RESOURCE DOCUMENTS

AMERICAN MEDICAL ASSOCIATION (1979):
GUIDELINES FOR PHYSICIAN INVOLVEMENT IN THE CARE OF SUBSTANCE-ABUSING PATIENTS

In 1979, the American Medical Association adopted a policy statement entitled "Guidelines for Physician Involvement in the Care of Substance-Abusing Patients." The Guidelines articulate the principle that every physician must assume clinical responsibility for the diagnosis and referral of patients with substance use disorders, and broadly define the competencies required to meet that responsibility. The Guidelines thus represent one of the first efforts by a major medical organization to highlight the need for all physicians to have competence to address substance use disorders. The Guidelines are published here in their entirety.

> *"Alcoholism and other drug dependencies are among the most difficult to treat of medicine's challenges. As physicians, we all have a role in the prevention and treatment of alcohol — and drug-related problems, and this role must be addressed now. The future of too many of our current and future patients demands that we no longer accept such losses silently."*
>
> – Otis R. Bowen, M.D., Secretary of Health and Human Services, and
> James H. Sammons, M.D., Executive Vice President, American Medical Association

LEVEL I

For all physicians with clinical responsibility: Diagnosis and Referral:

- Recognize as early as possible alcohol- or drug-caused dysfunction.
- Be aware of the medical complications, symptoms, and syndromes by which alcoholism (or drug abuse) is commonly presented.
- Ensure that any complete health examination includes an in-depth history of alcohol and other drug use.
- Evaluate patient requirements and community resources so that an adequate level of care can be prescribed, with patients' needs matched to appropriate resources.
- Make a referral to a resource that provides appropriate medical care.

LEVEL II

For physicians accepting limited treatment responsibility (to restore the individual patient to the point of being capable of participating in a long-term treatment program):

- Assist the patient in achieving a state free of alcohol and other drugs, including management of acute withdrawal syndrome.
- Recognize and treat, or refer, all associated or complicating illnesses.
- Apprise the patient of the nature of his disease and the requirements for recovery.
- Evaluate resources — physical health, economic, interpersonal, and social — to the degree necessary to formulate an initial recovery plan.

- Determine the need for involving significant other persons in the initial recovery plan.
- Develop a long-term recovery plan in consideration of the above standards and with the patient's participation.

LEVEL III

For physicians accepting responsibility for long-term treatment:

- Acquire knowledge, by training and/or experience, in the treatment of alcoholism (and other drug dependence).
- The following responsibilities should be conducted or supervised by the physician:
  - Establish a supportive, therapeutic, and nonjudgmental relationship with the patient.
  - Periodically evaluate and update the recovery plan with the patient's participation.
  - Involve the patient with an abstinent peer group when appropriate.
  - Become knowledgeable about and be able to utilize various health, social, vocational, and spiritual support systems.
  - Evaluate directly or indirectly significant other persons and, unless clearly contraindicated, involve them in treatment.
- Continually monitor the patient's medication needs. After treatment of acute withdrawal, use psychoactive drugs only if there is a clear-cut and specific psychiatric indication.
- Be knowledgeable about the proper use of pharmacotherapy.
- Throughout the course of treatment, continually monitor and treat, or refer for care, any complicating illness or relapse.
- Be available to the patient as needed for an indefinite period of recovery.
  - Within the confines of this relationship, establish specific conditions and limits under which the therapy will be conducted, and carefully explain them to the patient.

THE MACY CONFERENCE (1994): RECOMMENDATIONS FOR TRAINING ABOUT ALCOHOL AND SUBSTANCE ABUSE FOR ALL PRIMARY CARE PHYSICIANS

In 1994, the Macy Conference on Training About Alcohol and Substance Abuse for All Primary Care Physicians moved the conversation forward by elaborating on the competencies articulated in the American Medical Association's policy statement. The report of the conference also contained a number of thoughtful essays on the subject by conference chair David Lewis, M.D., and other leaders in medical education.

The essay excerpted here, by David C. Lewis, M.D., of the Mt. Sinai Medical School, offers insights into why this body of knowledge has been so difficult to integrate into medical education, as well as recommendations for addressing the problem.

Chairman's Summary and Conclusions

David C. Lewis, M.D.

According to studies cited during this Macy Conference, our nation is paying almost $240 billion a year for undiagnosed and untreated substance abuse in the form of medical complications and social problems. It seems obvious that, to save time and money, physicians need to be better trained to make diagnoses and perform interventions in the course of their practice, so that we are not just dealing later with the much more expensive complications of substance abuse.

How to make the case for more adequately training physicians to routinely attend to the substance abuse problems they encounter was the challenge presented to the conference planning committee. The committee responded by deciding to focus on the residency review committees and specialty boards in the primary care disciplines in an effort to convince them to strengthen their requirements for training in substance abuse. . . .

It became clear . . . that the conference participants were well aware of the new demands of our emerging health care system. . . . There was a discouraging recitation of reasons why medical students and residents are not now receiving more training in substance abuse, [including] physicians' negative attitudes toward substance-abusing patients, social and professional stigmas associated with physicians who treat these patients, and a shortage of trained faculty. But the arguments for enhanced training were convincing, especially since the competencies needed by physicians are clearly defined and training programs already know how to teach and develop these competencies. As a result, the discussions centered on the issue of timing — a shift from whether more training in substance abuse should be required to how soon this requirement could be implemented *[see the Concluding Statement of the Conference Participants].*

. . . Because the conference planning committee knew that the key decisions about how to implement the goals of the conference would be made by the boards and residency review committees, the conference had not been organized to arrive at conclusive decisions. As I reviewed the proceedings of the conference, however, I found a number of strong, action-oriented recommendations that had been made during the course of the discussions [which follow].

I. Action Steps for Certifying Boards of Primary Care Medical Specialties and the American Board of Medical Specialties

1. Convene primary care boards to determine a set of enhanced requirements that board-certified physicians must meet with respect to demonstrated expertise and training regarding substance abuse.
2. Consider pilot projects in which the boards use standardized patients to evaluate professional skills related to managing substance abuse patients. Coordinate with certifying examiners to ensure that questions gleaned from encounters with standardized patients are reflected on certifying examinations.

II. Action Steps for the Accreditation Council for Graduate Medical Education (ACGME)

1. Define substance abuse training standards in ACGME general requirements and for the residency review committees in all the medical specialties.
2. "Fast track" all new general and special requirements regarding substance abuse training in graduate medical education.

III. Action Steps for Residency Review Committees in Primary Care Specialties (Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology)

1. Require more residents' training to involve experience with substance-abusing patients.

2. Work collaboratively with the Residency Review Committee in Psychiatry to develop common language for all special requirements involving training in the management of substance abuse.
3. Require training programs to have faculty members who have been trained specifically to manage substance abuse.
4. Require training programs to include substance abuse treatment centers as training sites, and assign residents for a one-month rotation in these centers.
5. Require residents to maintain a case registry of substance abuse patients, and routinely survey residents about their experiences.
6. Require program directors to have residents directly observed while managing substance abuse patients to ensure their competence. This requirement should be part of the annual RRC program audit.
7. Require training programs to provide residents with special training and experience with physicians who are impaired due to substance abuse problems.

IV. Action Steps for the Liaison Committee on Medical Education and the National Board of Medical Examiners

1. Specify the requirements for medical school educational programs related to substance abuse.
2. Reinforce and emphasize these requirements in the United States Medical Licensing Examination and subject tests of the National Board of Medical Examiners.

V. Action Steps for Medical School Leaders

1. Reject applicants to medical school whose attitudes toward [patients with substance use disorders] . . . would make them incapable of treating [such patients] . . . in a professional manner.
2. When recruiting new clinical faculty, seek individuals with training in the management of substance-abusing patients. (The Association for Medical Education and Research in Substance Abuse and the American Society of Addiction Medicine can assist in identifying potential faculty members with this expertise and experience.)

VI. Action Steps for Leaders of the Medical Professions

1. Educate professionals to understand that substance abuse is an intermittent, relapsing chronic disease that is preventable, can be treated effectively, and is not usually a manifestation of mental disease.
2. Educate professionals that, in addition to mastering problems with drinking or a drug, functional improvements in family, work, and social adjustment are also important in achieving gains in quality of life.
3. Fight professional stigmas attached to physicians and other providers who care for substance- abusing patients.
4. Develop treatment protocols and performance standards for physicians and other providers who care for substance-abusing patients.

VII. Action Steps for Public Policy Makers

1. Recognize that substance abuse is a disease and reimburse for its treatment comparably to any other disease.
2. Eliminate managed care restrictions on referrals to substance abuse specialists — especially restrictions that hinder access to substance abuse treatment.
3. Establish national standards for accrediting substance abuse treatment centers.
4. Support the establishment of fellowship programs to train medical school faculty in the management of substance abuse.
5. Support basic research and treatment outcomes research related to substance abuse.

Dr. Richard DeVaul's survey eight months after the conference revealed that the boards and residency review committees had taken significant steps toward implementing the goals of the conference.

Concluding Statement of the Participants

We recommend that the specialties of Family Practice, Internal Medicine, Pediatrics, and Obstetrics-Gynecology promptly respond to the need to improve the quality of care provided by physicians trained in these specialties to patients with alcohol and other drug problems.

These primary care specialties should require all residents to be trained to develop and to demonstrate those skills necessary to prevent, screen for and diagnose alcohol and other drug problems; to provide initial therapeutic interventions for patients with these problems; to refer these patients for additional care when necessary; and to deliver follow-up care for these patients and their families.

The certifying boards and residency review committees of these specialties should expeditiously take specific actions to strengthen their requirements so that the performance of residents in managing substance abuse patients is measurably improved.

PROJECT MAINSTREAM (2002): RECOMMENDED PHYSICIAN COMPETENCIES

Project Mainstream, organized by the Association for Medical Education and Research in Substance Abuse (AMERSA) with assistance from the Health Resources and Services Administration and the Center for Substance Abuse Treatment, represents a multi-year effort to describe in detail the areas of knowledge and skills required by practitioners of many health professions.

The competencies and recommendations offered in the Project Mainstream report have been endorsed by many health professions organizations, including the American Medical Association, the American Osteopathic Academy of Addiction Medicine, and the Society of Teachers of Family Medicine.

Brief excerpts from the report are presented here. The full report and accompanying documents can be accessed at the AMERSA Web site at www.amersa.org.

Recommendations

CORE COMPETENCIES IN SUBSTANCE ABUSE EDUCATION FOR PHYSICIANS

The following competencies are presented as three levels of involvement in the care of patients with SUD. All physicians with clinical contact should strive to provide Level I competence. (e.g., primary care and generalist physicians). Level III competence should be sought by all physicians providing specialty services to patients with SUD. Table 1 lists the competencies for each level.

Table 1. Critical Core Competencies in Substance Abuse Education for Physicians

Level I: All physicians with clinical contact should:

1. Be able to perform age, gender, and culturally appropriate substance abuse screening.
2. Be able to provide brief interventions to patients with SUD.
3. Be able to use effective methods of counseling patients to help prevent SUD
4. Be able to refer patients with SUD to treatment settings that provide pharmacotherapy for relapse prevention.
5. Recognize and treat or refer comorbid medical and psychiatric conditions in patients with SUD.
6. Be able to refer patients with SUD to appropriate treatment and supportive services.
7. Be aware of the ethical and legal issues around physician impairment from SUD and of resources for referring potential impaired colleagues, including employee assistance programs, hospital-based committees, State physician health programs, and licensure boards.
8. Identify the legal and ethical issues involved in the care of patients with SUD.

Level II: All physicians coordinating care for patients with SUD in addition should:

1. Use effective methods to assess patients with SUD.
2. Provide pharmacologic withdrawal to patients with SUD.

Level III: All physicians providing specialty services to patients with SUD in addition should:

1. Provide pharmacotherapy for relapse prevention in patients with SUD.
2. Provide, or refer for psychosocial counseling for relapse prevention in patients with SUD.

RECOMMENDATIONS FOR LEVEL I COMPETENCIES

All physicians with clinical contact should have Level 1 competencies.

Level I, Competency 1

Physicians should be able to perform age, gender, and culturally appropriate substance abuse screening.

1. **Physicians' training curricula and licensing examinations at all levels should be modified to include content on the use of effective methods of screening patients for SUD. A curriculum in screening for SUD should be required and integrated into the standard curricula of all medical schools and residency training programs. As a requirement for graduation, medical students should demonstrate competency in screening, intervention, and referral for SUD**

(consistent with Competencies I-2 and I-4 below). Licensing examinations should include content and questions relevant to appropriate screening strategies for patients with SUD. Increased curricular content on screening for SUD should be available through CME programs. The development, dissemination, and maintenance of these curricula should be coordinated by a lead Federal agency with input from all appropate Federal agencies and professional societies.

Rationale. Screening involves identifying patients with unrecognized SUD.[12] Screening for diseases is warranted if the following conditions are met: the disease has a significant prevalence and consequences; effective and acceptable treatments are available; early identification and treatment are preferable; and there are effective screening instruments available that are easy to administer. There is strong research evidence to support the fact that SUD meet all of these criteria; therefore, screening for SUD is indicated although not often implemented.

Recommended Actions. Training in screening for SUD should include attention to the rationale, utility, operating characteristics, and use of various methods including the importance of raising the topic and the appropriate role of formal screening instruments (e.g., CAGE, AUDIT), quantity-frequency questions, and biological markers (e.g., MCV, AST, ALT, carbohydrate-deficient transferrin).[12, 48-54]

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, United States Medical Licensure Examination (USMLE), and American Board of Medical Specialties (ABMS).

Level I, Competency 2

Physicians should be able to provide brief interventions to patients with SUD.

2. **A required curriculum in brief treatment interventions for individuals with SUD should be integrated into the standard curricula of all medical schools and residency training programs. This curriculum should outline the components of brief interventions that have demonstrated effectiveness. As a requirement for graduation, medical students should demonstrate competency in brief intervention for patients with SUD. Licensing examinations should include content and questions relevant to appropriate treatment strategies for individuals with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of these curricula should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.**

Rationale. There is evidence that brief interventions can reduce alcohol consumption to below hazardous levels for patients with hazardous and harmful drinking.[31,55] The incorporation of substance abuse services into settings will allow for a direct expansion of the capacity of the health care system and will help increase access to care for a wide range of patients.[56,57]

Recommended Actions. Training in SUD should devote attention to the effectiveness of office-based interventions for SUD, including the role of brief interventions in patients with alcohol problems.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 3

Physicians should use effective methods of counseling patients to help prevent SUD.

3. **A required curriculum in counseling to help prevent the development and progression of SUD should be integrated into the standard curricula of all medical schools and residency training programs. This should include information on community prevention of SUD. Licensing examinations should include content and questions relevant to appropriate prevention of SUD. Increased curricular content should be available through CME. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.**

Rationale. Prevention of harm from the use of psychoactive substances can help decrease the impact of SUD on the individual and society.[58,59] For instance, decreasing alcohol consumption among pregnant women can have a significant impact on the incidence of the fetal alcohol syndrome.[23] In addition, recent efforts at early recognition and treatment from hazardous and harmful drinking are aimed at decreasing progression to more severe alcohol problems that are traditionally less amenable to treatment.[55] While the risk factors for SUD, including specific genetic markers, are still being elucidated, and the determinants of progression from substance use to abuse and subsequent dependence are under evaluation, early recognition and intervention by physicians can be effective in decreasing progression from less severe to more severe SUD.

Recommended Actions. Training in SUD should devote specific attention to the effectiveness of counseling patients to help prevent the development or progression of SUD using formal counseling and brief interventions.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 4

Physicians should be able to refer patients with SUD to treatment settings that provide pharmacotherapy for relapse prevention.

4. A required curriculum in the available pharmacotherapy for SUD should be integrated into the standard curricula of all medical schools and residency training programs. Licensing examinations should include content and questions relevant to appropriate prevention of SUD. Increased curricular content should be available through CME. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. Recent research has highlighted the role of neurochemistry in the etiology and maintenance of SUD. For instance, there is evidence for involvement of the dopamine, GABA, serotonin, and opioid systems in alcohol use disorders, and chronic exposure to narcotics is known to create fundamental changes in receptors and intracellular messaging in patients with opioid dependence.[7,60-62] These insights have created new pharmacologic therapies such as naltrexone, acamprosate, and buprenorphine that are aimed at preventing relapse.[26,28,31,63]

Recommended Actions. Training in SUD should devote attention to the effectiveness of pharmacotherapy to help prevent relapse in abstinent patients with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 5

Physicians should recognize and treat or refer comorbid medical and psychiatric conditions in patients with SUD.

5. A required curriculum in the medical and psychiatric comorbidities of SUD should be integrated into the standard curricula of all medical schools and residency training programs. Increased curricular content should be available through CME. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. Population surveys have revealed high rates of comorbid medical and psychiatric disorders in patients with SUD. For instance, the Epidemiological Catchment Area and the National Comorbidity Study surveys have found a 29% to 37% prevalence of comorbid psychiatric disorder in patients with alcohol problems.[2,64] In addition, abused substances and the route used to administer (e.g., injection) these substances are associated with significant comorbid medical conditions such as hepatitis B and C, endocarditis, human immunodeficiency virus infection and AIDS, tuberculosis, and cirrhosis.[65,66]

Recommended Actions. Training in SUD should devote attention to the recognition, treatment, or referral of comorbid medical and psychiatric conditions in patients with SUD. **Responsible Agents.** LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 6

Physicians should be able to refer patients with SUD to appropriate treatment and supportive services.

6. A required curriculum in the process of evaluation and referral of patients with SUD should be integrated into the standard curricula of all medical schools and residency training programs. As a requirement for graduation, medical students should demonstrate competency in referral for patients with SUD. Licensing examinations should include content and questions relevant to the appropriate referral of patients with SUD. Increased curricular content should be available through CME. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. Multicenter randomized clinical trials such as Project MATCH and data from the Drug Abuse Treatment Outcome Study have demonstrated the efficacy of a variety of treatment services for patients with SUD.6[7-69] In addition, successful referrals to treatment require an accurate assessment of a patient's diagnosis and an understanding of the treatment process.

Recommended Actions. Training in SUD should devote attention to the effectiveness of appropriate referral of patients to substance use services, including formal treatment programs. Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 7

Physicians should be aware of the ethical and legal issues around physician impairment from SUD and of resources for referring potential impaired colleagues, including employee assistance programs, hospital-based committees, State physician health programs, and licensure boards.

7. Physicians' training curricula and licensing examinations at all levels should be modified to include content on the recognition and referral for treatment of physicians and health professionals impaired by SUD. A required curriculum in the recognition and referral of physicians and other health professionals impaired by SUD should be integrated in the standard curricula of all medical schools and residency training programs. Licensing examinations should include content and questions relevant to the recognition and referral of physicians and other health professionals with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. Unrecognized and untreated physicians and other health professionals impaired by substance use can constitute a major threat to patient safety and the integrity of the medical profession.[70] Successful programs have been developed to assist physicians and other health professionals who have been recognized and referred to treatment.[38,71] The RRC has recognized the importance of these practices and specified institutional requirements for policies that cover physician impairment, and in one instance (i.e., internal medicine), there is a specialty requirement.[45]

Recommended Actions. Training in SUD should devote attention to the effectiveness of recognition and referral of impaired physicians and other health professionals with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level I, Competency 8

Physicians should identify the legal and ethical issues involved in the care of patients with SUD.

8. A required curriculum in the ethical and legal complications of SUD should be integrated into the standard curricula of all medical schools and residency training programs. Licensing examinations should include content and questions relevant to the ethical and legal complications of SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. SUD are frequently associated with legal complications stemming from use (e.g., driving under the influence) or impaired judgment. Ethical considerations, such as patient confidentiality, are important aspects of caring for patients with SUD.

Recommended Actions. Training in SUD should devote attention to the legal and ethical issues in caring for patients with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Recommendations for Level II Competencies

All physicians coordinating care for patients with SUD (e.g., primary care and generalist physicians) should have Level I and Level II competencies.

Level II, Competency 1

Physicians should use effective methods to assess patients with SUD.

1. A curriculum in the assessment of patients with SUD should be integrated into the curricula of all medical schools and appropriate residency training programs. Licensing examinations in the appropriate disciplines should include content and questions relevant to methods to assess patients with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.

Rationale. Assessment involves identifying the realms of a patient's life affected by SUD. Criteria exist for the diagnosis of substance dependence syndromes[72] and instruments are available to assess the severity of SUD, such as the Addiction Severity Index,[73] which evaluates the spectrum of areas affected by SUD (e.g., medical, psychosocial, legal, and family domains). Assessment of these domains is necessary to understand the full impact of SUD on the individual.

Recommended Actions. Training in SUD should include attention to the medical, psychological, family, legal, and employment complications attributed to SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level II, Competency 2

Physicians should provide pharmacologic withdrawal to patients with SUD.

2. **A curriculum in the pharmacologic withdrawal of patients with SUD should be integrated into the curricula of all medical schools and appropriate residency training programs. Licensing examinations in appropriate disciplines should include content and questions relevant to methods to provide withdrawal to patients with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.**

Rationale. Recent clinical trials have provided empirical evidence for efficient and effective care of patients requiring detoxification services in office-based settings.13,74 In addition, the use of symptom-triggered, instead of fixed, doses of benzodiazepines has been shown to reduce length of stay and cost for patients treated for alcohol withdrawal.[13,75] In opioid-dependent patients, updated regimens and new medications have extended the utility of these services in inpatient and outpatient settings.[32,63,76,77]

Recommended Actions. Training in SUD should include attention to the role and logistics of detoxification for patients with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Recommendations for Level III Competencies

Level III competence should be sought by all physicians providing specialty services to patients with SUD.

Level III, Competency 1

Physicians should provide pharmacotherapy for relapse prevention in patients with SUD.

1. **curriculum in pharmacotherapy to help prevent relapse in abstinent patients with SUD should be integrated into the curricula of all medical schools and appropriate residency training programs. Licensing examinations in appropriate disciplines should include content and questions relevant to pharmacotherapy for relapse prevention in abstinent patients with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.**

Rationale. Effective new therapies are available for patients with alcohol problems.26,28,31,63 Methadone maintenance has demonstrated efficacy in decreasing illicit drug use, HIV transmission, and criminal activity.63 In addition, office-based pharmacologic treatments have been shown to be effective for opioid-dependent patients previously stabilized at narcotic treatment programs 78-80 and for those actively using drugs.33,76,77 **Recommended Actions.** Training in SUD should include information on the effectiveness of pharmacotherapies to help prevent relapse in abstinent patients with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, and ABMS.

Level III, Competency 2

Physicians should provide, or refer for, psychosocial counseling for relapse prevention in patients with SUD.

2. **A curriculum in psychosocial therapies to help prevent relapse in abstinent patients with SUD should be integrated into the curricula of all medical schools and appropriate residency training programs. Licensing examinations in appropriate disciplines should include content and questions relevant to psychosocial therapy for relapse prevention in abstinent patients with SUD. Increased curricular content should be available through CME programs. The development, dissemination, and maintenance of this curriculum should be coordinated by a lead Federal agency with input from all appropriate Federal agencies and professional societies.**

Rationale. Effective new psychosocial therapies are available for patients with SUD.[24,31,55,68,69]

Recommended Actions. Training in SUD should include information on the effectiveness of psychosocial therapies to help prevent relapse in abstinent patients with SUD.

Responsible Agents. LCME, RRC of the ACGME, AMA, AOA, USMLE, ABMS, and appropriate Federal agencies.

PROGRAM MODEL: CONTINUING MEDICAL EDUCATION

Clinical, Legal and Ethical Issues in Prescribing Controlled Drugs

Continuing Education Program Offered Annually by The University of South Florida College of Medicine; Joseph Krzanowski, Ph.D., Chair

Since the mid-1980s, the University of South Florida's College of Medicine has offered a CME program on "Clinical, Legal and Ethical Issues in Prescribing Controlled Drugs." Offered annually, the course is the longest-running and best-evaluated CME program on prescribing issues and prescription drug abuse in the U.S.

The course was developed by the university in collaboration with the Florida Board of Medicine, the Florida Alcohol and Drug Program Office, and the Florida Medical Association in response to reports of physicians misprescribing controlled drugs or being deceived by patients who wished to obtain such drugs for personal use or resale. It is co-directed by Joseph J. Krzanowski, Jr., Ph.D., Professor of Pharmacology & Therapeutics and Associate Dean for Graduate Affairs at the USF College of Medicine, and addiction expert John C. Eustace, M.D., representing the Florida Society of Addiction Medicine. The course is taught by faculty from the University of South Florida College of Medicine, representatives of the Florida Board of Medicine and the U.S. Drug Enforcement Administration, and other experts.

The course focuses on pharmaceutical agents (including analgesics, CNS stimulants and depressants, antidepressants, anabolic steroids, neuropsychopharmacologic agents) which, because of their effects on the central nervous system, have a potential for abuse. Lectures encompass basic pharmacology, appropriate clinical use, ethical considerations, and legal implications involved in the use of these drugs. Presentations also address the currently accepted medical uses of controlled drugs, compliance with Federal and state laws and regulations, risk/benefit considerations, and problem avoidance for both patients and physicians.

Upon completion of the course, participants are expected to be able to:

- Understand the basic pharmacokinetic principles relating to prescription drugs with abuse potential;
- Describe the basic pharmacology of drugs subject to abuse, including opiates, sedative — hypnotics, psychotropic agents, steroids and stimulants;
- Assess the indications for and proper use of these drugs in managing acute and/or chronic pain and mood disorders;
- Identify the legal basis of Federal and state drug control policies, with special emphasis on compliance with the Florida Medical Practice Act;
- Discuss recordkeeping, enforcement agency practices, and risk mitigation.

The course is specifically designed for physicians but is open to all health care professionals. Physicians are referred to the course by medical boards in many states. It is approved for 23 Category I credits toward the AMA Physician's Recognition Award. For more information, contact the CME Office, University of South Florida College of Medicine, 12901 Bruce B. Downs Blvd., MDC Box 60, Tampa, Florida, 33612 or phone (813) 974-4296.

Screening and Brief Office Interventions for Patients with At-Risk and Harmful Drinking

Continuing Education Program developed by the Rochester (NY) Academy of Medicine, 2003-2005

Those involved will learn:

- How to screen patients for risky, harmful, and dependent drinking;
- How to make connections between medical problems and underlying alcohol abuse;
- How to make a brief office intervention around alcohol abuse; and
- How to develop office systems that make screening and brief interventions flow easily.

THE PROGRAM

Step 1: Read one to three monographs or articles or attend a one hour lecture (2 hours credit for reading all 3, one hour credit for reading one monograph or attending the lecture)

Step 2: Spend 1 to 2 hours with a substance abuse trainer who will review this material and have you read, and help you practice screening and brief interventions. In addition, the trainer will meet with your office staff in helping to develop a system for your particular practice, which will enable you to actually do this screening and the brief interventions. 1-2 hours credit

Step 3: Screen patients and use your trainer as a resource person for questions. After you and others in your office have a few positive screens, the trainer will return to discuss these patients with you. The trainer will return several times, but two follow up visits to discuss the process and review patients are the norm. Dr. Norman Wetterau, an addiction medicine specialist who is also in primary care, will also be available to meet with you if you desire.

Additional credit hours are available for additional directed study in this area including in motivational interviewing or adolescent interventions.

Providers who complete the initial training, begin to screen patients, and attempt an intervention with an at-risk patient will be eligible for CME credit for time spent in this program (up to 10 hours). A program evaluation will be required.

This program is co-sponsored by the Rochester Demand Treatment Team and the Rochester Academy of Medicine. The Rochester Academy of Medicine designates this continuing medical education activity for a maximum of 10 hours of Category I credit toward the Physicians Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.