABAM), an offshoot of the American Society of Addiction Medicine (ASAM), was one stepping stone in this coming of age process. The Addiction Medicine Fellowship was conceived by ABAM, in order to meet American Board of Medical Specialties (ABMS) requirements for an independent national board for a specialty. The ultimate goal is to apply to the ABMS for formal recognition of Addiction Medicine as a subspecialty.

The Addiction Psychiatry Fellowship, which has existed since 1985 and already has formal recognition from ABMS and the Accreditation Counsel for Graduate Medical Education (ACGME), is open only to psychiatrists, severely limiting the pool of applicants, and ignoring the need for a more broad-based approach to the ever-growing problem of addiction.

The power of the Addiction Medicine Fellowship is its interdisciplinary ideology, as illustrated by the broad range of physician sub-specialists who are eligible, and by its far reaching and varied curriculum, with rotations in emergency medicine, internal medicine, obstetrics, pain, pediatrics, psychiatry, inpatient detoxification, outpatient chemical dependency, and residential treatment. Addiction Medicine Fellowships provide the most current teachings in the treatment of addiction, incorporating approaches that range from abstinence-based spiritual models to opioid replacement harm reduction models, with as strong an emphasis on co-existing medical/surgical problems (e.g., infectious diseases, acute injuries and chronic pain) as on behavioral approaches to addiction.

To date 18 Addiction Medicine Programs across the U.S. and Canada are accredited, which translates to 47 addiction medicine fellowship slots available, although some slots are not yet funded.

Currently the SAMP has only one fellowship slot per year, but we hope to expand this to two or more in the future. One of the challenges we face is finding resources to sustain and grow the program; SAMP welcomes any ideas about developing funding including philanthropic sources. ■

REFERENCES:

1. Addiction Medicine in America: Its Birth and Early History (1750-1935) with a Modern Postscript, by William L. White, in *Principles of Addiction Medicine*, Fourth Edition, Eds Ries, R.K., Fiellin, D.A., Miller, S.C., Saitz, R.

Dr. Lembke is Program Director, Stanford Addiction Medicine Program; Chief, Dual Diagnosis Clinic and Assistant Professor; Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine

Impact of Health Care Reform

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currently not only limit care, require higher co-pays, or mandate "carved out" services for substance abuse treatment, but they also preclude reenrollment based upon this status. Under the ACA, equity in access and health benefits will be the law. This is good.

In addition, the Affordable Care Act includes provisions to promote higher-quality and cost-effective care through integrated medical and behavioral services. Integrated care for substance abuse is essential, since as many as 40 percent of hospital admissions and the majority of chronic conditions such as diabetes, hypertension, and asthma, are all negatively impacted by substance abuse. In primary care practices, 20 percent of patients drink at levels that exacerbate their chronic medical disorders. National guidelines provide simple and clear instruction on how to identify at-risk drinking and provide advice for both adults and youth. What is undiscovered are optimal ways to integrate these clinical solutions into comprehensive systems of care.

Recently, new care delivery models co-locate (or reverse-co-locate) substance abuse treatment in primary care clinics (and vice versa). These models have been piloted statewide in federally qualified health centers (FQHCs) and many county medical and behavioral health clinics. In these clinics, substance abuse and/or mental health counselors are embedded alongside internists, family medicine physicians, nurse practitioners, and health care case managers. When substance abuse issues arise, as in the context of managing opioids for chronic pain conditions, or in managing hypertension in patients who drink excessively, the medical care team has all the counseling resources needed to address the problem quickly and efficiently.

The proximity of substance abuse (and behavioral health) services is essential to good outcomes. Research indicates that the warmer the handoff between primary care clinicians and the substance abuse specialist, the greater the likelihood of engagement. Similarly, the quicker a referral is to a specialist, the higher the treatment initiation rate will be. If referrals take longer than forty-eight hours, motivation to enter treatment plummets, resulting in less than 25 percent actively enrolling in treatment. While some of us jokingly assume these patients stopped off at a bar because the wait (for treatment) was too long, we all know we can do better than this.

One of the promising implementations of co-location that results in "no wait" is the inclusion of medical services in methadone clinics, or the relicensing of methadone clinics as FQHCs. Methadone clinics serve patients who not only carry high medical burden — hepatitis C, HIV, and STDs — but also have disorders exacerbated by poor self-care, chronic stress, and poverty. In these situations, the methadone-dispensing window presents an opportunity to attend to the daily health needs of the marginally insured. Along with their methadone dose, patients in clinics with embedded medical services can receive daily observed therapy for diabetes, tuberculosis, and other conditions, including blood pressure monitoring and glucose checks. This is a public health triple-play!

Beyond this, some innovative clinics are looking for ways to leverage electronic health records (EHRs) as a means to promote greater integration of services. Researchers in academic hospitals are experimenting with using EHR systems to cue clinicians to screen and provide effective substance abuse care management. One new and exciting area is the creation of patient registries for tobacco smokers and substance abusers.

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The ability to track adherence to treatment for these disorders has many positive implications, as has been demonstrated for cancer, asthma, and diabetes registries. For example, tracking appropriate stepped-based usage of medications such as acamprosate, topiramate, naltrexone, or disulfiram for alcohol dependence; naltrexone or buprenorphine/naloxone for opioid dependence; and nicotine replacement, varenicline or bupropion for nicotine dependence can improve adherence in the patient and efficiency in the primary care provider. In short, the days of managing tobacco and substance abuse with an exasperated dismissal or hard glare, admonishing a patient to "Just quit!" are over.

While not specifically funded by ACA dollars, a comment must be made regarding substance abuse treatment's venturing into the world of online and multi-media care. Perhaps we could say these are preventive or health-maintenance services when promoted under the rubric of health reform. Online, medically supervised peer-support communities for substance abuse can be creative and effective uses of internet technology. Multiple vendors who have discovered this treatment niche are vying for this potentially unlimited market, spurred by a youth-oriented, social media culture-- where virtual Facebook friends offer just as much support as "friends of Bill W." in Alcoholics Anonymous. This may be the future of medicine for a new generation.

Concluding this short tour of new systems of care for substance use disorders in the era of health care reform, I must also mention the impact of new cycles of drug epidemics,

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For Well-Being Committees

CPPPH Workshops and Guidelines

This article was contributed by Gail Jara, Executive Director of CPPPH

Gail Jara

Once a month, in one of the regions of California, CPPPH holds a Saturday morning workshop designed for members and staff of physician health committees in any organization (hospital medical staff, medical group, county medical society, specialty society).

The CPPPH website **www.CPPPH.org** shows not only the full calendar of upcoming workshops in four regions but topics with downloadable information from all the past workshops. You will find *Physician Support and Monitoring in the Post-Diversion Era: Who Does It and How It Is Done* by Francine Farrell, LMFT of the Pacific Assistance Group; *Assessing the Aging Physician: Neuropsychological and Psychological Factors Pertaining to Fitness for Duty* by William Perry, PhD; and *How (and Why) Physician Health Committees Work: Legal Counsel's Overview of their Role and Function* by Gregory Abrams, Esq., as well as information from 16 other past workshops (2010 to the present).

The Guidelines section of the website has downloadable copies of guidelines and policy documents from CSAM, CPPPH, ASAM, the Federation of State Medical Boards, and the Federation of State Physician Health Programs. The most recent are *Evaluation of Health Care Professionals* (2013 from CPPPH) and *Guidelines for Physician Well-Being Committees Policies and Procedures* (2013 from California Medical Association) with three appendices: CMA Model Medical Staff Bylaws, Making a Well-Being Committee Effective, and Monitoring.

There is a large collection of relevant articles, links, three downloadable PowerPoint files suitable for talks about physician health and impairment, and all past issues of CPPPH's eNewsletter. A treasure trove: www.CPPPH.org.

CPPPH REGIONAL NETWORKS

- Deliver practical **information, education and training** for committees and persons currently doing physician health work in California. At **workshops offered every four months in each region**, topics are covered in depth with ample opportunity for questions and information sharing
- Provide the structure for ongoing communication and **statewide information sharing**
- Identify and share information about the **resources** that the committees currently use
- **Identify needs** for CPPPH to address as it develops plans for a statewide program
- **Contribute to CPPPH's voice** to speak for physician healthin California

Participation is by invitation of CPPPH and is designed for members and staff of physician health committees in any organization (hospital medical staff, medical group, county medical society, specialty society).
Please visit the CPPPH website at www.cppph.org for more detailed information.

Justice Department Seeks to Curtail Stiff Drug Sentences

Attorney General Eric H. Holder Jr., in a speech at the American Bar Association's annual meeting in San Francisco on August 12, announced a major shift in criminal justice policy for drug related offenses. Holder ordered federal prosecutors to omit listing quantities of illegal substances in indictments for low-level drug cases, sidestepping federal laws that impose strict mandatory minimum sentences for drug-related offenses.

"Too many Americans go to too many prisons for far too long and for no good law enforcement reason," Holder said in his speech.

"Although incarceration has a role to play in our justice system, widespread incarceration at the federal, state and local levels is both ineffective and unsustainable. It imposes a significant economic burden — totaling $80 billion in 2010 alone — and it comes with human and moral costs that are impossible to calculate." ■

Keep up with the latest scientific and clinical advances...

Addiction Medicine: State of the Art Conference

October 16-19, 2013 • Sheraton San Diego Hotel and Marina

Earn up to 28.5 Units of *AMA PRA Category 1 Credit™*

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FACULTY HIGHLIGHTS:

The Addiction Medicine State of the Art Conference (October 16-19 in San Diego) features top experts in Addiction Medicine on topics that you need to know. Here are some of the faculty who will be presenting at the conference. For a full schedule and other conference information visit the CSAM website: csam-asam.org

GEORGE KOOB, PHD

Common Elements in the Neuroplasticity of Addiction: Implications for Treatment

Development of Vaccines for Treatment of Opioid and Psychostimulant Addiction

Dr. Koob is Chair of the Committee on the Neurobiology of Addictive Disorders at Scripps Research Institute. He is one of the world's authorities on the neurobiology of drug addiction. He has contributed to our understanding on the neuroadaptations of reward circuits associated with the transition to dependence.

Current research is focused on understanding the neurobiological bases for altered motivational states associated with drug addiction at the neurocircuitry, cellular and molecular level and using these studies as a heuristic approach to the study of emotions. The ultimate goal is to understand how cellular and molecular changes produce changes in particular neurocircuits to convey negative emotional states that contribute to the motivation to seek drugs, but also contribute to other disorders of motivation in psychopathology.

RICHARD SAITZ, MD, MPH

Primary Care-Addiction Medicine Integration: Successes and Barriers

Dr. Saitz is Professor of Medicine and Epidemiology, and directs the Clinical Addiction Research & Education (CARE) Unit at Boston University School of Medicine. He is co-editor in chief of *Addiction Science & Clinical Practice*, as well as the editor of *Alcohol, Other Drugs, and Health: Current Evidence*. He is an expert on primary care-addiction medicine integration.

His primary areas of expertise and research are screening and brief intervention for unhealthy alcohol and drug use, integrating substance-related and general health care (e.g., chronic disease/care management), and improving the quality of care for people with addictions across the spectrum of use particularly in general medical care settings. He is the author of over 130 peer-reviewed publications.

H. WESTLEY CLARK, MD, JD, MPH
The Affordable Care Act: How It Will Impact Your Addiction Medicine Practice

Dr. H. Westley Clark is the Director of the Center for Substance Abuse Treatment (CSAT), and leads the agency's national effort to provide effective and accessible treatment to all Americans with addictive disorders. Dr. Clark is a noted author and educator in substance abuse treatment, anger and pain management, psychopharmacology, and medical and legal issues.

DONALD L. "HUGH" MYRICK, MD
Alcohol Detox: Alternatives to Benzodiazepines

Dr. Myrick is an Associate Professor of Psychiatry in the Center for Drug and Alcohol Programs at the Medical University of South Carolina, where he also currently serves as the Medical Director of the Center for Drug and Alcohol Programs. In addition, he is the Associate Director of the Mental Health Service Line at the Veterans Administration Medical Center in Charleston.

Dr. Myrick's research interests include the pharmacological treatment of addictive disorders. Specifically, he has completed trials using anticonvulsant agents in the treatment of alcohol withdrawal, alcoholism, and cocaine dependence. In addition, Dr. Myrick was awarded a K Award by NIAAA to use neuroimaging to determine the neuronal networks associated with craving.

ROBERT H. LUSTIG, MD
Sugar, Hormones, and the Reward System

Dr. Lustig is Professor of Pediatrics in the Division of Endocrinology at University of California, San Francisco, and Director of the Weight Assessment for Teen and Child Health (WATCH) Program at UCSF.

Charged with the endocrine care of many children whose hypothalami had been damaged by brain tumors, or subsequent surgery, radiation, or chemotherapy, Dr. Lustig observed that patients who survived became massively obese. Dr. Lustig theorized that hypothalamic damage led to the inability to sense the hormone leptin, which in turn, led to the starvation response. Since repairing the hypothalamus was not an option, he looked downstream, and noted that these patients had increased activity of the vagus nerve which increased insulin secretion. By administering the insulin suppressive agent octreotide, he was able to get them to lose weight; but more remarkably, they started to exercise spontaneously. He then demonstrated the same phenomenon in obese adults without CNS lesions. Dr. Lustig wove these threads into a unifying hypothesis regarding the etiology, prevention, and treatment of the current obesity epidemic including the specific role of fructose as a specific mediator of both chronic disease, and continued caloric consumption.

STACI GRUBER, PHD
Gone to Pot: The Impact of Early Onset Marijuana Use on Neurocognitive Function and Structure

Dr. Staci Gruber is the Director of the Cognitive and Clinical Neuroimaging Core at McLean Hospital's Brain Imaging Center and an Assistant Professor of Psychiatry at Harvard Medical School. Dr. Gruber's clinical and research focus is the application of neurocognitive models and multimodal brain imaging to better characterize neurobiological risk factors for substance abuse and psychopathology, particularly disruptions of the frontal network. In recent work, her lab has examined the etiologic bases of neural models of dysfunction in patients with bipolar disorder as well as marijuana-abusing adults, the results of which have been published in numerous peer-reviewed journals and discussed at national and international symposia and press conferences.

DAVID W. OSLIN, MD
Treating Addiction in the Aging Baby Boomers

Dr. David Oslin is an Associate Professor of Psychiatry at the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania Medical Center. Dr. Oslin is the Director of the Mental Illness, Research, Education, and Clinical Center (MIRECC) and the Associate Chief of Staff for Behavioral Health at the Philadelphia VAMC. He is the author of over 75 research publications and numerous chapters, books, and editorials.

Dr. Oslin's research includes studies aimed to improve access to behavioral health intervention care, improving treatment outcomes for addictive disorders, and the study of pharmacogenetics. Specific projects include an adaptive treatment study of naltrexone to develop strategies for maintenance treatment and for non-response to treatment. Two studies examine endophenotypes associated with alcohol craving, subjective high and intoxication. Two other studies explore improving access to treatment for alcohol misuse with a focus on brief interventions and care management services.

LEE ANN KASKUTAS, DRPH
Why Does 12-Step Facilitation Work? Sponsorship, Service, Support, Comfort

Dr. Kaskutas is a Senior Scientist and Co-Director of Training at the Alcohol Research Group in Berkeley, California. She has done extensive research into the effectiveness of Alcoholics Anonymous and has numerous articles published including: *Alcoholics Anonymous Effectiveness: Faith Meets Science*, in the Journal of Addictive Diseases and *Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ): A Group Format 12-step Facilitation Approach*, in the Journal of Substance Abuse Treatment.

Addiction Medicine: State of the Art

Pain, Addiction and Prescription Opioid Abuse

FDA statistics indicate that more than 33 million Americans, teens and older, misused extended-release and long-acting (ER/LA) opioids during 2007, up from 29 million in 2002. However, these drugs have long been a major tool in the management of acute and chronic pain. Highly effective, yet highly addictive, the challenges posed by ER/LA opioid prescribing include proper assessment, prescribing guidelines, managing treatment and addressing alternatives when opioids fail.

PRE-CONFERENCE WORKSHOP: Wednesday morning, October 16
Opioids: Safe Prescribing and Abuse Management

This workshop is designed to provide participants with an understanding of the emerging trends and treatment options in opioid addiction. It will cover the natural history of prescription drug abuse and will present the latest research on the use of buprenorphine in treatment of prescription opioid addiction, including soon to be available innovations. Opioid safety strategies, including the use of naloxone will be provided. *(Faculty: Karen Miotto, MD, Chair; Phillip Coffin, MD; Walter Ling, MD; Larissa Mooney, MD; Mike Small)*

PRE-CONFERENCE WORKSHOP: Wednesday afternoon, October 16
Chronic Pain: The Other Factors

This workshop will examine the wider issues in chronic pain including past trauma, the socio-economic aspects of disability, and the role of the pharmaceutical industry. The workshop will explore clinical strategies for addressing these, including psychosocial treatments and motivational interviewing. New developments in the use of buprenorphine for the treatment of chronic pain also will be presented. *(Faculty: Karen Miotto, MD, Chair; John J. Coleman, MA, MS, PhD; P. Joseph Frawley, MD; Anna Lembke, MD; Nicola Longmuir, MD)*

PLENARY SESSION: Friday morning, October 18
Managing Prescription Drug Abuse and Pain

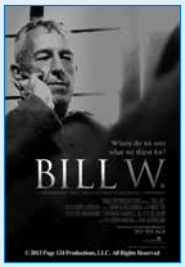
- ***Safe Opioid Prescribing in Primary Care: A Long Way to Go***
  Daniel Alford, MD, MPH
- ***Transitioning Patients Away from Prescription Opioid Abuse***
  Karen Miotto, MD
- ***Legal Issues in Pain Treatment***
  David Kan, MD
- ***Chronic Pain Management: Opioids and Beyond***
  Andrea Rubinstein, MD

POST-CONFERENCE WORKSHOP: Saturday, October 19, 12:30 pm - 4:00 pm
ER/LA Opioid REMS Course: Achieving Safe Use While Improving Patient Care

Jointly sponsored with the American Society of Addiction Medicine and the California Academy of Family Physicians. Free for all physicians. Registration is limited and pre-registration required. Box lunch included.

The FDA has approved a Risk Evaluation and Mitigation Strategy (REMS) for prescribing extended release/long acting (ER/LA) opioid medications. This initiative will provide a unique opportunity to reach and provide effective prescriber-focused education on the safe and effective prescribing of ER/LA opioids to safely manage pain. ■

Special Events at Addiction Medicine State of the Art Conference



Thursday
October 17, 7:30 pm
Movie Night with Popcorn and Discussion
(Guests welcome)

Excerpts from the documentary "Bill W." about the co-founder of Alcoholics Anonymous will be shown along with a discussion with **George Vaillant, MD**, Professor at Harvard Medical School, Former AA Trustee and author of *Natural History of Alcoholism, Revisited*.

"Laudatory but never simplistic, *Bill W.* is a thoroughly engrossing portrait of Wilson, his times and the visionary fellowship that is his legacy." — *Los Angeles Times*

Friday
October 18, 6:00 pm
BBQ Dinner on the Marina
(Included in conference registration, guests welcome with additional fee)

While listening to live jazz, relax and mingle with fellow attendees, Southern California-style, overlooking the San Diego Marina.

CSAM Public Policy Update

CSAM's Committee on Public Policy, chaired by Christy Waters, MD, researches and takes positions on legislation that is currently making its way through the California legislature. In 2013, CSAM is sponsoring three pieces of legislation that if passed, will positively impact access to treatment, harm reduction, and public safety.

The summary below outlines 2013 legislation and initiatives:

Drug Residential Treatment Facilities

Goal: *Revise regulations pertaining to physicians providing treatment in facilities.*

AB 395 Residential Facilities (CSAM IS SPONSOR)
In California, doctors are being blocked from stepping foot in alcohol and drug residential treatment facilities. The dangerous detoxification period prior to treatment can take place without any medical protocol. State regulations of licensed residential treatment facilities are so outdated that they ignore best practices for providing multiple forms of treatment to find the right response for addicted patients.

Overdose Prevention / Harm Reduction / Public Safety

Goal: *Provide proper training and awareness to protect the public.*

AB 635 (CSAM IS A CO-SPONSOR)
This bill authorizes licensed health care providers to issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist the person at risk. In 2012, with active CSAM support, legislation was passed to provide limited immunity from arrest or prosecution for minor drug law violations for people who summon help at the scene of an overdose.

- √ **AB 831 (Bloom) - Drug overdoses. (SUPPORT)**
- √ **SB 419 (OPPOSE):** Would authorize probation officers to incarcerate persons on probation or mandatory supervision for up to ten days for any alleged violation of the conditions of probation or mandatory supervision.
- √ **SB 649 (SUPPORT):** At the request of the California ACLU, CSAM is actively supporting the reform of California's drug sentencing laws for simple possession.
- √ **SB 664 (SUPPORT):** Mental Health: Laura's Law
- √ **SB 809 (SUPPORT):** Controlled Substances: "CURES"

SB 22 (CSAM IS A CO-SPONSOR)
Insurance Parity: Provides reimbursement for substance use disorders and mental health care. This has now become a 2-year bill and will not be voted on until 2014.

CCWH represents the state's largest mental health and alcohol and drug stakeholder organizations and is chaired by a CSAM physician. CSAM is a prominent voice in this effort. The Coalition believes that there can be no real health without effective treatment of mental health and substance use disorders. David Pating, MD, past president of the California Society of Addiction Medicine (CSAM), has been at the center of this advocacy effort.

The governor signed a state budget last month that substantially increased MediCal coverage for addiction treatment — known as Drug MediCal. In addition, the benefit offered through private insurance will step up in areas that have historically been stronger under MediCal, including offering methadone maintenance. According to David Pating, methadone will soon be an Essential Health Benefit (EHB) as the Federal DHCS ruled that the initial attempt to exclude was not consistent with parity and was discriminatory. Now methadone maintenance will be covered for addiction treatment, just as insulin is covered for diabetes. This level of parity is a dramatic change, and brings coverage in California for opioid addiction into compliance with the Wellstone-Domenici Parity Act of 2008. Judith Martin, MD said, "It is almost a miracle and something I didn't expect to see in my lifetime."

Tobacco

Goal: *Prevention and research.*

SB 648 (SUPPORT)
Regulates the use of and advertising of electronic cigarettes (devices that allow users to inhale a vapor containing nicotine). There is no adequate scientific evidence establishing the safety of e-cigarettes. Therefore, due to safety and health concerns around these products, CSAM supports SB 648 as an effort to regulate e-cigarettes similar to the manner in which tobacco products are currently regulated. This has now become a 2-year bill and will not be voted on until 2014.

The Accountable Care Act Implementation

Goal: *In conjunction with the CA Coalition for Whole Health (CCWH), to ensure parity and access to treatment for Substance Use Disorders and Mental Illness*

The new health care law — the Affordable Care Act — improves access to substance use disorder services by extending an existing federal law that requires mental health or substance use disorder (MH/SUD) benefits be provided at parity or "equivalence" with medical and surgical benefits to most people who will be insured under the ACA. The ACA also provides a significant focus on expanding and improving home-and-community based — services to individuals with disabilities, including those with a mental health or substance use disorder.

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Public Policy Update

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Marijuana Policy

Goal: *Provide protection of youth and ensure scientific accuracy of legislation and/or voter ballot initiative anticipated in 2016.*

In 2012, CSAM published its *Youth First* Initiative designed to reduce the harm to young Californians from marijuana use, from ineffective and punitive regulations, and to address the serious treatment needs of those adolescents who become harmfully involved with marijuana. Currently CSAM is working on a white paper, tentatively titled: "Marijuana Use by Youth in a Culture of Risk." Its goal is to identify policies that maximize freedom within a rational, evidence-based public health framework. In addition, CSAM is sponsoring a "Lessons Learned" invitational forum to explore lessons learned from passage of marijuana legalization propositions in Colorado and Washington. Goals are to promote scientific accuracy, increase the safety of youth, reduce the stigma of addiction, and earmark funding from any taxation for youth prevention, treatment and outcomes research. A report from this forum will be published late in 2013.

Physician Health & Well-Being

Goal: *In conjunction with the Public Protection & Physician Health, Inc. (CPPPH) , to ensure access to programs that address physician health.*

In June of 2007, the Medical Board of California (MBC) voted to end the 27-year-old California Physician Diversion Program, making California one of only a few states in the U.S. without any central physician health program. Along with the California Medical Association and other state medical organizations, CSAM responded by forming CPPPH in 2009, an independent non-profit corporation, to develop a statewide physician health program to fill the void that now exists. Since that time, CPPPH has proceeded to address these needs while its parent organizations (including CSAM) pursue the establishment and funding for a state-sanctioned program. ■

This Just In…

Initiative to call for Drug Testing of California Physicians and Increased Payouts to Trial Attorneys

An initiative was filed on July 24, 2013 for the November 2014 ballot that seeks to raise the $250,000 cap for damages in medical malpractice cases as currently set by California's Medical Injury Compensation Reform Act (MICRA). Any increase to the cap is expected to result in an increase in meritless lawsuits and produce higher payouts to trial attorneys, both of which add up to higher health care costs and reduced access to care. Also included in the ballot measure is a proposal for drug testing of all physicians. CSAM supports the proper use of effective methods for identifying physician impairment but opposes an increase to MICRA because it will raise health care costs and reduce access. CSAM and 700+ medical organizations are opposing changes to MICRA as supporters of Californians Allied for Patient Protection (CAPP).

For more information on CSAM's public policy efforts described here, contact CSAM at 415-764-4855 or e-mail csam@csam-asam.org

Impact of Health Care Reform

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which last on average four to six years. Currently we are in the middle of a prescription opioid epidemic. Prior to this was the methamphetamine scourge, now waning. Next may be the new synthetics, or even an old drug newly reborn: high-potency cannabis. Whatever the drug of abuse du jour, no amount of health reform will be effective without physicians being willing to reform their bias and stigma about alcohol and drug abusers. Substance use disorders are common, treatable, and manageable — the real reform is our own willingness to tackle this public health issue, one patient at a time. ■

Dr. Pating is Chief, Addiction Medicine at Kaiser in San Francisco and is a past president of CSAM.

A version of this article originally appeared in the Journal of the San Francisco Medical Society and has been edited and reprinted with permission.

REFERENCE:
Pating DR, Miller MM, Goplerud E, Martin J, Ziedonis DM, New systems of care for substance use disorders: Treatment, finance, and technology under health care reform. *Psychiatric Clinics N Am*. 35(2102); 327-356.

American Board of Addiction Medicine (ABAM) Certified or Recertified in 2012

The ABAM certificate is recognized as signifying excellence in the practice of Addiction Medicine. It demonstrates that a doctor has met vigorous standards through intensive study, assessment, and evaluation. Certification is designed to assure the public that a medical specialist has successfully completed an approved educational program and an evaluation, including a secure examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality patient care.

The next examination is scheduled for November 8, 2014.

The following California physicians were certified or recertified by the American Board of Addiction Medicine in 2012.

Mudassir Syed Ali, MD
Rod Amiri, MD
Gilbert Andersen, MD
Angela Dawn Angstmann, MD
Daniel Sean Aronow, MD
Steven Leo Balt, MD, MS
Michelle Banta, MD
Angella Ann Barr, MD
Christine Bell, MD
Lynn Denise Bertram, MD
Bharat Bhushan, MD
Burke Joseph Bonilla, MD
Thomas J. Brady, MD
Angela Jo Bymaster, MD
Joseph A. Cabaret, MD
Eugene V. Caine, MD
Anna Cristina Carrillo, MD
Paul Finn Cassedy, MD
David Lewis Cherry, MD
Sudhakar Cherukuri, MD, MPH
Richard R. Cicinelli, MD
Ralph Clark, MD, MPH
Davida Coady, MD, MPH
Sara Doorley, MD
Jodie Ann Escobedo, MD
Thos Ross Farnham, MD
Edwin Keith Flower, MD
Gillian Stephany Friedman, MD
Kenneth Kambiz Gheysar, MD
Thomas A. Gonda, Jr., MD
Timothy McCajor Hall, MD, PhD
Jann Melanie Hanscome, MD
Dana L. Harris, MD
Carol Havens, MD
Brian Kelly Hunt, MD
Sandra Cowden Johnson, MD
Edward Kaftarian, MD
Salma S. Khan, MD
Akindele Emmanuel Kolade, MD
Sean Eric Koon, MD
Paul Gregory Kreis, MD
Nishant Kumar, D.O.
Anna Lembke, MD
Richard A. Levine, MD
Timothy Shijade Lo, MD, MPH
Nicola J. Longmuir, MD
Michael Howard Lowenstein, MD
John Francis Mackey, MD
Nikhil D. Majumdar, MD
Jose R. Maldonado, MD
Zaid Bin Hussain Malik, MD
Leonid Markman, MD
Judith Ann Martin, MD
Robert A. McAuley, MD
Katherine Lynn McLane, MD
Martin Mennen, MD
Mohan Nair, MD
Jorge Naranjo, MD
Bahman Omrani, DO
Priya Sanjana Parmar, MD
Nicole Poliquin, MD
Saqib Rashid, MD
Ilan Remler, MD
Albert Ridlovski, MD
Carol Rogala, DO
Nicholas Zingarelli Rosenlicht, MD
Daniel Benjamin Saal, MD, PhD
David A. Sack, MD
Mohammad Safi, MD
Carolyn Ann Schuman, MD
Manish Vallabhdas Sheth, MD
Lee Thomas Snook, Jr., MD, FASAM
Amy Solomon, MD
Serena Roxana Srikueja, MD
Erika Marianne Steffe, MD
Randall Stenson, MD
Maureen Strohm, MD
Nicole Suprovici, MD
David Paul Taylor, MD
Aung Thu, MD
Matthew Alexander Torrington, MD
Joshua David Woolley, MD, PhD
Martha Jane Wunsch, MD, FASAM
Farzin Yaghmaie, MD
Daniel A. Yahya, MD
Dykes Maxwell Young, MD
Todd Stephen Zorick, MD

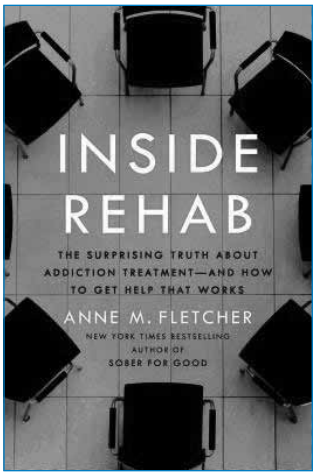
Welcome New CSAM Members

Sheldon K. Cho, MD, *Los Angeles*
Aidan Clarke, MD, *Palm Springs*
Deborah Finklestein, MD, *Rancho Palos Verdes*
Ako Jacintho, MD, *San Francisco*
Arsalan Malik, MD, *Santa Monica*
Ron Merchant, MD, MPH, *Edmonds*
Kurt Miller, MD, *Fresno*
Joseph Mott, MD, *San Francisco*
David Paul, MD, *Santa Barbara*
Rhonda Robinson-Beale, MD, *Glendale*
Scott Steiger, MD, *San Francisco*
Stefan Ursu, MD, *Sacramento*
Michael Vagts, MD, *San Mateo*

Book Review:

Inside Rehab: The Surprising Truth about Addiction Treatment — and How to Get Help That Works by Anne M. Fletcher, MS, RD

Reviewed by C. Y. Angie Chen, MD, FACP, Editor *CSAM News*



If you are in the business of addiction treatment, then you need to know about a book that was recently published this past February 2013 entitled *Inside Rehab: The Surprising Truth about Addiction Treatment—and How to Get Help That Works* by Anne M. Fletcher, MS, RD, an author, speaker and consultant who published *Sober for Good* in 2002, and *Thin for Life* in 2003; and if you manage to read all 400-some odd pages of *Inside Rehab*, then you'll either love it or wish you hadn't heard about it at all.

Fletcher's latest work, as the title suggests, adopts the tone of a thorough survey of the residential and outpatient addiction treatment industry, yet it is important to remember that she bases her information on patient interviews, nationally, and visits to only 15 sites—mainly from Minnesota, including Hazelden; the Philadelphia area, home to Thomas McLellan, PhD's research center; and a couple of centers in California. Notably absent from her research is any mention of the Betty Ford Center (BFC) or the Kaiser Chemical Dependency facilities. I asked CSAM member, Carol Rogala, DO, about this when she first proposed to have a book review written about *Inside Rehab*. She mentioned that in her email correspondence with the author, BFC had actually declined participation in the author's research.

Inside Rehab is an unabashed criticism of the traditional rehab experience, which has for better or worse, been ubiquitously 12-Step based, and Fletcher's true feelings about this clearly come out toward the end in the last chapter, "As I was finishing *Inside Rehab* and a friend called looking for alcohol treatment recommendations for his brother-in-crisis, it was painfully obvious that, at the end of four years, I didn't have much positive direction to offer. I found myself sending the message 'Be cautious, and be skeptical.' In short, almost everything I'd read, observed and heard from the experts kept arguing against the traditional rehab model—the one where people go away from daily reality for intense treatment for varying periods of time, be it thirty days or ninety days. And whether someone goes to a residential or outpatient facility, the model used is often too one-size-fits-all and says addiction is a disease, but then doesn't treat it the way we treat other chronic illnesses. Common interventions include groups, lectures, rules and 'we-know-best' attitudes that aren't necessarily in the client's best interest and are often unsupported by science."

Following up on Dr. Rogala's comment on the Betty Ford Center, I spoke to their Physician Director, Dr. Haroutunian, who stated that he didn't know about the details of whether or not BFC was approached by Fletcher, but that first and foremost BFC was not so much a rehab as it was a "chemical dependency treatment hospital that addressed addictive disorders according to evidence-based medicine." When I asked Dr. Haroutunian about the growing backlash of the 12-Step model and the move toward providing more individualized, harm reduction treatment, he stated that they have always provided individualized detoxification protocols and treatment, but was not apologetic about BFC promoting the 12-Step model of recovery. "Patients know upfront what we are, that we believe the 12 Steps do work and we hope they try it; if they don't feel that is a good fit, they can go elsewhere." *Inside Rehab* is a direct response to that kind of answer.

I applaud Fletcher's audacity to speak up against the status quo, and to give voice to the thousands that have not been able to find remission from their affliction with drug and alcohol dependency, despite multiple encounters with the system; she also provides an informative guide to terminology, resources, and cost analysis of varying tiers of treatment; however, what seems problematic overall is a gnawing sense that something appears contradictory. Maybe this is because the field is still fraught with differences that when we write about addiction and its treatment we reflect those polarities and inconsistencies.

For example, she brings up on page 142 the finding that evidence-based approaches thus far have not been shown to be significantly different than "treatment-as-usual" (due to common study biases such as variability of provider and exclusion criteria) and follows up this insight on page 144 with a quote from Dr. William Miller, that "while there is no one superior treatment that works for all or even most people, we have a rich array of different approaches with reasonable evidence of efficacy," and therefore providers should not be discouraged from offering these services given there is some efficacy and some measure of "quality control"; despite knowing this, it does not keep her from disparaging the treatment that is usually found in most rehab centers.

On one hand she deplores the idea that most treatment facilities believe that one needs to hit bottom before treatment will work, and on the other hand she quotes Dr. Horvath of Practical Recovery, with whom she aligns much of her thinking, as stating on page 183, "People quit when it becomes important enough." Couldn't this be interpreted as hitting bottom? It does seem a

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shortcoming on the part of medicine to be unable to effect more pronounced change earlier in the addiction trajectory, but the real issue is not about hitting bottom, it is about understanding that behaviors are difficult to change whether you are managing diabetes or drug addiction—the plain fact is that people don't change until they hit something internally to motivate change, be it the bottom or a wall.

Alcoholics Anonymous has always been a simple yet highly nuanced program that has never been one size fits all, and more importantly within its Traditions has strongly advised against affiliations of any kind, which also includes rehabs. What detracts from the overall power and credibility of Fletcher's work is that although she does offer perfunctory acknowledgement to the differences between 12-Step Programs such as Alcoholics Anonymous, the 12-Step model that might be espoused by a treatment facility, and 12-Step facilitation (a studied technique that is meant to guide participants in their 12-Step work), she does not hold back from taking a strong stance against the usual 12-Step approach, when a more tempered, conciliatory view might better highlight the day to day clinical struggles that we face in the addiction treatment field, simply because the science and evidence is still controversial, inconclusive, and debatable. If treatment as usual usually works, then what we need to find out is what we can do to make it work better.

What is particularly controversial is the nomenclature surrounding the addictions' pathology paradigm: Is it a disease model or isn't it? Fletcher seems to refer to the disease model in an arbitrary way and when convenient to support or refute a point. Fletcher argues on page 81 that even Bill Wilson, co-founder of Alcoholics Anonymous, refrained from using the "disease' model", however what she fails to mention is that he did so not because he didn't believe it was a medical malady, but because he believed "there isn't a thing called heart disease" and so by analogy since the disease process of alcoholism could not yet be elucidated, he refrained from calling it such. This specific misunderstanding in Fletcher's argument is probably not her fault, given the science of addiction, although advancing rapidly, is far from incontrovertible. We at least now recognize the entity of heart disease and are getting closer to where we can say the same for addictive disorders.

When I asked Stephen Dansiger, PsyD, former Executive Director of a high-end rehab in the Los Angeles area what they offered in terms of treatment at the center he used to help run, he explained they worked closely with physicians from UCLA and Cedars-Sinai to provide evidence-based treatments that were no different than what we are taught at CSAM education conferences and practiced at Betty Ford Center, Hazelden, and Kaiser. What was perhaps deficient programmatically and very difficult to execute was adequate family therapy and follow-up in a community-based manner (a criticism echoed many times in *Inside Rehab*). One of the reasons for this may be that many rehab centers attract patients from out of town, and getting family members to participate and knowing their local resources for adequate follow-up is difficult to arrange. Additionally, to Fletcher's credit, the salient point that adolescents are not little adults has an entire chapter devoted to this issue. Nowhere does family therapy and community support play a more pivotal role than in treating adolescents.

To ignore the concerns raised by *Inside Rehab* is to be, as we say, in denial. The uproar is present, patients need help and they won't all love AA; families are getting impatient, and treatment outcomes need improvement. However, to side emphatically with Fletcher's viewpoint and admonish the 12-Step approach and the paradigm that addiction is a spiritual disease as much as a

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CSAM Executive Council

CSAM Applauds Rehab Fraud Crackdown, Warns of Risks to Patients

The following is the text of a press release from CSAM issued on August 13, 2013 in response to the report on CNN that aired on August 9, 2013.

SAN FRANCISCO — The California Society of Addiction Medicine (CSAM) supports the Department of Health Care Services (DHCS) investigation into alleged fraud in the Drug Medi-Cal program, but urges that funding cut-offs to treatment centers must not be allowed to jeopardize the health and safety of addiction treatment patients.

The Executive Council of CSAM, California's professional society of physicians who specialize in treating the disease of addiction, issued a statement saying: "Every dollar intended for treatment that is stolen or wasted hurts those individuals desperately in need of treatment. However, it is critical that the Department of Health Care Services ensures that there is no interruption of treatment for legitimate patients with the disease of addiction."

The California Department of Health Care Services, which recently took over regulation of Drug Medi-Cal funding from the now defunct Department of Alcohol and Drug Services, has temporarily cut off funding for 38 firms operating 108 clinics following a media investigation alleging fraud. CSAM applauds these efforts to insure that limited addiction treatment Medi-Cal funding is used effectively. At the same time, "patients with the disease of addiction at these facilities are trapped in the middle. We request that DHCS arrange for these individuals to be transferred as quickly as possible to DHCS-approved programs," said Jeffery Wilkins, MD, CSAM President and the Lincy/Heyward-Moynihan Chair in Addiction Medicine at Cedars-Sinai Medical Center in Los Angeles.

CSAM has long urged that addiction treatment centers should be regulated like other healthcare facilities that treat acute and chronic diseases, and that physicians should have integral roles in treatment center operations. CSAM also has advocated for increasing training and certification requirements for treatment counselors and providers to help professionalize the practice of addiction treatment, which for decades in California has operated without the high standards of mainstream medical practice. ■

Notice of Annual Business Meeting

CSAM members are invited to attend the CSAM Annual Business Meeting at 12:15 pm to 1:30 pm on October 18, 2013 at the Sheraton San Diego Hotel and Marina. The results of the election of officers and directors are announced at this meeting.

Member News: Judith Martin, MD, Becomes Medical Director for Substance Abuse Services in San Francisco

Judith Martin, MD

"A year ago I moved from directing a very busy clinic in San Francisco's Tenderloin to working at the City and County of San Francisco as Medical Director of Substance Use Services. At my previous clinic position we had many contracts with the county, so I had worked with my predecessor Dave Hersh (ASAM member for many years), and with the County Administrator for SUD Services, Dr. Alice Gleghorn (recently recognized by CSAM, receiving the Community Service Award for her groundbreaking work in addressing HIV and heroin addiction). I stepped into a very well-designed treatment system for access to opioid pharmacotherapies. A significant part of my work in the past year has been focused on alcohol use disorders. We have been improving access to outpatient detoxification and maintenance medications for alcohol. The San Francisco Public Health Department provides housing first, yet there is a subset of severely ill drinkers who don't thrive in housing first, even with social services on site, and end up homeless, dying from their disease. It's been interesting to watch the Sobering Center and Homeless Outreach Team colleagues work with chronic street drinkers. We have a pilot project now to follow this group of San Franciscans' craving scores as we offer them injectable naltrexone." ■

Do you have news to share with CSAM about your clinical or research experience related to addiction medicine? For each CSAM News issue we will select members' contributions to highlight here or on our website: contact csam@csam-asam.org

CSAM Comments on CNN Report "Weed"

CSAM sent the following comment to CNN:

"We found Dr. Sanjay Gupta's report which aired on CNN on August 11, 2013, to be accurate and well balanced. As specialists in addiction medicine, CSAM is particularly pleased that Dr. Gupta spoke honestly about the proven potential for addiction in some marijuana users and the special risks to young users, including impact on brain development, disruption of cognitive functions and greater risk of addiction than among adults. While the show correctly demonstrated the potential of chemicals in marijuana to alleviate disease, intensive research should be conducted to determine their most effective use and potential side effects. Dr. Gupta is to be congratulated for his forthright approach to this complex and often contentious subject. Additional evidence-based information about marijuana and the brain can be found in a special section on the CSAM website." ■

Book Review

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bio-psycho-social one is to be dismissive of a time-tested solution that has even dovetailed beautifully with ancient traditions such as Buddhism. Though as scientists we would like nothing more than to be able to target a receptor to suppress symptoms or slow down disease progression, as insulin does for diabetes, the reality is that the etiology and phenotypes of addiction are multi-faceted, with behavioral and psychological components playing a large role (as we are discovering with many chronic illnesses). Let's face it—I have yet to see the kind of attachment to Lipitor as towards Suboxone. Addiction is complex and we haven't figured it out; let's not pretend otherwise.

I urge you to read *Inside Rehab*, if for no other reason than to be well-informed. With the Affordable Care Act on the horizon, many of the newly insured will be those with mental health and substance use disorders and we need to be ready to deliver care to them in an effective way—on par with other chronic illnesses. As providers and leaders in the field of addiction, we need to pay attention to the criticism, address any corruption, advocate for funding, institute consistent oversight, advance the science, educate those who need and want it—and even those who don't; refute poor arguments and debunk the myths. *Inside Rehab* is part of all that—that which keeps the dialogue going. ■

President's Message

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scene of an overdose;

- Through CSAM's sister organization, the Medical & Education Research Foundation (MERF), we launched the Faculty Champions Project, to prepare faculty members from primary care residencies for teaching about SUDs including the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- CSAM published its *Youth First* Initiative designed to reduce harm to young Californians from marijuana use as well as ineffective criminal justice interventions, and to address the serious treatment needs of adolescents who become detrimentally involved with marijuana. The use of a governance model entitled Knowledge-Based Decision Making (see discussion below) provided CSAM with a process of evaluating the complexities of the marijuana debate within the context of CSAM's leadership and membership. Surveys of our membership played a key role in helping us to place our focus on adolescents and young adults, for whom this potentially addicting drug can impair brain development and long-term function;
- CSAM held its bi-annual Leadership Development Retreat in August where it provided an opportunity for members to meet and work together using a process called knowledge-based decision-making to build consensus around challenging issues of the day. Members also received tools to sharpen personal skills and further one's own leadership abilities;
- Both CSAM's leaders and members are part of ASAM's Practice Improvement and Performance Measurement Action Group (PIPMAG); they are members of the ASAM Board of Directors as well as the Board of the American Board of Addiction Medicine (ABAM), and are active in statewide and national forums on the integration of addiction medicine into the roll out of the Affordable Care Act (ACA).

In summary, CSAM stands for improving the prevention and treatment of substance abuse disorders through physician education and fostering of physician leadership. To this end, CSAM has committed itself to a decision-making process based on Knowledge-Based Decision Making principles (American Society of Association Executives). As a result, 4 critical questions guide all strategic decisions:

1. What do we know about the needs and expectations of members and other stakeholders?
2. What do we know about the capacity and strategic position of CSAM and ASAM?
3. What do we know about the current realities and evolving dynamics of addiction medicine?
4. What are the ethical implications of our decision?

The desired outcome of the above decision-making process is to emphasize the free exchange of evidence-based information as the foundation for discussion and subsequent development of policy — with the entire process consistently impacted by a well-informed membership. ■

California Society of Addiction Medicine
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Addiction Medicine Online Journal Club Launched

Free CME credit available for CSAM Members
Available at www.csam-asam.org

CSAM has launched the **Addiction Medicine Online Journal Club**, organized by **John Tsuang, MD**. This is an exciting new opportunity to learn about important emerging issues in addiction medicine. The purpose of the journal club is to promote learning and discussion through reviews of research studies specific to its members' field of clinical practice. The Journal Club will make a new article available quarterly.

Now online: Issue #2

Article: **Buprenorphine/Naloxone and Methadone Maintenance Treatment Outcomes for Opioid Analgesic, Heroin, and Combined Users: Findings From Starting Treatment With Agonist Replacement Therapies** (START)

This article documents differences in the clinical characteristics of individuals with opioid dependence as opioid use varies by type and route. It should enable you to discuss the potentially important factors that may be associated with clinical outcomes of opioid replacement therapy (ORT) with your patients. Published in the Journal of Studies on Alcohol and Drugs, July 2013.

Issue #1 still available for Credit

The Issue 1 article (Persistent cannabis users show neuropsychological decline from childhood to midlife) and quiz are still available.

The Addiction Medicine Online Journal Club can be accessed on the CSAM website: csam-asam.org