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Addiction Medicine: An International Perspective

ADDICTION MEDICINE FORUM

Introduction by Chwen-Yuen Angie Chen, MD, Editor

Addiction Medicine from an international perspective is the primary focus within this issue of *CSAM's Newsletter*. An estimated 149-271 million people used an illicit drug worldwide in 2009, with illicit opioid use as a major cause of mortality, mostly as a result of fatal overdose and dependence with considerable co-morbidities arising from unsafe injection practices.[1] Borders, whether natural or designated, that may have once contained disease and information within certain regions are becoming permeable in the age of internet and efficient transport. With this comes a host of new problems but also access to solutions, which we can more easily share. We asked our colleagues around the globe who are CSAM and ASAM members to tell us their experiences treating substance use disorders. We have commentaries from Germany, New Zealand, Iraq, Vietnam, the Netherlands and Portugal. It is a fascinating read, to learn what issues in our practices and institutions are similar or different according to country and how as a global nation, we are poised to learn how to deliver better care to the suffering addict.[2]

1. What is the legal status of cannabis in your country and what is it like treating cannabis dependence? What percentage of patients is dependent? Is use on the rise? What challenges do you face treating cannabis use disorders? What is society's relationship to cannabis and what changes in this relationship have you noticed over time, if any?

New Zealand

Tony Farrell, MD

It is illegal to obtain, use, or sell cannabis. There have been recent legislative changes that reduce the penalties for private use, with referral for treatment after several misdemeanors, or jail if the justice system thinks someone is dealing cannabis.

The challenge of treating cannabis use disorders is engaging clients into a treatment centre. I find that sodium valproate is very useful for cannabis withdrawal, but feel slightly uneasy prescribing it outside its indication. Other challenges include limited access to quantifiable urine screening to assess progress, and trying to determine when to stop a client from driving for personal and public safety. New Zealand society is very conservative and there can be a hysterical and uninformed view of cannabis, especially in our media. For example one of our politicians has introduced a scheme whereby social security payments will be cut for people who produce positive drug urine results, which obviously is a problem for cannabis users. There has been a huge focus on workplace drug testing, consequently creating a rise in the use of "legal highs" or synthetic cannabis. As a result, we are seeing more psychoses and various drug reactions.

New Zealand

Sarz Maxwell, MD, FASAM

Cannabis is illegal and treatment of cannabis dependence is limited to younger patients. Many older patients, including at least half of the Opiate Substitution Therapy (OST) patients in our program use cannabis to some extent, but we only see problematic use with younger patients. Many of our patients with serious addictions began smoking cannabis early in life.

Vietnam

Peter Banys, MD, MSc

Cannabis is illegal in Vietnam. Its prevalence is difficult to estimate, but it is likely to be mostly a youth drug (along with alcohol, tobacco, and ecstasy).

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Germany
Monika Koch, MD

Cannabis is considered a narcotic, so it cannot be traded legally. It is illegal to deal cannabis or to give it as a gift; dealing is prosecuted regularly. Its consumption is not illegal but possession is, if it is not clearly "a small amount for own consumption". There is a lot of grey area in this law and its interpretation can vary from state to state and from situation to situation, e.g., one state can consider possession of 4g as small enough to qualify for "small amount for own consumption" and another state's can be 30g. State officials have not addressed this effectively.

Cannabis use disorders can be treated at any drug treatment center, and payment for treatment is covered by national health insurance. The majority of these places are residential centers. There is nearly free access to outpatient centers; however, these usually function on a social model.

Overall, cannabis is seen as harmless. Traveling from Germany to a Dutch cannabis cafe is not uncommon and rarely frowned upon, especially for younger people.

Netherlands
Loes Hanck, MD, GGD

One of 220 "coffee shops" that sell marijuana and hashish (with less than 15% THC) to patrons.

In the Netherlands, individuals are allowed to have 5 grams of cannabis in their possession and have 5 plants for one's own use. Cannabis with more than 15% THC is considered a "hard drug". Coffee shops (that's the name for weed smoking cafes) are only allowed to sell cannabis with less than 15% THC and only to Dutch citizens (as of January 2013).

Dependency amongst cannabis users has increased from 2005 to 2009. Holland has the same number of actual cannabis users compared to the European mean. There is a rise in people seeking medical help for cannabis use problems.

In 2009, 25.7% of Dutch people between the ages 15 and 64 had used cannabis in their lifetime, 7.0% had used in the past year and 4.2% had used it in the past month.

The big problem here is that the THC levels keep rising and the CDB (cannabidiol) level is very low to absent. I think that's the reason why more people need to get help for cannabis dependency. When I worked on the detox ward from 2002-2005 we hardly ever admitted someone for cannabis detox; now in 2010-2012, it's a very common reason for an admission.

Portugal
Graca Vilar

A Dissuasion Commission, a non-judicial framework used in Portugal for drug possession.

Cannabis cultivation, possession, trafficking, selling, offering or use is forbidden by law in Portugal. However, there is a differentiation between possession for personal use, which is decriminalized, and trafficking. If a citizen is intercepted by police with cannabis, he/she will have the drug seized and will be presented to a Dissuasion Commission (rather than face a court of law.) This Commission will decide, after hearing the citizen and analyzing the police report, the extent of his or her involvement: occasional abuse, misuse, or dependency? Accordingly, a decision by this Commission is issued that may involve a fine, community work, or addiction treatment. If the amount seized is in excess of the limit set by law for personal use then an indictment for the crime of drug trafficking will be issued, and the judicial system will be activated.

Data from Population Inquires show a stabilization or slight increase of cannabis use. Usually, a combination of pharmacological and psychological intervention is implemented according to each patient's needs.

The percentage of patients that are dependent on cannabis cannot be determined with any precision. Although some patients enter treatment solely for cannabis, in the majority of cases, its use is a part of a poly-substance use disorder.

Some of the challenges of treating cannabis addiction are managing anxiety and psychotic conditions that result from, or are triggered by, cannabis use and persist after abstinence.

It seems that no significant changes have occurred in Portuguese society with respect to its relationship towards cannabis. Some lobby groups defend legalization of cannabis, or its use for medical purposes, but no drastic changes in policies regarding this issue are being consistently discussed.

2. Opioid use disorders have hit epidemic proportions in the United States. What has been the trend in your country? How is chronic pain viewed in your culture and what roles do opioids play in chronic pain? How does management of this affect your addiction practice and what approaches are used to treat pain patients with addiction?

New Zealand
Tony Farrell, MD

Opioid use disorders are also rising here, but with a twist. We are seeing a lot more people addicted to prescription painkillers

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rather than illicit opioids. We probably overprescribe methadone in New Zealand, so there are people becoming addicted to the opioid replacement therapy due to diversion from pain and addiction clinics throughout the country.

My addiction practice has been affected greatly by the number of people who have been prescribed opioids inappropriately and developed addictive responses with poorer pain relief.

New Zealand

Sarz Maxwell, MD, FASAM

The vast majority of opioid addiction in NZ is prescription opioids; heroin addiction is very rare. There is a severe shortage of pain specialty services; most treatment is left to General Practioners (GP), who vary widely in their expertise and comfort level with opioids. A lot of addicted pain patients end up in Opioid Substitution Therapy (OST) programs, where they receive variable treatment; most OST programs are very reluctant to split methadone doses, which is a necessity for pain.

OST is fairly readily available. It's free, completely subsidized by the National Health Insurance (NHI), and there is a new initiative this year that patients who are fully stabilized can be moved to their GP with the GP prescribing the methadone (under certification). NHI pays for quarterly GP visits to monitor the OST, plus coverage for any medical problems that occur.

NZ is more conservative about methadone than the U.S. Doses are a bit higher (average ~100mg) but quite uniform. Takeaways are also quite restrictive. It is more normalized and convenient for patients to pick up their methadone at their community pharmacy rather than a methadone clinic. Patients carrying three take home doses per week are considered to be on a liberal regimen. Very few patients are on weekly pickups, and nothing over a week of takeaways is allowed.

Most patients I've talked to say they like their takeaways and appreciate the structure and socialization of going to the chemist several times weekly. The retention rate at our clinic is >85%.

Vietnam

Peter Banys, MD, MSc

All of Southeast Asia is struggling to cope with the dual epidemics of HIV and injection heroin use. But there is relatively little use of prescribed opioids for chronic pain in Vietnam. Methadone is not used for pain management at all, but has been introduced as a highly effective bulwark against HIV transmission by injection drug users. Heroin is cheaper than methamphetamine and benzodiazepines. Afghanistan sources much of the heroin, and, Myanmar (Burma) sources much of the methamphetamine and MDMA.

Germany

Monika Koch, MD

There has been an increase primarily in prescription pills use, but also heroin consumption. Several heroin replacement projects in Germany were started as a research project around the year 2000, some are still open, for example, an outpatient clinic in Frankfurt received special support from the city as a harm reduction model. Methadone is available in special clinics and for some patients in private practices.

Chronic pain has a similar image as the United States; opioids are used regularly. There is easier access to pain management tools, such as physical therapy and alternative medicine.

Netherlands

Loes Hanck, MD, GGD

I work on the methadone maintenance and heroin substitution program in Amsterdam and we have seen a decline in the number of patients getting addicted to heroin.

About the use/abuse/addiction to opioids prescribed for pain, I don't think we have any data on that over here. It might be a hidden problem, I don't know. I remember once talking to a patient from the United States that got admitted to a private clinic here for opioid dependency and he told me that it was really easy to get his doctor to prescribe him Oxycontin.

For chronic pain management here in Holland, we always start with paracetamol, an NSAID, or a combination of the two.

In the past two years I've worked at different kinds of detox wards/outpatient clinics, and the few people I've encountered there with an addiction to prescription painkillers were also people with a history of addiction to other substances.

Portugal

Graca Vilar

In the 1980s through 1990s, Portugal was one of the countries in Europe that endured this epidemic in a large scale. Nevertheless, since the beginning of this century, the number of new cases has been consistently dropping, and by 2004 heroin use has no longer been the main cause for entering treatment in public services.

Although we are aware of the gravity of this issue in the United States today, in Portugal the trend of opioid abuse by patients with chronic pain has not changed much in decades. Pooling data from the clinical activities of all public centers nationally, there are only a very few patients that became addicted to opioid medications prescribed in a chronic pain situation.

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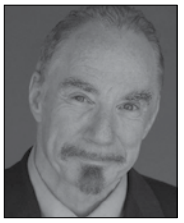
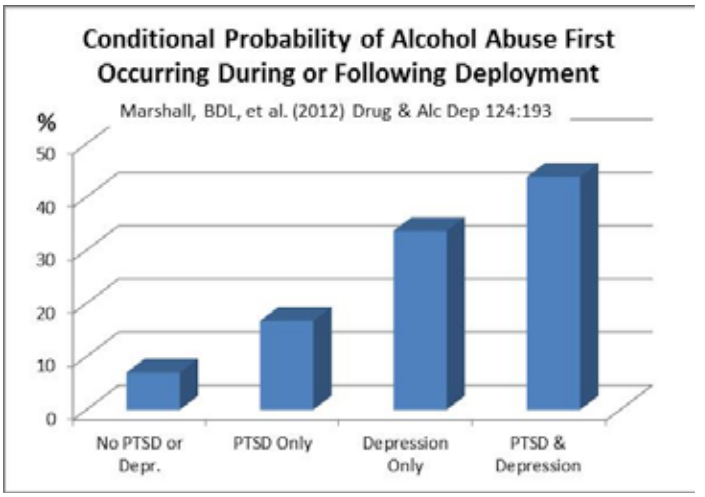
President's Message:
Announcing the Launch of *Military Behavioral Health*

By Jeffery Wilkins, MD, CSAM President



Jeffery Wilkins, MD

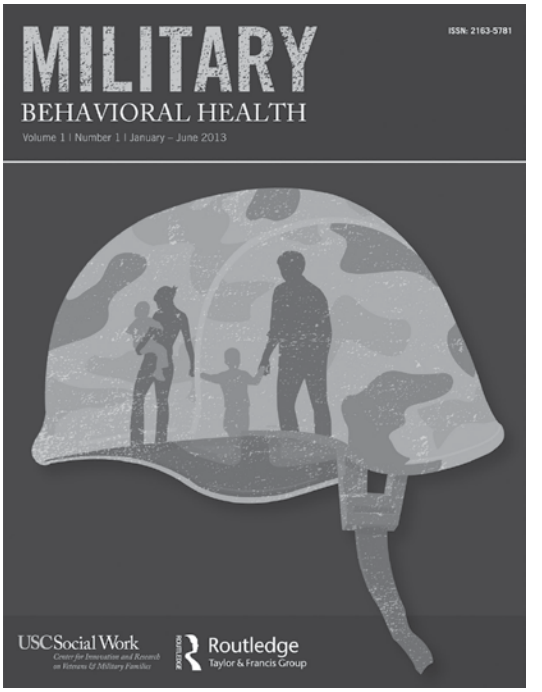
Since September 11, 2001, over two million U.S. service members have deployed to Iraq or Afghanistan. Combat and long deployments impact both the service members and their families: 55% of service members are married, 40% have at least two children and almost half of the service members have served two or more deployments[1]. Approximately 20% of service members across the armed forces report their post-deployment health as worse than before being deployed — the Army and Marines have the highest rates (25.7 and 18.8, respectively)[2]. Alcohol abuse is a common problem with rates significantly increasing when associated with deployment-related mental health disorders. (see below).[3]



Evaluation and treatment of active-duty service members is provided either by the military or through TRICARE, a regionally managed and community-based health care program that covers activated National Guard and reserves, as well as retired members of the uniformed services, their families, and survivors. It is likely that within the next two years, there will be opportunities for CSAM members to provide prevention, evaluation and treatment services for recently returned veterans and their families. For example, a report by the Institute of Medicine (IOM) has strongly recommended increases in community care of service members and their families, as well as an update in the TRICARE substance abuse treatment benefit to "reflect the practices of contemporary health plans and to be consistent with the range of treatments available under the Patient Protection and Affordable Care Act."[4]

For my part, I oversee the training of two Addiction Psychiatry Fellows at the Sepulveda VA Medical Center within the UCLA-San Fernando Valley Psychiatry Training Programs. The fellows provide supervised addiction treatment within, apparently, the largest women veterans' ambulatory program in the country as well as providing addiction treatment within the medical home program for returning Afghanistan and Iraq veterans of both genders. I have also joined a Department of Defense (DOD)-funded project within The Center for Innovation and Research on Veterans and Military Families (CIR), a program of the USC School of Social Work. In this capacity, I oversee a project that has created a "virtual marine" who can be interviewed live by mental health trainees.

VIRTUAL MARINE



In addition, I serve as Senior Editor of a newly published international journal entitled Military Behavioral Health (www.tandfonline.com/UMBH).

The experience of using avatars as proxies for patients has evolved to where virtual patients are now being used in pilot studies of medical student Objective Structured Clinical

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Record-Breaking Attendance at Review Course

More than 800 people attended the Addiction Medicine Review Course on Sept. 5-8, 2012 in San Francisco making it the largest CSAM educational conference ever. More than 450 attended the Certification Exam Preparation Track, a part of the conference designed to prepare participants to take the Certification Exam of the American Board of Addiction Medicine (ABAM).

Anthony Albanese, MD
Conference Chair

Murtuza Ghadiali, MD
Certification Exam Preparation Track Chair

The feedback from conference attendees was enthusiastic. 95% of participants rated the conference excellent or very good on the post-conference evaluation.

"*This conference is by far the most comprehensive and informative review that I have ever attended. It will have a positive impact on improved patient care throughout the country,*" said **Mike Schwartz, MD** of Eugene, OR.

April Clark, DO, another conference participant, said, "*the CSAM conference was hands-down the best conference I have ever attended. I feel very confident about taking the exam. It was better than I had hoped and I will go out of my way to attend CSAM conferences in the future.*"

The conference included a roster of the preeminent leaders in the field of addiction research and treatment including **George Vaillant, MD, Francis Vocci, PhD, George Koob, PhD**, **Marc Fishman, MD, Neal Benowitz, MD, Stephanie Brown, PhD, Scott Fishman, MD** and **Thomas Kosten, MD**.

Gabor Maté, MD, author of the best-selling *In the Realm of Hungry Ghosts: Close Encounters with Addiction* spoke at the dessert reception. The Friday evening dinner, with a San Francisco theme, allowed a chance for attendees to relax, meet and enjoy the company of others. All conference participants received free access to all conference lectures through **www.AddictionMedicineCME.org** as well as access to three post-conference webinars.

Members of the Certification Exam Preparation Track Committee were: **Murtuza Ghadiali, MD** (chair)**, Angella Barr, MD, Juliane Bohan, MD, MPH, Chwen-Yuen Angie Chen, MD, Christina Fritsch, MD, James Golden, MD, John Nguyen, MD** and **Emjay Tan, MD**.

Members of the Planning Committee were: **Anthony Albanese, MD** (chair), **Jean Marsters, MD** (vice-chair), **Sharone Abramowitz, MD**, **Dana Harris, MD**, **Kenneth Saffier, MD, Mario San Bartolome, MD,** and **Mason Turner, MD**. **William Brostoff, MD** was Facilitator Coordinator. **Steven Eickelberg, MD** was the MERF representative.

Welcome New CSAM Members!

Dan Aronow, MD - *Santa Monica*
Davida Coady, MD - *Berkeley*
David Deyhimy, MD - *Laguna Hills*
Kurt Frauenpreis, MD - *Hemet*
Alejandro Esteban Gil, MD - *Los Angeles*
Karen Hord-Sandquist, MD - *Arroyo Grande*
Said Jacob, MD, MPH - *Glendora*
Armen Antranik Kassabian, MD - *Burbank*
Brooks Carlton Michaels, MD - *Simi Valley*
K. Mitchell Naficy, MD - *San Juan Capistrano*
Christian O'Neil, MD - *El Granada*
Jijibhoy Patel, MD - *Stockton*
Ilan Remler, MD - *Oakland*
Ken Starr, MD - *Los Osos*

CSAM Educational Activities Expand in 2012; Big Plans for 2013

By Michael Barack, Continuing Medical Education Manager for CSAM

Michael Barack

CSAM's mission is, in part "to advance the treatment of alcoholism and other addictions through education of physicians." This year, there have been many advances in CSAM's educational efforts.

AddictionMedicineCME.org

In 2012, CSAM announced the launch of a new website dedicated to providing continuing medical education on topics related to addiction.

The first offering on the site, an online version of the 2012 Review Course, consists of 26 lectures providing an overview of the core elements of addiction medicine and offers 21.25 AMA PRA Category 1 Credits™.

Also available on the site is the ABAM Certification Exam Preparation Track Online that consists of 6 hours of presentations featuring several hundred sample questions presented in an interactive format as well as test taking strategies and other material to help participants prepare for the American Board of Addiction Medicine Certification Exam.

Participants can view the lectures at their own pace and return to them as often as they like. If learners prefer to only complete some lectures, they can do so and print their CME certificate at any time. In addition to the video and PowerPoint presentations, participants can download PDF and MP3 audio of all talks.

There are plans to expand the site in 2013 with webinars as a benefit for CSAM members.

Online CSAM CME Journal Club

An online CME Journal Club will be offered as a new benefit to CSAM members in 2013. The planning group is chaired by **John Tsuang, MD** and includes **Monika Koch, MD** and **Itai Danovitch, MD**. A list of 40 experts has been created and invited to suggest clinically relevant articles. Articles will be sent to members, beginning early in 2013 via e-mail and after review they will be able to answer questions and print out a CME certificate online.

East Bay Addiction Medicine Discussion Group

A group of 10 CSAM members meet in the East Bay quarterly in the home of one of the participants to discuss topics and articles as they relate to their clinical experience. If you are interested in starting a discussion group in your area contact CSAM for suggestions and how to offer CME credit.

CME Courses Offered by CSAM to Outside Organizations

CSAM organized and participated in two conferences that met the needs of primary care physicians as well as dentists, in providing training and guidance in addiction referrals and treatment.

Together with the San Mateo County Health System and ASAM, CSAM was able to offer a training course on *Buprenorphine and Office-Based Treatment of Opioid Dependence* on October 25, 2012 to more than 40 primary care physicians. **Judy Martin, MD** served as Faculty Director.

On November 2, 2012, in San Francisco, CSAM also partnered with the Union of American Physicians and Dentists (UAPD), the trade union that represents medical professionals in collective bargaining. UAPD's annual conference featured a training, organized by CSAM during their annual conference entitled, *Addiction and Recovery: Strategies for Practitioners* on November 2, 2012 in San Francisco. More than 175 physicians and dentists attended. **Lori Karan, MD** served as Faculty Director. Lectures were given by CSAM members **Susan Ferguson, MD, Timmen Cermak, MD, Karen Miotto, MD** and **Igor Koutsenok, MD** and others. Six lectures from the 2012 Review Course are being made available to all UAPD members via an online portal. ■

Recognition of Monika Koch, MD

On May 4, 2012 at its annual conference, the Institute for Medical Quality (IMQ) of the California Medical Association (CMA) presented **Monika Koch, MD**, Chair of CSAM's Committee on Education, with one of its highest honors: the CME Chair of the Year Award. This award recognizes a volunteer Chair of the Continuing Medical Education (CME) program *"who provides outstanding leadership, tireless dedication and overall guidance to strengthen the entire continuing medical education effort within his or her organization."*

CSAM members are invited to give suggestions to the Committee on Education for other activities to advance the organization's educational mission. ■

Monika Koch, MD

CSAM Awards

Timmen Cermak, MD, Immediate Past President presents the CSAM Community Service Award to Alice Gleghorn.

Alice Gleghorn Receives CSAM Community Service Award

CSAM presented the *Community Service Award* to **Alice Gleghorn, PhD** in recognition of her work that has enhanced access to substance abuse prevention and provided harm reduction and treatment for substance use disorders in high risk populations, including reducing HIV risk among injection drug users, integrating substance abuse and mental health services in San Francisco, developing a centralized, walk-in access point for mental health and addiction services in San Francisco, creating the first office-based methadone treatment program, establishing the first mobile methadone van service in the state of California, and introducing community overdose prevention strategies using naloxone to San Francisco. For the past 17 years she has worked for the San Francisco Department of Public Health. ■

Judith Martin Receives Vernelle Fox Award

Judith Martin, MD received CSAM's 2012 *Vernelle Fox Award* in recognition of "the standards she holds and fights for; the model she provides as a clinician, teacher, and policy advocate; her unwavering commitment to make practical, realistic patient care available to those who need it; her untiring efforts to expand access to treatment for opioid dependence; her role as a persistent advocate in the regulatory wars in Sacramento, as chairperson of the CSAM Committee on the Treatment of Opioid Dependence and as CSAM President." ■

Judith Martin (center) with members of CSAM's Executive Council.

Angie Chen Named New Editor of *CSAM News*

CSAM is pleased to introduce the new editor of *CSAM News*, **Chwen-Yuen "Angie" Chen, MD, FACP**. She earned a BFA in Film & Television from New York University in 1990 and in 2004 received her MD degree from UC Davis. She became board certified in Internal Medicine in 2008 and in 2010 was certified by the American Board of Addiction Medicine (ABAM.) In addition to having worked in primary care, hospi¬talist settings, and at Kaiser CDRP, she has spent time under Drs. John Mendelson and Gantt Galloway conducting studies in MDMA, methamphetamine, opioid and cocaine addiction pharmacology. She is now in private practice. She assumes the post of editor from **Itai Danovitch, MD** who ascends to the position of CSAM President in October 2013.

To reach Dr. Chen with editorial questions or comments, send an email to: csameditor@yahoo.com ■

MERF Champions Project:
One Small Step for MERF, One Giant Leap for our Patients

By Steven Eickelberg, MD

Steven Eickelberg, MD

May you long remember where you were in September 2012 when Medical & Education Research Foundation (MERF) launched the Faculty Champions Project at the CSAM Review Course.

With the commitment and dedication exemplified in the Apollo Mission to the Moon, faculty members from five primary care residencies embarked on a mission to set foot upon, well…earth, by May of 2014 as highly qualified and well prepared Faculty Champions for teaching about substance use disorders (SUDs). From that point forward, in each of their programs, residency education and advocacy for access to quality care for patients with SUDs will be forever transformed.

In this two-year faculty development project, two faculty and one or two residents from each program are receiving education and personalized mentoring and support to assist them in designing and integrating SUD education into the required curriculum *in their residency programs*. Equally, or perhaps even more important, they are being coached on how to employ the teaching skills that will make a lasting impact on the young physicians in their programs.

These Champions-in-training are learning about screening, brief intervention, and referral to treatment (SBIRT) for harmful alcohol and drug use, motivational interviewing to facilitate behavior change, the science and treatment of substance use disorders, and advocacy for access to effective care for their patients.

As we know well, a mountain of incontrovertible evidence reveals that SUDs and the enormous number of consequences associated with them are common among patients seen in primary care medical settings.[1,2] Medical and behavioral research clearly demonstrates that patients with SUDs can be reliably identified and can receive effective, evidenced-based care and/or referral for treatment.[1,3,4-5] Despite this evidence, there exist profound, yawning gaps between the number of patients who need treatment and those who receive it, and between the quality of care delivered and what we know to be effective care. [2,5] The reason for these gaps is two fold: first, physicians fail to recognize SUDs[2-3]; and second, physicians receive inadequate training about effective treatment.[6-9]

To address the gap between our knowledge (including advances in neuroscience and behavioral research in effective screening, intervention and treatment) and current physician practices, the Betty Ford Institute, with MERF, in December 2008 convened a Consensus Conference, bringing together a group of recognized experts who reviewed and debated the objectives, the barriers to education, as well as possible strategies to overcoming them, and reached consensus on these recommendations for how it would be possible to improve training in SUDs in primary care residency programs:

1. Integrate substance abuse competencies into training.
2. Assign substance abuse teaching the same priority as teaching about other chronic diseases.
3. Enhance faculty development.
4. Create addiction medicine divisions or sections in academic medical centers, and
5. Make substance abuse screening and management routine care in new models of primary care practice.[6]

> MERF believes that Addiction Medicine should commit itself to achieving the goal, before this decade is out, of integrating the knowledge and experience about effective identification and treatment of substance use disorders into the training for all primary care residents. Few other areas of health care delivery will have a greater impact on the public health.
>
> President Kennedy said of the Apollo Mission that none would be so difficult or expensive to accomplish. MERF, with the generous support of the Open Society Foundation, will challenge that assertion.

Pursuing these recommendations, MERF and CSAM developed The Champions Project — a 24-month effort to attract potential champions, engage them in a step-by-step process of mastering the content (the curriculum), developing effective SUD teaching skills, learning methods to integrate SUD curriculum innovations and clinical teaching into their residency curriculum, identifying ways to advocate for access to effective treatment for all patients. The Project aims to increase access to high quality, evidenced-based, addiction care for primary care patients and adolescents.

MERF responded to the charge with focus and commitment similar to our national response to JFK's "Moon Speech" ["…to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win…"] (Rice University 09/12/62).

MERF recruited and selected five primary care or pediatric residency programs to participate. To be eligible, the programs needed the support of their residency directors and had to have the commitment of two faculty and one or two residents to participate throughout the two-year project.

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The Project kicked off just prior to the 2012 CSAM Review Course when Faculty Champions began assessing the knowledge base of their residents and the educational needs of their programs. Then, for five consecutive days — Tuesday through Saturday — in concert with the CSAM Review Course, Faculty Champions received mentored support while being immersed in education and training about motivational interviewing, addiction medicine, "soup to nuts" fundamentals of assessing and meeting residents' educational needs, and methods for making curricular changes in their programs.

In the 12 months following the Review Course, Faculty Champions will work together with their mentors via collaborative videoconferences as they continue to deliver lectures in their programs and evaluate how their residents are applying the information.

In October 2013 all Faculty Champions participants will reconvene for two days before the CSAM State of the Art Conference in San Diego to refine the curriculum and teaching plans that each program has designed and tested during the project.

After the October 2013 conference, participants will continue the videoconference sessions with their mentors and continue testing and evaluating their curriculum modules and teaching methods throughout the final year of the program.

Data collected throughout the Champions Project will be analyzed to measure the impact of the project and will be published, we hope, in an article that will be a companion to the report of the Betty Ford Institute Consensus Conference: Integrating Addiction Medicine Into Graduate Medical Education in Primary Care: The Time Has Come.[6]

By mid-decade, the MERF Faculty Champions Project will have planted the flag representing advocacy for, and improved access to, SUD treatment by working with these primary care residency training programs. And MERF will have met the Kennedy-esque challenge: "…to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win…" — educating all physicians to provide state of the art SUD recognition and treatment.

MERF plans to carry this momentum forward to affect similar improvements throughout the graduate medical educational system before this decade is out. ■

MERF 2012 Champions Project and scholarship recipients.

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MERF Faculty Champions Project Director:
Kenneth Saffier, MD, *Contra Costa Family Medicine Residency Faculty; Clinical Professor, UCSF Family Medicine*

Associate Directors:
Maureen Strohm, MD, *Family Medicine Residency Director at Eisenhower Medical Center, Rancho Mirage, CA*
Steven Eickelberg, MD, *President of MERF. Private practice: Addiction psychiatry, aviation psychiatry, and psychotherapy, Paradise Valley, AZ*

Education Consultant:
Julie G. Nyquist, MD, *Professor, Department of Medical Education; Director, Master of Academic Medicine Program, Keck School of Medicine of USC*

The Five Faculty Champions Programs:

Contra Costa Regional Medical Center Family Medicine Residency Program

Harbor-UCLA Family Medicine Residency

Phoenix Children's Hospital / Maricopa Medical Center Pediatric Training Program

San Joaquin General Hospital Family Medicine Residency Program

Valley Family Medicine Residency of Modesto

MERF: Inspiring a Career Transformation

By Steven Eickelberg, MD

MERF, The Medical Education and Research Foundation for the Treatment of Addiction, has been providing scholarships to residents and residency faculty to attend mentored learning experiences at CSAM conferences since 1995. A goal of the mentored experiences is to provide evidenced based, state of the art, addiction medicine education while introducing scholars to the warmth and compassion of CSAM members and the camaraderie of CSAM organization as a whole.

This year we had the good fortune to reconnect with Anna Lembke, MD, who was a MERF scholar in 2000. After listening to Dr. Lembke share how MERF influenced her I invited her to write about her experiences. Her email to me is reproduced below:

"When I finished my residency in psychiatry at Stanford, I went right into an NIH fellowship in mood disorders, and then joined the staff at Stanford with the intention of specializing in the treatment of mood disorders. Like my colleagues, I screened out any patients with co-occurring addiction, because my grand plan was to treat mood disorders, not this other messy business of substance abuse. The only problem was that after screening out for addiction, I had no patients left. I reluctantly set about trying to educate myself about addiction in order to better care for my patients, but I was not optimistic about my ability to help them. I felt I had nothing to offer them. Not surprisingly I had received almost no training in this area in medical school or during my residency.

Somehow I found out about CSAM, applied for the MERF scholarship, and went to the meeting with pretty low expectations. One of the first things I noticed about the meeting was how warm and friendly the doctors were, and how they all seemed to know and like each other. I hadn't been to a lot of medical meetings before then, but enough to know that this was a different sort of vibe. Then we had a noon meeting, and all the MERF scholars and our meetings mentors sat around the table and talked about the rewards they experienced in treating addiction. This in itself was inspiring, but what I remember most of all was discovering that many of these bright, compassionate, funny, and wise folks around the table had had their own struggles with addiction. Through a kind of implied language and subtle humor, these physicians were communicating how they themselves were flawed, broken, and humbled, just like their patients. I was genuinely shocked. I had never before encountered a physician who admitted to any flaw, much less admitted to the stigma of addiction. It wasn't as if they went on and on about it, but there was a subtext that pervaded the discussion, and made plain that they did not view themselves as 'above' their patients. This moment was transformative for me. I saw that if these wonderful people overcame addiction, then my patients could too. Moreover, I was glad to be among colleagues who had been humbled by life, and made stronger for it. They appealed, this tribe of wounded warriors, and I wanted to belong to them.

Since then, I have joined the faculty at Stanford and am now Chief of a newly begun Dual Diagnosis Outpatient Clinic, and chief of a broader Addiction Initiative to improve education and treatment of addiction at Stanford. I am a member of CSAM, ASAM, and AMERSA, and have been an Alcohol Medical Scholar under the tutelage of Marc Schuckit, another great mentor. I have been working with folks at ABAM to start an Addiction Medicine Fellowship at Stanford beginning in July of 2013. I have published chapters and peer-reviewed articles in the area of addiction, working with great collaborators here at Stanford like Keith Humphreys and Alex Harris. I've been lucky to have these great teachers along the way.

So you see, one experience like the MERF scholarship can change the course of a career." ■

— **Anna Lembke, MD**, Assistant Professor Department of Psychiatry and Behavioral Sciences, Stanford University

MERF Scholarship recipients from 2000 from left to right (current position follows name): John Thompson, MD (Board Certified FP at Sutter Medical Group in Sacramento); Eric Li, MD (Child and Adolescent Psychiatrist at UCLA Neuropsychiatric Institute); Sean Kooon, MD (Chief, Kaiser Fontana Chemical Dependency Recovery Program); unknown; Nancy Wu, MD (Board Certified Child and Adolescent Psychiatry in Los Angeles); Anna Lembke, MD (Assistant Professor of Psychiatry, Stanford University School of Medicine); Reef Karim, DO (Board Certified Psychiatrist, Beverly Hills, CA); Denise Greene, MD (Board Certified in Psychiatry and Addiction Medicine, Phoenix, AZ); Gilbert Villela, MD (Associate Clinical Professor of Psychiatry, UCSF); Shahin Sakhi, MD, PhD (Private Practice of Psychiatry, Los Angeles; Clinical Faculty, UCLA Neuropsychiatric Institute)

To donate to MERF visit the MERF website www.merfweb.org/donate.vp.html

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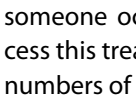
3. What differences do you see between addiction medicine practices in your country compared with the United States?

New Zealand
Tony Farrell, MD

Addiction medicine in the United States appears uncoordinated and non-integrated, complicated by systemic issues of funding and access. It concerns me that "pill mills" can exist in a country with the level of resources and technological expertise that the United States has. I have noticed with some of the American physicians that they are very abstinence-focused, which leaves little room to negotiate some of the many gray areas we find with our patients. I see abstinence as part of harm reduction, the gold standard, but not the only goal for my patients and me.

New Zealand has definitely tried to engage and train most mental health workers with addiction skills, and addiction specialists are working closely with pain clinics to provide more flexible solutions to those patients who refuse addiction treatment but will attend a pain clinic. I have found that an addicted patient referred for a psychiatric opinion will be seen, which was not always the case in the past.

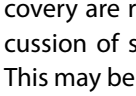
We are developing a nationwide Hepatitis C plan that is focused on breaking down barriers to treatment so that even someone occasionally injecting or using other drugs can access this treatment. In general, we also have problems with low numbers of addiction specialists with good skills in many areas.



New Zealand
Sarz Maxwell, MD, FASAM

NZ has a national policy of harm reduction, which removes the enormous barrier of requiring complete abstinence as a condition of beginning treatment, which is often seen in the United States. In NZ gradual improvement is expected and relapse is de-stigmatized. These expectations help normalize and medicalize substance use disorders.

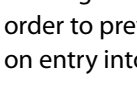
There are active AA meetings, and referrals to 12-step recovery are routine as adjunct therapy but never required. Discussion of spiritual matters is not usual in routine treatment. This may be due to the influence of the Maori, who are unfortunately over-represented in addictions and whose spiritual beliefs do not follow the Judeo-Christian tradition.



Vietnam
Peter Banys, MD, MSc

Medical detoxifications are handled in hospital by medicine or psychiatry, but generally lead to simple discharge home. Vietnam has a long history of a strong reliance on education and re-education centers. It has 121 compulsory rehabilitation centers managed by a non-medical ministry, the Ministry of Labor, Invalids, and Social Affairs. Its divisions include social assistance, social protection, and social evils (including addiction and prostitution). An administrative process can place a heroin user there for two months to five years, but the results are dismal (>90% relapse). Twelve United Nations agencies and Human Rights Watch have criticized both this and similar compulsory systems in Asia on the basis of non-evidence-based treatments, forced labor, punishments, increased HIV transmission risks, and poor outcomes. The government has begun a renovation process to open most, but not all, compulsory centers to voluntary enrollment. However, much work needs to be done to introduce effective treatments.

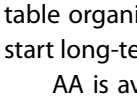
Since 2008, Vietnam, with substantial international donor help especially from U.S. President's Emergency Plan for AIDS Relief (PEPFAR), has developed 62 Methadone Maintenance Treatment (MMT) Clinics. Vietnam treats 11,000 patients in MMT with a goal of 80,000 by 2015. There are no take-home doses in order to prevent diversion, and about 35% of patients are HIV+ on entry into care.



Germany
Monika Koch, MD

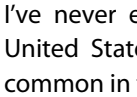
Addiction is separated into medical issues (usually detoxification) and rehabilitation issues (usually residential, followed by some social model outpatient treatment). The medical issues are paid for by the National Health Insurance, in some instances it covers up to three weeks of residential treatment/detoxification hospital stay. The rehabilitation and outpatient models are covered by the disability insurance system in addition to charitable organizations. Because of this separation it is difficult to start long-term outpatient treatment programs.

AA is available but much less prevalent than in the United States — it is often considered "too religious" and "very American".



Netherlands
Loes Hanck, MD, GGD

I've never encountered addiction medicine practices in the United States. 12-step programs are a lot more known and common in the United States. In Amsterdam we've got loads of 12-step fellowships and meetings but most patients have never heard of them.



Portugal
Graca Vilar

In 1987, a nationwide network of treatment centers (both outpatient and inpatient care), supervised by state institutions was established. Private institutions, (both for-profit and non-profit)

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reinforced by the network. These private institutions, together with the state, established protocols for patient treatment. The operation of such a network had consequences at several levels: a rough estimation suggests that 95% of all people with a drug problem were at least once in contact with some agency of this network.

The majority of drug addicts are treated in these public or publically funded centers. This has fostered discussion and exchange of experience and knowledge amongst addiction providers that has contributed to the creation of a theoretical – clinical framework now adopted as a common practice in public treatment centers.

Because the network of public outpatient treatment centers in Portugal is centralized and coordinated, it is possible to refer patients to other units (inpatient, detoxification, or therapeutic community treatment), or to other public health services, such as hospitals, or mental health facilities. In these cases, patients never lose their connection to the original service, and once finished with his/her treatment, that person can return to the original point of service.

4. What are the top 3 obstacles you face in helping your patients recover from addiction?

New Zealand
Tony Farrell, MD

1) Stereotypes and prejudice;
2) Lack of provider skill, provider attitudes and ignorance; and
3) Poor coordination systemically

New Zealand
Sarz Maxwell, MD, FASAM

1) Time and money: demand outstrips capacity, as in all public health systems. Programs must settle for giving less intense treatment to more people;
2) Stigma: addiction continues to be stigmatized including, unfortunately, amongst medical colleagues. For example, I have to battle to admit a patient to the medical ward for alcohol detoxification, as the internists want the beds for "real" patients;
3) Access: This is an aspect of the time/money/capacity problem, but it is exacerbated in NZ with its large rural/bush areas. Treatment is available in the cities, but not for those in more remote areas.

Iraq
Keith Humphreys, PhD

The main challenges are the security situation, strong stigma against addiction, which makes many people unwilling to seek help, many doctors unwilling to treat addiction and the rapid influx of opiates from Iran, which has the world's worst opiate addiction problem.

The Nejat drug rehabilitation center in Afghanistan, an organization funded by the United Nations providing harm reduction and HIV/AIDS awareness. With little funding and no access to substitution drugs such as methadone, treatment is rudimentary for a problem that is growing in a poor country riven by conflicts.

Iraq's main challenges in terms of drugs are opiates, coming from the now open border with Iran, as well as some black market pharmaceutical diversion, most particularly Artane (benzhexol).

Alcohol is a problem in some areas. For some, alcohol represents liberation from Islamist influence, to others it is evil and remains condemned.

There is little specialty addiction treatment in Iraq, although a center of excellence is being founded in Baghdad.

Vietnam
Peter Banys, MD, MSc

One of 121 compulsory rehabilitation centers in Vietnam managed by a non-medical ministry, The Ministry of Labor, Invalids and Social Affairs.

First, there is a half-century of social evils thinking about addiction. The country is trying to shift from social evils to public health models, but it is difficult. For now, there is an unrealistic expectation that detoxification constitutes a form of cure. In effect, detoxification is conceptualized as effective, but a subsequent relapse is conceptualized as a willful antisocial act that can reasonably be treated in a compulsory manner (despite manifest evidence of ineffectiveness).

Second, there is no tradition of counseling of any kind. Doctors tend to give instructions without much open-ended listening. There is no profession of counseling; and, social workers tend to work in schools on learning problems or in industry. As the country continues to become wealthier, this is sure to change. Counseling functions are eventually more likely to be carried by a growing cadre of social workers than by doctors. Instruction, rather than counseling, remains the prevailing norm.

Third, government funding for addiction treatment is limited and still centralized in ineffective '06 Centers. At present, all methadone medications are paid for by donor entities, and almost all MMT technical assistance is provided by international NGO's.

Additionally, because United Nations Office on Drugs and

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Crime (UNODC) and other interdiction agencies have concatenated ecstasy and methamphetamine under a single rubric, ATS (amphetamine-type stimulants), this has led to little ability to discriminate between major stimulants and club/dance drugs. Alcohol and tobacco use are rampant and treated mainly for their extreme consequences. It is culturally acceptable for physicians to drink over lunch and return to work. This used to be acceptable in the U.S. several decades ago.

Germany
Monika Koch, MD

First, as above there is not enough interface between the medical community, which addresses mostly detox issues in inpatient settings, and the social model workers and residential treatment center staff. Addiction medicine physicians can usually just bill for detox/medication visits and are rarely part of a comprehensive treatment center.

Second, alcohol is a large part of German culture and it is more difficult than in the United States to limit triggers.

Third, addiction medicine is a very small, young specialty in Germany; most addiction medicine is done by psychiatry providers with limited special training. There is one addiction medicine department in Mannheim, associated with the University of Heidelberg. All other academic treatment is integrated into psychiatric departments. There are very few national resources available for addiction medicine research or developing practice guidelines, as we see with NIDA, NIAAA, SAMHSA, etc.

Netherlands
Loes Hanck, MD, GGD

1) Helping a patient with their motivation to become abstinent is still the most important challenge;
2) Treating people with an IQ too low to follow regular treatment; facilities for mentally challenged or cognitively impaired people are reluctant to deal with addiction, so those patients sometimes end up on the streets;
3) Waiting lists to obtain addiction treatment.

Portugal
Graca Vilar

1) Dealing with co-morbidities: physical, psychiatric, and related social problems;
2) Encountering patients using the newer psychoactive substances or the legal highs. There is a paucity of evidenced based scientific knowledge about the short-term and long-term consequences of their use;
3) Dealing with poly-substance abusers and with a new type of patients that are very different from heroin users we have treated in the past. There is a cohort now that is much younger (adolescents and young adults), with higher degree of education (mainly, are at school or have a job), higher different economic status, living with their families.

5. How does one stay up to date with the addiction field in your country? Do you rely on any particular journals, conferences, or web-based resources for this purpose?

New Zealand
Tony Farrell, MD

I am a lecturer for one of the universities here in NZ and so I can read from the online library (e.g., addiction journals). I am also in a peer review group, which is most valuable.

New Zealand
Sarz Maxwell, MD, FASAM

ASAM continues to be a huge source for me — their conferences, the weekly ASAM newsletter, and their Journal.

Iraq
Keith Humphreys, PhD

An international group of experts has been working with Iraqi addiction colleagues for eight years, which is a key way that they receive information. Funds have also been provided to allow Iraqis to attend international conferences and to have training in other countries, which they were not allowed to do under Saddam Hussein.

Vietnam
Peter Banys, MD, MSc

Medical education relies on training, testing, and certification. There is no tradition of continuing medical education or recertification. Most physicians are unable to read English language journals.

Germany
Monika Koch, MD

Conferences are offered as well as access primarily to English language journals. None are as good as CSAM conferences and there are a lot less stringent rules about commercial bias.

Netherlands
Loes Hanck, MD, GGD

I have a big network of colleagues in the field over here. We have an association of addiction medicine doctors: VVGN (we are

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linked to the ISAM). We have a Masters in Addiction Medicine program for doctors, which is now in the end stages of the process of being acknowledged as a registered medical specialty; learning how to keep up to date is an important part of the training.

Portugal
Graca Vilar

We rely on a vast array of bibliographic sources (Medline, Cochrane, PsychLIT), covering all areas related to addiction, from the biological basis of this phenomenon, to its anthropological dimensions. We keep up to date with documents issued by the international agencies such as WHO and EMCDDA.

6. What are the most significant changes you have noticed in the addiction field in your country over the past decade?

New Zealand
Tony Farrell, MD

Over the past decade, I have been impressed by the number of highly trained specialists and the level of evidence to support current practice. The bar is being raised in terms of the standards expected for treating these patients, and I am thankfully noticing less prejudice and judgmental attitudes.

New Zealand
Sarz Maxwell, MD, FASAM

All the problems I have cited: resources, stigma, and access are improving. I firmly believe this is due to the increasing medicalization of the addiction field. Brain research, along with more widespread, improved pharmacotherapies were hugely responsible for de-stigmatizing and normalizing psychiatry in the past 50 years — the same will be true for addiction.

Vietnam
Peter Banys, MD, MSc

The capacity to learn. The international HIV epidemic mobilized the country into rapid change. Harm reduction methods such as needle exchange and condoms have been widely adopted. And, local data supports dramatic efficacy and unusually high retention in Methadone Maintenance Therapy programs. That said, there remains a profound, older belief in detox as a core intervention, whereas, in the United States, detox is now considered a prelude to ongoing treatment. Vietnam has one International Society of Addiction Medicine (ISAM)-certified addiction medicine physician. The future development of a Vietnam Society of Addiction Medicine would be a welcome component to establish a specialist network and strengthen professional identity.

Germany
Monika Koch, MD

Addiction Medicine is emerging as a young specialty. There is openness to unconventional and pragmatic approaches, such as using heroin as opiate agonist treatment. Large cities, such as Berlin, Frankfurt, Hamburg, and Munich have started their own programs and are starting to communicate and work on coordinating efforts.

Netherlands
Loes Hanck, MD, GGD

1) Addiction to GHB and
2) More people getting admitted for cannabis addiction

Portugal
Graca Vilar

The emergence of new patterns of drug abuse: cocaine/alcohol/stimulants, as well as newer psychoactive substances and legal highs; the aging of heroin dependents and their increasing co-morbid medical issues along with attendant psychological, social problems.

7. How is Buprenorphine used and perceived in your country?

New Zealand
Sarz Maxwell, MD, FASAM

Suboxone has been here for awhile but not subsidized by the NHI. That subsidy began only recently in July 2012. There is great interest in it, but unfortunately its prescription is limited to docs in addictions treatment programs, and most of them are seeing Suboxone as just a new flavor of methadone, applying the same restrictions in terms of takeaway doses. The restriction is not yet mandated by the Ministry of Health. Legally, prescribing is quite open and theoretically I could write prescriptions for a 90-day supply. In practice, most clinics are dosing exactly the way they do methadone (for takeaways, not milligrams.) As for the dose, the daily average is 16-24mg.

Germany
Monika Koch, MD

Buprenorphine can be used in the agonist treatment of opioid dependence. Buprenorphine, as well as methadone, (and for methadone intolerant patients, codeine) can be prescribed by specially licensed physicians, mostly general practitioners that have less than 10 patients per practice although there is no official limit and some treatment centers have many more patients.

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Until the late 1990s abstinence from opiates was the main treatment goal. For repeated treatment failures the main substitution was codeine (as it was not regulated) and some with methadone (for which the practitioners were later prosecuted). In 1998 opiate agonist treatment became more widely available as described above. It is mainly used for heroin addiction. There are no clear numbers for opioid pill addiction.

Vietnam
Peter Banys, MD, MSc

BPN is not presently available but a new Opioid Substitution Decree opens the door to it and to private clinics. So, for the wealthy, this will become an option.

Netherlands
Loes Hanck, MD, GGD

We have buprenorphine in low dosages (0.2mg), in higher dosages (2mg and 8mg) and the buprenorphine/naloxone combination Suboxone (2/0.5 and 8/2) registered.

Buprenorphine in high dosages is not covered by health care insurance, so we only use the buprenorphine/naloxone combination for our patients.

When we started treating opioid addicted patients with buprenorphine high dosages about 10 years ago we were required to fill out all kinds of forms to get the medication imported and patients had to pay for it themselves (although sometimes we were able to convince health care insurance to pay for it).

Because of all this hassle some colleagues started treating patients with the low dosage tablets, resulting in too low dosages (either because it was prescribed in a low dosage or because of wrong ways of taking the tablets).

I think that in 2006 Suboxone became available in Holland. Since then our association of addiction medicine doctors have organized several classes on how to prescribe Suboxone. And gradually people become more aware of this alternative option and are prescribing it.

Portugal
Graca Vilar

Unlike methadone prescribing, which is only delivered in public treatment centers, high doses of buprenorphine can be prescribed by any doctor, and bought by patients at local pharmacies. ■

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2. The views and comments expressed within the "International Perspective" are solely that of the authors and do not represent the views of CSAM nor have comments been verified.

President's Message

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Examinations.[5] With regards to the virtual marine, we have structured his "brain" to initially deny that he has any mental health or substance abuse problems. However, when the avatar is interviewed by a student with sufficient interviewing skill, the marine starts to speak of his problems with depression and alcohol abuse – then, in response to continued excellence in technique, the marine shares his distressful experience of suicidal ideation. Of note, the avatar technology provides a complete transcription of the interview that can be shared with a single student or multiple trainees during supervision.

With regards to the journal, its first edition contains results from a study that evaluated 14, 253 Canadian Forces personnel deployed to Afghanistan who, upon completion of their deployment, entered a 1-week "Third-Location Decompression Program" in Cyprus designed to mitigate combat trauma disorders. We have chosen to focus the Military Behavioral Health journal on an international scale because conflict resolution has become an international issue and lessons learned throughout the world on PTSD, substance abuse and other combat related mental health disorders may prove useful in supporting U.S. troops. ■

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Dr. Wilkins is President of the California Society of Addiction Medicine and a Fellow of the American Society of Addiction Medicine. He is also the Lincy/Heyward-Moynihan Chair of Addiction Medicine; Vice Chair, Dept. of Psychiatry, Cedars-Sinai Medical Center; Director, American Board of Addiction Medicine; and Clinical Professor, Department of Psychiatry; and Biobehavioral Sciences, David Geffen School of Medicine at UCLA. He can be reached at: jefferywilk@gmail.com.

State Regulations for Drug Treatment Centers Must Include Doctors Making House Calls

By Christy Waters, MD, Chair, CSAM Committee on Public Policy

Christy Waters, MD

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. According to a recent report, "Rogue Rehabs," released by the California Senate last year, the failure to allow appropriate medical oversight of sick patients at some California treatment centers has resulted in deaths.

The responsibility for changing these outdated regulations rests in the hands of the California Department of Alcohol and Drug Programs. However, for many years the department has failed to make the necessary changes. The State of California has for decades maintained regulations for licensing addiction treatment facilities that favor certain treatment modalities and obstruct others. The regulations that can prohibit doctors from attending patients inside treatment facilities were put in place in the 1960s to inhibit medical model programs, which were out of favor at the time.

But progress has led to treatment regimens that are patient-centered, not program-centered. Today, there are a number of successful treatments for substance use disorders, including 12-step facilitation, therapeutic community, cognitive-behavioral therapy, motivational-enhancement therapy and FDA-approved medications. Treatment experts throughout the world now recommend rigorous individual assessment and treatment modeled to fit the patient, instead of favoring one treatment modality over another for all. Best practices for treatment match patients to the most promising therapy for the individual. If one modality doesn't work, another is tried — the same as with other chronic diseases.

Prescribing certain treatments isn't the only reason addicts need doctors. Following years of abusing their bodies with alcohol and drugs, alcoholics and drug addicts have much greater medical needs than people without substance use disorders. The toxic effect of alcohol and drugs, the failure of addicts to recognize their own health problems, and the risky lifestyles many lead may result in great need for medical care. The greatest need for medical care may be during the detoxification phase.

Today's evidence-based principles of addiction treatment also call for addressing other needs of the patient to improve treatment outcomes. Leading those other needs are treatments for medical and psychiatric problems. That can't be effectively accomplished if doctors are not allowed inside treatment centers.

But California's regulations prevent doctors from treating patients at residential treatment centers. Therefore, a patient must be sent out from the treatment facility to a medical provider. At the same time, doctors can be refused from attending people during the dangerous period of detoxification from drugs and alcohol. A detox patient experiencing difficulties must be sent from the treatment facility to a medical facility, usually by ambulance.

California's treatment center licensure regulations are clearly out of date, and an effort is afoot to alter them. But opposition still remains, despite the overwhelming expert opinion that providing all evidence-based treatment options is in the best interest of those suffering from the disease of addiction, and so is providing on-site medical care. State licensing regulations for addiction treatment facilities need to protect the lives of addicted patients by allowing doctors to provide the care they need, when and where they need it. CSAM is working on new legislation intended to remedy this. Stay tuned.

CSAM seeks members who are interested in advocacy to join the Committee on Public Policy. The committee meets monthly via conference call. Contact CSAM at: csam@csam-asam.org. ■

CSAM's Public Policy Priorities for 2013

1. **Drug Residential Treatment Facilities** – regulations pertaining to physicians providing treatment

2. **Physician Health & Well-Being** – in conjunction with the CA Public Protection & Physician Health, Inc.

3. **Marijuana** – protection of youth and ensuring scientific accuracy of legislation and/or voter ballot initiative anticipated in 2016

4. **Safe Opioid Prescribing and Dispensing and Funding for the Controlled Substance Utilization Review and Evaluation System (CURES)** – to ensure proper implementation

5. **Overdose Prevention** – such as EMT training on naloxone and publicizing of newly passed Good Samaritan law.

6. **The Accountable Care Act** – implementation of parity in CA for Substance Abuse Disorders and Mental Health (in conjunction with the CA Coalition for Whole Health)

7. **Tobacco** – prevention and research

If you have an interest in public policy issues and wish to participate in CSAM's work in this area, contact Christy Waters, MD, Chair, CSAM Committee on Public Policy at: Christy.Waters@kp.org

"911 Good Samaritan" Fatal Overdose Prevention

At the urging of CSAM and other health organizations in California, Governor Jerry Brown signed legislation seeking to reduce the number of preventable deaths resulting from accidental drug overdoses. The passage of Assembly member Tom Ammiano's AB 472, the "911 Good Samaritan bill," received bipartisan support and makes California the tenth state in the country to take action to reduce accidental overdose fatalities by removing barriers to accessing emergency health services.

As of January 1, 2013, California now provides limited immunity from arrest or prosecution for minor drug law violations for people who summon help at the scene of an overdose. The protection is intended to reduce bystanders' hesitation to assist, for fear of being sued or prosecuted for unintentional injury or wrongful death.

Good Samaritan laws do not protect people from arrest for other offenses, such as selling or trafficking drugs, or driving while intoxicated. These policies protect only the caller and overdose victim from arrest and/or prosecution for simple drug possession, possession of paraphernalia, and/or being under the influence.

Accidental overdose deaths are now the leading cause of accidental death in the United States, exceeding even motor vehicle accidents among people ages 25 to 64. Many of these deaths are preventable if emergency medical assistance is summoned, but people using drugs or alcohol illegally often fear arrest if they call 911, even in cases where they need emergency medical assistance for a friend or family member at the scene of a suspected overdose. The best way to encourage overdose witnesses to seek medical help is to exempt them from arrest and prosecution for minor drug and alcohol law violations, an approach often referred to as Good Samaritan 911.

"Accidental overdose deaths are now the leading cause of accidental death in the United States, exceeding even motor vehicle accidents among people ages 25 to 64."

Now it's important to get the word out, so in 2013, CSAM is joining dozens of organizations to raise awareness of the new law. If you wish to help spread the word, please contact: Meghan Ralston, Drug Policy Alliance, at 323-681-5224. ■

Announcing: AddictionMedicineCME.org

The California Society of Addiction Medicine (CSAM) has launched of a new website **AddictionMedicineCME.org** dedicated to providing continuing medical education on topics related to addiction.

The first offering on the site, an online version of the 2012 Review Course, consists of 26 lectures providing an overview of the core elements of addiction medicine, presented by top experts in the field.

Participants can view the lectures at their own pace and return to them as often as they like. If learners prefer to only complete some events, they can do so and print their CME certificate at any time. In addition to the video/Powerpoint presentations, participants can download PDF and MP3 audio of all talks.

Also available on the site is the ABAM Certification Exam Preparation Track Online consists of 6 hours of presentations featuring several hundred sample questions presented in an interactive format as well as test taking strategies and other material to help participants prepare for the American Board of Addiction Medicine Certification Exam.

The online Review course offers 21.25 *AMA/PRA Category 1 Credits™ and the Certification Exam Preparation Track offers 6 Credits.*

California Public Protection and Physician Health (CPPPH)

By Gail Jara, Executive Director, CPPPH

Gail Jara

In June of 2007, the Medical Board of California voted to end the 27-year-old California Diversion Program, making California one of only a few states in the U.S. without any central physician health program. The California Medical Association (CMA) quickly convened a "Workgroup on Public Protection and Physician Health" with a coalition of stakeholders, including California Society of Addiction Medicine (CSAM), California Psychiatric Association (CPA), The Permanente Medical Group (TPMG), California Hospital Association (CHA), the California Society of Anesthesiologists (CSA), and eventually many other organizations and individuals who would be affected by the dissolution of the Diversion Program including liability carriers, well-being committee members, and individual service providers. That Workgroup met regularly to coordinate new strategies for addressing public protection and appropriate responses to physicians who experience medical, psychological, emotional, behavioral or substance use issues in the absence of a Medical Board-run program.

The Medical Board's Physician Diversion Program was formally closed in 2008 and some 300 physicians who had not yet completed the program were released. Private organizations and programs emerged to provide some of the needed services, but Workgroup members continued to report a serious loss of options and concerns. Some of the concerns were about the lack of a central entity that could provide physicians and other consumers (hospitals, well-being committees, treatment providers) with evaluation tools and service referrals, individual case consultation, or information about credible educational and treatment resources, monitoring programs and testing services. Also cited was a lack of standardization or guidelines with which to measure the range and quality of services that did exist.

There was also significant concern that some physicians who needed ongoing support and monitoring continued to practice without aid and supervision.

In a survey of 1,891 practicing U.S. doctors that appeared in July 2010 in the *Journal of the American Medical Association (JAMA)*, researchers found that 17% of the physicians surveyed reported direct, personal knowledge of a physician who may be experiencing mental health or substance use issues, but many said they did not report these physicians. Lack of a trusted confidential resource was one of the reasons mentioned.

It is from this backdrop that California Public Protection and Physician Health, Inc. (CPPPH) was established in 2009 as an independent non-profit corporation dedicated to developing a statewide physician health program to respond to the needs articulated by the Workgroup members and others. From its inception, CPPPH founders recognized that a full-scale program that promotes physician wellness and coordinates all the services needed to address the spectrum of physician health issues would take time, energy and funding to reach full potential.

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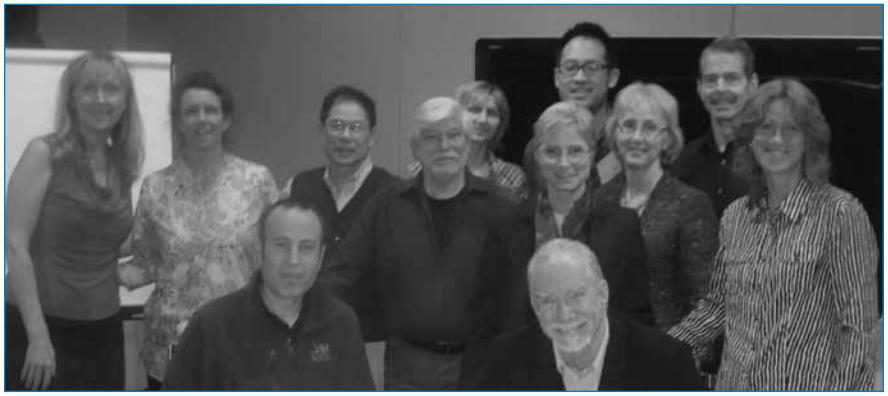
CPPPH has proceeded to address these needs while its parent organizations pursue legislation to establish and fund a state sanctioned program. CPPPH seeks to respond to the American Medical Association (AMA) Resolution that all states should provide access to programs that address physician health so that colleagues will know how to intervene appropriately.

CPPPH fosters dialogue, information sharing and co-ordination among physician health committees by convening half-day workshops every four months in three regions of the state, with these objectives:

- Deliver practical information, education and training for committees and persons currently doing physician health work in California. 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 that CPPPH will want to address as it develops plans for a statewide program and that will allow CPPPH to serve as the voice for physician health in California

For information about CPPPH, its Regional Networks and other details, see **www.CPPPH.org**. ■



The CSAM Executive Council meeting for its annual board meeting in Los Angeles on February 2, 2013. Pictured sitting from left are: Itai Danovitch, MD, President-elect and Jeff Wilkins, MD, President. Standing from left are: Kerry Parker, CAE, Executive Director, Jean Marsters, MD, David Pating, MD, Timmen Cermak, MD, Monika Koch, MD, Karen Miotto, MD, David Kan, MD, Christy Waters, MD, Steven Eickelberg, MD, and Stephanie Shaner, MD. Not pictured, but present earlier at the meeting, was Romana Zvereva, MD, Treasurer.

Call for Nominations

The Nominating Committee, appointed by CSAM's President, is selecting candidates for open positions on the California Society of Addiction Medicine's Executive Council. If you are interested in nominating a member or yourself running for election for member-at large or other open positions, please e-mail the CSAM office at csam@csam-asam.org. Please provide a brief statement of why you think the person you are nominating would be a good choice or why you are interested in the position. If self-nominating, please include your CV.

The nominating committee will announce the slate and ballots will me mailed to all eligible members 30 days prior to the annual meeting of members on Friday October 18 at the Addiction Medicine State of the Art Conference in San Diego. Elected candidates will be announced at this meeting.

Nominations are also being accepted for CSAM's two annual awards. The Vernelle Fox Award is given to a physician or other medical professional to recognize "achievement in clinical, research, education, prevention, or legislation/administration areas of chemical dependence." The Community Service Award is usually presented to someone outside the health profession who has advanced the treatment of addiction. A list of previous award recipients is on the CSAM website. ■

Get Certified by the American Board of Addiction Medicine (ABAM)

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.

ABAM encourages new applicants to begin doing CMEs in addiction medicine to meet the 50 required Category 1 Hours. Applicants are expected to have completed some CMEs in addiction medicine prior to filing an application.

2014 Examination Date: Nov. 8, 2014. CSAM will offer a Review Course to help those preparing for the exam September 3-6, 2014 in Anaheim, California. ■

2014 Deadlines (& Fees): Early: Oct. 31, 2013 - $1,950
Regular: Jan. 31, 2014 - $2,350 • Final: May 31, 2014 - $2,650

CSAM Executive Council

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San Francisco, CA 94105

SAVE THE DATE

Conference Chair
Sharone Abramowitz, MD

October 16-19, 2013

Sheraton San Diego Hotel and Marina

Keep up to date with the latest scientific and clinical advances in addiction medicine.

Addiction Medicine State of the Art 2013

SELECTED TOPICS INCLUDE:

- Improving Addiction Medicine-Primary Care Collaboration
- Managing Prescription Drug Abuse and Chronic Pain
- Marijuana Update
- Engagement and Relapse Prevention
- Best Clinical Practices in Addiction Medicine
- Geriatric Addiction
- How the Affordable Care Act Will Impact Your Addiction Medicine Practice

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Register online at csam-asam.org