AddictionEducationNews

Newsletter of the Coalition On Physician Education in Substance Use Disorders (COPE)

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In this issue:

COPE News

Region IV Medical Educators Agree on Goals and Priorities at May Meeting

Faculty and administrators from medical schools in the Southeastern U.S. (HHS Region IV) met with officials of State and Federal agencies in Charlotte, North Carolina, on May 8th, to discuss strategies and priorities for enhancing medical education about substance use disorders. The meeting, which was co-sponsored by COPE and Region IV of the Substance and Mental Health Administration (SAMHSA), was designed to strengthen ties between leaders in medical education and in State and Federal health agencies. It is part of a series of Regional Meetings SAMHSA and COPE are co-sponsoring around the U.S.

SAMHSA Region IV Administrator Stephanie McCladdie, M.P.A., and COPE Board Chair David C. Lewis, M.D., welcomed participants to the day-long session, which attracted faculty and staff from medical schools and officials from State health departments in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. James W. Finch, M.D., delivered a special welcome on behalf of the North Carolina Governor's Institute on Substance Abuse.

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Special Presentations

The meeting featured several special presentations, including one by Kathleen Hanley, M.D., of New York University's Langone School of Medicine, on the SARET (Substance Abuse Research Education and Training) model of developing future alcohol and drug researchers, and another by Steven J. Kassels, M.D., author of the critically acclaimed novel "Addiction on Trial," who discussed strategies for changing medical students' negative attitudes toward addictions and the patients who suffer from them.

A highlight of the program was a presentation by P. Bradley Hall, M.D., on prevention of and intervention for substance use and related disorders in medical students. Dr. Hall is Executive Medical Director of the West Virginia Medical Professionals Health Program and incoming President of the Federation of State Physician Health Programs.

The special presentations were followed by updates on several COPE activities. A preliminary report on the Region IV COPE curriculum survey was presented by COPE Board member J. Harry (Bud) Isaacson, M.D., of the Cleveland Clinic Lerner College of Medicine, who explained that the survey also seeks faculty members' input regarding the challenges they face in teaching about substance use disorders, as well as approaches and resources they have found helpful and would recommend to others.

Jenifer Van Deusen, M.Ed., Curriculum Director at the University of New England's College of Osteopathic Medicine, described the results of research by the relevant COPE committee, which found that an up-to-date statement of SUD core competencies for undergraduate medical education does not currently exist. (Current LCME standards call for four hours of training on SUDs, but they do not specify the content of that training.)

COPE Executive Vice President Bonnie Wilford briefly described the work plan developed by the COPE Resource Committee, which is to: (1) Use the COPE curriculum survey and other sources of information to understand the resource needs of medical school faculty in multiple departments; (2) Collect resources that are likely to meet those needs; (3) Devise a method for curating the resources and for faculty to provide feedback on their usefulness in real academic settings; and (4) Organize the resources in an online COPE Resource Center in a way that is user-friendly and easy to access and update.

Goals and Priorities

The second part of the day was devoted to discussion of strategies and priorities for enhancing medical school curricula and medical students' learning experiences with regard to the diagnosis and treatment of substance use disorders (SUDs) and related conditions. Meeting participants reached consensus that COPE and its partner organizations should give highest priority to the following activities:

PRIORITY 1. Identify a set of core competencies related to SUDs that should be mastered by all students during the medical school years. Participants encouraged COPE to collaborate with faculty at medical schools across the country to define the specific knowledge and skills (*"core competencies"*) related to addiction that all students should acquire by the time they complete their undergraduate medical education. Such a description of core competencies would provide a useful baseline for resource development, as well as a common frame of reference for medical school faculty and curriculum developers.

In response to the recommendation, the COPE Committee on Core Competencies will collect and analyze statements of essential knowledge and skills related to SUDs that are found in relevant articles and policy documents, as well as core competencies developed for other disciplines or levels of medical education (such as residents and practicing physicians).

PRIORITY 2. Develop *model curricula* that correspond to the core competencies. COPE is using its medical school curriculum survey and other means to identify existing curricula that correlate with the core competencies. (To date, the survey has been administered in four of the 10 HHS regions, encompassing medical schools in New England, the Mid-Atlantic States, the Midwest, and the Southeastern U.S. Responses have been received from more than 60 medical schools. COPE shares the preliminary results of the survey at its own Medical Education Summits, at other groups' medical education meetings, and through the COPE newsletter and website.)

Speeding up information collection will increase the potential that the survey will identify existing curricula that support the core competencies. Therefore, Region IV participants recommended that the curriculum survey be administered at medical schools in the remaining areas of the U.S. as soon as possible, independent of any Regional Summits that may be scheduled. They also suggested that efforts be redoubled to obtain survey responses from schools that have not yet submitted information.

PRIORITY 3. Create an *online Resource Center.* Region IV participants endorsed the work plan developed by the COPE Resource Committee (chaired by Charles P. Reznikoff, M.D., of the University of Minnesota Medical School) and urged that immediate attention be given to the following steps:

- Use multiple sources of information (including the curriculum survey) to understand the resource needs of medical school faculty in multiple departments;
- Collect resources that are likely to meet those needs and devise a method to curate the resources, as well as for faculty to provide feedback on their usefulness in real academic settings; and
- Organize the resources in an online Resource Center in amanner that is user-friendly and easy to access and update.

PRIORITY 4. Use multiple *communication methods* to reach out to and provide support for teaching faculty, curriculum developers, and medical school administrators. At present, COPE shares information about research and policy developments and available resources with medical educators through its newsletter, *Addiction Education News*, which is emailed to more than 3,600 readers, and

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through its website (www.cope-assn.org). Meeting participants recommended that COPE find additional methods (e.g., dedicated Listservs, future regional meetings, and enhancements to the website) to make it easy for participants in Region IV and other regions to communicate and share information with each other.

To implement this recommendation, COPE will organize a new Communications Committee to focus on broadening channels of communication and collaboration among medical school faculty and between medical schools and the Federal and State health agencies that are charged with workforce development and improving the quality of and access to health care services. The planned website upgrade will be coordinated with the new Communications Committee.

Other Recommendations

Other actions recommended or resources requested by meeting participants (either during the meeting or in their responses to the curriculum survey) include the following:

- Encourage the Liaison Committee on Medical Education (LCME) to specify SUD-related content that must be part of undergraduate medical education. Ideally, this content should be integrated into the existing curricula at multiple points and in many disciplines, as well as included in OSCEs.
- Seek ways to harness students' energy and interest in (and influence their attitudes toward) substance use disorders, as by connecting them with patients in recovery and those who represent treatment success. Also pay attention to sustaining students' interest in SUDs, which often "gets squashed" when students enter the clinical phase of training.
- Provide faculty and students with up-to-date information on new treatments for substance use disorders. This is particularly important in view of the widely recognized tendency among physicians not to diagnose problems for which they cannot offer treatment. Despite a growing number of evidence-based treatments for SUDs, and the fact that NIH, SAMHSA, and private sector groups work hard to disseminate information about them, the availability and efficacy of such therapies is not as widely understood in the practice community as it should be.
- Encourage every medical school to create a student assistance program that is linked to the State's Physician Health Program. Encourage faculty to be alert to signs of problems in their students, including evidence of depression, "burnout," misuse of stimulants as study aids, et al. Continually remind students that assistance is available. Also consider conducting a national survey of medical students to assess their personal use of alcohol, tobacco and other drugs.
- Adopt a comprehensive approach that views COPE's goals within the context of other changes occurring in medical education, such as increased emphasis on inter-professional collaboration, new models of care (such as Accountable Care Organizations), and renewed attention to basic questions such as "what is the role of the physician?"

COPE Board member Mark L. Kraus, M.D., who moderated the session, remarked that the goals and priorities articulated by the Region IV meeting participants are remarkably compatible with the goals established by participants in earlier Regional Meetings held in the New England (HHS Region I), Great Lakes (HHS Region V), and Mid-Atlantic States (HHS Region III).

Website

Many of the meeting presentations will be posted on the COPE website (go to www.cope-assn.org, then click on "Regional Meetings"). In addition, meeting participants suggested that COPE revise the website to allow participants in each of its Regional Summits to communicate and share information with each other.

The website also will be revised to incorporate progress reports on the high-priority initiatives described above. These changes are expected to be completed in 2015. Watch future issues of *Addiction Education News* for updates.

Acknowledgements

In addition to support from SAMHSA, the Region IV Summit was made possible by generous assistance from the Mindy Ellen Levine Behavioral Health Fund and the Carolinas HealthCare System, both of Charlotte, North Carolina, as well as the Connecticut Society of Addiction Medicine (CtSAM) and other benefactors.

In addition, COPE Board member Stephen A. Wyatt, D.O., and his colleagues Mary Reid English and Gay F. Boswell led the meeting preparations. COPE is very grateful for their support.

Education News

Study Assesses the Effectiveness of Global ADM Training

Over the past decade, a number of addiction medicine training curricula have been developed to prepare medical students to work with patients who have substance use disorders. The authors of a recent study argue that such efforts are urgently needed, given that patients with SUDs frequently experience co-occurring psychiatric disorders and physical complications. For example, the psychiatric disorders that most commonly co-occur with SUDs are mood disorders (seen in 25% to 42% of patients with SUDs), attention deficit hyperactivity disorder (in 26% to 41% of SUD patients), conduct disorders (in 60% of SUD patients), psychotic disorders (in 28%), and anxiety disorders (in 17% to 23%). Commonly reported physical complications include hepatitis C (seen in 47% of SUD patients), HIV and hepatitis B (in 20% and 15%, respectively, of injecting drug users). In alcohol-dependent patients, liver cirrhosis is present in 6% to 41% of patients, cardiac complications are present in 2.5 to 5.3% of patients, and neurological complications are seen in 10% to 21%.

In order to understand current approaches to medical education about SUDs and assess their effectiveness, the investigators searched the international literature for articles that describe the content of addiction medicine curricula and/or evaluate evidence for the effectiveness of such curricula in preparing health professionals to treat patients with SUDs. The search was conducted using the search terms "substance abuse," "addiction medicine," and "education and training." All articles about addiction medicine training initiatives at any educational level were included.

The search identified 29 articles, of which 9 reported on the need for addiction medicine training, 9 others described ADM curricula in use at various academic levels, and 11 evaluated the effectiveness of such training.

Of the 9 papers that discussed the need for ADM training, there was general agreement as to the lack of such training at the undergraduate level. At the postgraduate level, addiction medicine training generally was available within psychiatry and family medicine, but no time was allocated to teaching about SUDs in almost half of other postgraduate training curricula. All nine studies concluded that while faculty members said addiction medicine training is highly relevant, most reported a lack of availability of adequate training programs. There was consensus that ADM training "still needs to be improved, in order to improve care for patients with substance use disorders by general physicians."

The 11 articles that focused on the efficacy of addiction medicine training programs generally demonstrated that such programs are capable of improving students' knowledge and skills. In one study that examined the effectiveness of addiction medicine training at the undergraduate level, researchers evaluated perceptions of alcohol dependence and attitudes toward patients with alcohol dependence on the part of third-year medical students, using a self-report questionnaire that was administered both before and after a psychiatric clerkship rotation (5 weeks psychiatry and 1 week SUDs). They found that a one-week rotation at an SUD treatment site led to a more professional attitude toward SUDs, as indicated by an increase in the perception that SUD is a treatable condition that requires medical care. (Similar changes in perception were observed with regard to major depression.)

Basic Addiction Medicine Competencies Identified for Generalist Physicians

- Screening, prevention, and brief intervention
- Assessment and diagnosis
- Management
- Complications
- Special populations
- Epidemiology
- Neuroscience and genetics

Source: Ayu AP et al. Eur Addict Res. 2015 May 5; 21(5):223–239

Although the articles reviewed consistently endorsed the importance of ADM training at the undergraduate level, they reported that, on average, the number of hours devoted to teaching addiction medicine were half those allocated to other chronic disorders such as hypertension or diabetes. Evidence of the impact of this deficit is found in surveys in which most medical school graduates say that they do not know how to treat addicted patients.

Barriers to training were identified as limited availability of curricular time, poor coordination of addiction medicine content between different departments, lack of addiction treatment facilities that can be used as education sites for clinical experiences, and an insufficient number of faculty members who are interested in and qualified to teach about addiction medicine.

On the basis of their findings, the investigators concluded that training in addiction medicine should be accorded the same priority as training related to other chronic disorders. They further recommended attention to faculty development and a clear policy concerning (international) certification of addiction medicine curricula, both of which they believe are essential to further improve addiction medicine training and thus the care of addicted patients.

Source: Ayu AP, Schellekens AF, Iskandar S, Pinxten L, De Jong CA. Effectiveness and organization of addiction medicine training across the globe. *Eur Addict Res*. 2015 May 5;21(5):223-239.

Addiction News

How Severe is the Shortage of Addiction Specialists?

Of the roughly 23 million Americans who suffer from drug and alcohol use disorders, only 11% received treatment at a specialty facility, according to the most recent data on the subject from the National Survey on Drug Use and Health.That figure compares unfavorably with U.S. treatment for diseases such as diabetes and hypertension, which are as high as 80%.

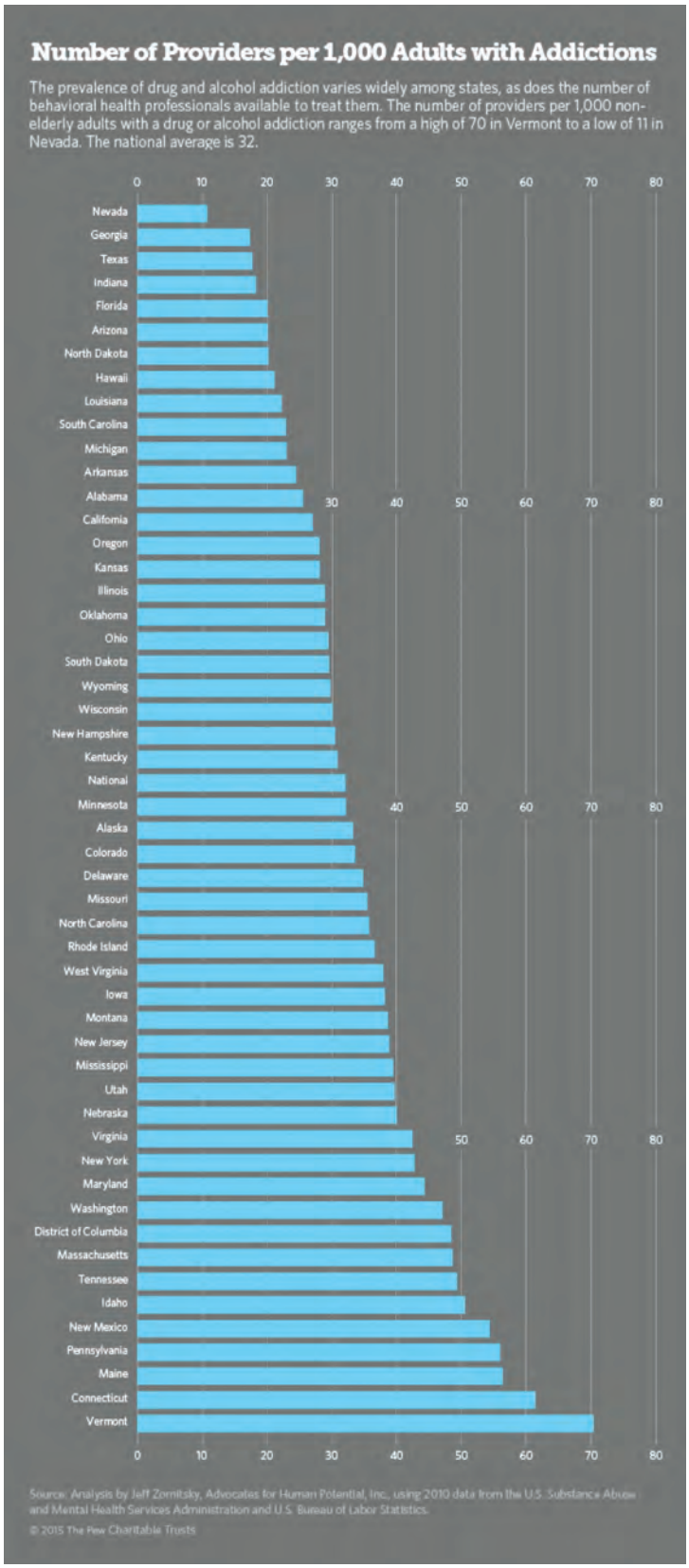
A major reason for the lack of specialized treatment for SUDs is the shortage of trained addiction specialists, Including physicians, psychologists, nurses, social workers, and counselors. Although the federal government has acknowledged the shortage of addiction treatment specialists, it has failed to quantify and assess it. The number of professionals in other areas of health care, including mental health and primary care, are tracked by the U.S. Health Resources and Services Administration (HRSA) to determine which communities are "underserved." Without this information, it is difficult to know where more addiction specialists are needed and whether the supply of professionals is expanding or shrinking in any given region.

Now the Pew Charitable Trusts has released a report by Jeff Zornitsky of the health care consulting firm Advocates for Human Potential (AHP), who developed a method to calculate how many addiction professionals are available to treat the millions of adults with a tobacco, alcohol or drug use disorder in each of the 50 states. Researcher Zornitsky used data from the U.S. Bureau of Labor Statistics on the current size of the labor force and its projected growth, in combination with data from the U.S. Department of Health and Human Services on the prevalence of substance use disorders among adults, to arrive at an estimate of the relative adequacy of the addiction treatment workforce in each State. His "provider availability index" — the number of health care professionals per 1,000 persons with a substance use disorder — ranges from a high of 70 in Vermont to a low of 11 in Nevada. Nationally, the average is 32 addiction specialists for every 1,000 persons afflicted. (No one has determined what the ideal number of providers should be, but experts agree the current workforce is inadequate in most parts of the country.)

The shortage of specialists threatens to stall a national movement to bring the prevention and treatment of substance use disorders into the mainstream of American medicine at a time when millions of persons with tobacco, alcohol or drug use disorders have a greater ability to pay for treatment because of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act.

For the first time, the ACA requires all insurers, including Medicaid, to cover the treatment of drug and alcohol use disorders. In the past, Medicaid covered only pregnant women and adolescents in most states. Private insurance either didn't pay for treatment or paid so little that most people could not afford to make up the difference. Federal officials estimate that, of the approximately 18 million adults potentially eligible for Medicaid in all 50 states, at least 2.5 million have a substance use disorder.

For anyone with insurance coverage, the Mental Health Parity and Addiction Equity Act ensures that the duration and dollar amount of coverage for substance use disorders is comparable to coverage for other medical and surgical care. Together, the two federal laws are expected to make billions of dollars available to pay for the treatment of substance use disorders. Of the 19 million uninsured adults who are eligible for subsidized insurance through the ACA, an estimated 2.8 million struggle with a substance use disorder, according to the most recent national survey by SAMHSA.



Source: Pew Charitable Trusts, April 1, 2015

Federal News

New Surgeon General Cites Substance Abuse As a Top Public Health Priority

Vice Admiral (VADM) Vivek H. Murthy, M.D., M.B.A.

On taking office as "America's doctor," new U.S. Surgeon General Vivek H. Murthy, M.D., M.B.A., identified achieving tobacco- and drug-free lifestyles and reductions in excessive alcohol use as one of his highest priorities.

At the top of his list of priorities, Dr. Murthy named "tobacco and drug free living," explaining that "Tobacco use is the leading cause of preventable death in the United States and worldwide. A tobacco free lifestyle not only means a lower risk of early death; it also means less chance of developing heart disease, cancer, lung disease, stroke, periodontal disease, and a host of other health conditions….Drug abuse and excessive alcohol use lead to motor vehicle crashes, violence, unwanted pregnancy, child abuse, sexually transmitted diseases, HIV/AIDS, injuries, cancer, heart disease, and lost productivity. Prevention of these unhealthy behaviors improves quality of life, academic performance, workplace productivity, and military preparedness."

Other priorities cited by Dr. Murthy, with the rationale for each, are:

- **Mental and Emotional Well-Being:** "Mental and emotional health is just as important to our overall well-being as our physical health."
- **Healthy Eating:** "A lifestyle that incorporates proper nutrition, a variety of healthy foods, and portion control is one that will reduce people's risk for heart disease, high blood pressure, diabetes, osteoporosis, and several types of cancer, as well as help them maintain a healthy body weight."
- **Active Living:** "Regular physical activity is one of the most important things that people of all ages can do to improve their health."

The Surgeon General is responsible for communicating to the public the best available scientific information on ways to improve personal and public health. He also oversees the operations of the U.S. Public Health Service Commissioned Corps, which is composed of approximately 6,700 uniformed health officers who serve in nearly 800 locations in the U.S. and around the world to promote, protect, and advance the health and safety of our nation and our world.

At 37 years of age, Dr. Murthy has a long list of accomplishments. The son of immigrants from India, Dr. Murthy received his Bachelor's degree from Harvard and his M.D. and M.B.A. degrees from Yale. He completed his residency training at Brigham and Women's Hospital and Harvard Medical School, where he later joined the faculty of internal medicine. As a clinician and educator, Dr. Murthy has cared for thousands of patients and trained hundreds of residents and medical students. He has said that caring for patients is the greatest privilege of his life.

Additional information about the Surgeon General and his priorities can be found at: http://www.surgeongeneral.gov/priorities/index.html.

CDC Says Naloxone Kits Have Saved More than 26,000 Lives

Drug overdose deaths in the United States have more than doubled since 1999 [1]. According to the National Center for Health Statistics, 43,982 drug overdose deaths (unintentional, intentional [suicide or homicide], or undetermined intent) were reported in 2013 [2]. To address the problem, community-based programs have offered opioid overdose prevention services to laypersons who might witness an overdose, including persons who use drugs, their families and friends, and emergency service providers. Also, an increasing number of programs provide laypersons with training and kits containing the opioid antagonist naloxone, which can reverse the potentially fatal respiratory depression caused by heroin and other opioids [3].

In July 2014, the Harm Reduction Coalition (HRC), a national advocacy and capacity-building organization, surveyed 140 managers of organizations in the United States known to provide naloxone kits to laypersons. Managers at 136 organizations completed the survey, reporting on the amount of naloxone distributed, overdose reversals by bystanders, and other program data for 644 sites that were providing naloxone kits to laypersons as of June 2014. From 1996 through June 2014, surveyed organizations provided naloxone kits to 152,283 laypersons and received reports of 26,463 overdose reversals [4].

Laypersons who received naloxone kits were characterized as persons who use drugs (81.6%); friends and family members (11.7%); service providers (3.3%); or unknown (3.4%). Sixty-eight organizations provided information about laypersons who reported administering naloxone, characterizing them as persons who use drugs (82.8%); friends and family members (9.6%); service providers (0.2%); or unknown (7.4%). Heroin was involved in 81.6% of reversed overdoses, while prescription opioids were involved in 14.1%.

Various program models were used by organizations to provide naloxone to laypersons, including distribution of naloxone kits by trained nonmedical staff or volunteers under a standing order (60 [44.1%]), by medical staff (49 [36.0%]), through prescriptions written by a medical provider and filled at a pharmacy (39 [28.7%]), by pharmacists dispensing directly via collaborative practice agreements and other mechanisms (12 [8.8%]), and under other protocols (19 [14.0%]). Thirty-three organizations used more than one model. (As a further step to reduce opioid overdose deaths, particularly in rural areas, the CDC recommends expanding training in the administration of naloxone to all emergency services personnel, as well as helping basic EMS personnel meet advanced certification requirements.)

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There has been a 183% increase in the number of organizations that provide naloxone kits to laypersons since a similar survey in 2010 [5] (from 48 to 136). Half of the responding organizations began operating

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during January 2013–June 2014. Although early adopters of naloxone kits were mainly syringe exchanges, other programs — including substance use treatment facilities, Veterans Administration health care systems, primary care clinics, and pharmacies — have started to provide naloxone to laypersons.

Based on these data, the HRC investigators concluded that providing naloxone kits to laypersons reduces overdose deaths [4], is safe [3], and is cost-effective [6]. U.S. and international health organizations recommend providing naloxone kits to laypersons who might witness an opioid overdose [3,7]); to patients in substance use treatment programs [3,7,8]; to persons leaving prison and jail [3,7,8]; and as a component of responsible opioid prescribing [8].

References:

1. Chen LH, Hedegaard H, Warner M. QuickStats: Rates of deaths from drug poisoning and drug poisoning involving opioid analgesics — United States, 1999–2013. *MMWR Morb Mortal Wkly Rep*. 2015;64:32.
2. Hedegaard H, Chen LH, Warner M. Drug-poisoning deaths involving heroin: United States, 2000–2013. *NCHS Data Brief No. 190*. Hyattsville, MD: National Center for Health Statistics, 2015. NCHS data brief no. 190. Available at http://www.cdc.gov/nchs/data/databriefs/db190.htm.
3. Doyon S, Aks SE, Schaeffer S. Expanding access to naloxone in the United States. *Clin Toxicol* (Phila) 2014;52:989–992.
4. Walley A, Xuan Z, Hackman HH et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013;346:1–12.
5. Wheeler E, Davidson PJ, Jones TS, Irwin KS. Community-based opioid overdose prevention programs providing naloxone — United States, 2010. *MMWR Morb Mortal Wkly Rep*. 2012;61:101–105.
6. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med*. 2013;158:1–9.
7. World Health Organization (WHO). *Community Management of Opioid Overdose*. Geneva, Switzerland: World Health Organization, 2014.
8. Substance Abuse and Mental Health Services Administration (SAMHSA). Opioid Overdose Prevention Toolkit. Rockville, MD: SAMHSA, U.S. Dept. of Health and Human Services, 2014. (Available at: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742).

Source: Wheeler E, Jones TS, Gilbert MK, Davidson PJ. Opioid overdose prevention programs providing naloxone to laypersons — United States, 2014. *MMWR Morb Mortal Wkly Rep*. 2015 Jun 19;64(23):631-635.

People in the News

NIDA Recognizes Dr. Charles O'Brien's Leadership in Medical Education

Charles P. O'Brien, M.D., Ph.D.

In a ceremony on May 5, 2015, National Institute on Drug Abuse Director Nora Volkow, M.D., presented researcher and medical educator Charles P. O'Brien, M.D., Ph.D., with NIDA's Lifetime Science Award. The annual award recognizes an individual who has dedicated his or her career to addiction science; whose lifetime work has led to new treatment and prevention strategies; and whose personal commitment and scientific endeavors have inspired others in the field.

Dr. O'Brien is Kenneth E. Appel Professor of Psychiatry and Founding Director of the Center for Studies in Addiction at the University of Pennsylvania's Perelman School of Medicine. He is board-certified in psychiatry, neurology and addiction psychiatry. Among his many honors, Dr. O'Brien was elected to the Institute of Medicine of the National Academy of Sciences in 1991 and received the Nathan B. Eddy award for research from the College on Problems of Drug Dependence in 2003. He has advised the U.S. government on drug policy over the decades and has chaired or served as a member of many Institute of Medicine committees dealing with science and drug abuse policy matters. He also has served as President of the American College of Neuropsychopharmacology and the Association for Research in Nervous and Mental Disease.

In presenting the award, Dr. Volkow said that Dr. O'Brien's work over the past 30 years has produced many important discoveries and contributions that have become the standard of care in addiction treatment across the globe. For example, Dr. O'Brien is a co-developer of the Addiction Severity Index, a tool now used worldwide to assess the extent of patients' substance use disorders. He also was the first to test the use of the opioid antagonist naltrexone in the treatment of alcohol addiction, based on his theory that alcohol reward is mediated by endorphins. Aside from developing medications to treat alcohol, opioid, and cocaine dependence, he also has conducted research crucial to understanding the clinical aspects of addiction and the neurobiology of relapse.

In accepting the award, Dr. O'Brien said: "Addiction is one of the most common and devastating disease that humans face -— not just in an advanced society like the United States, but all over the world. There are different kinds of addiction in Africa, or in India…but it is the same process. In the brain, addiction is a hijacking of the reward system, [leading to] a compulsion to seek drugs and get the reward system activated in an abhorrent, maladaptive way. In other words, in a way that doesn't contribute to well-being and happiness."

He added, "We've made tremendous advances in understanding addiction, but most physicians don't learn about this. It's not taught in medical schools and most of the teachers in medical schools don't know about it, even though we have spent billions of dollars on research that is very successful. But research is useless unless [it is] applied for the good of mankind. So I'm spending the years I have remaining in my career to try to push for the adoption of knowledge transfer in medical schools."

An interview with Dr. O'Brien can be viewed on NIDA-TV at: http://www.drugabuse.gov/about-nida/directors-page/nidas-lifetime-science-awards.

Resources

NIAAA Funds Health Education Program Addressing Alcohol Use Disorders

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is interested in funding dissemination science projects that increase the evidence base on how best to enhance the knowledge and skills of health professionals regarding the identification, prevention, and treatment of alcohol use disorders, so as to achieve improved patient outcomes.

A rigorous evaluation design is required, as well as articulation of the need for improved alcohol education in the target health profession and how the proposed project will fill this gap. For more information on PAR-15-054: Alcohol Education Project Grants (R25), visit http://grants.nih.gov/grants/guide/pa-files/PAR-15-054.html or contact NIAAA's Peggy Murray at pmurray@willco.niaaa.nih.gov.

ATTC Network Announces "Marijuana Lit" Series

To help sort out the confusion about marijuana use, its potential harms, and the effects of legalization, the Addiction Technology Transfer Center (ATTC) Network Coordinating Office has developed user-friendly education packages containing straightforward, accurate information and resources to help physicians and other health care physicians address these issues with their patients. Resource packages, which are available at no cost, include:

MARIJUANA'S EFFECTS ON THE BODY: This brief video features Wilson Compton, M.D., Deputy Director of the National Institute on Drug Abuse (NIDA) who discusses marijuana's effects on the body, including the cardiac and and respiratory systems. Dr. Compton also provides insight into the effects of exposure to secondhand marijuana smoke, the potency of marijuana available today, and current NIDA research on the impact of new marijuana policies on public health.

YOUTH AND FAMILIES: Marijuana use has a significant impact on adolescents. Yet the 2014 Monitoring the Future Survey found that 64% of high school seniors surveyed do not view regular marijuana use as harmful. In this video, Dr. Kari Franson of the University of Colorado's Skaggs School of Pharmacy and Pharmaceutical Sciences shares information about the long-term negative effects of marijuana on adolescent development.

PREGNANCY AND NEWBORNS: In this video, Dr. Laura Borgelt, Professor in the Departments of Clinical Pharmacy and Family Medicine at the University of Colorado, explains the negative impact of perinatal marijuana use on pregnant mothers, unborn children, and newborns.

CONSEQUENCES OF LEGALIZATION: Under Federal law, marijuana remains an illegal substance, yet 23 States and the District of Columbia have legalized medical marijuana, and four States have decriminalized recreational use. Given this shift in policy, we need to consider ways to address the growing impact and consequences of legalization. in this video, Dr. Rosalie Pacula, Director of the Bing Center for Health Economics at the RAND Corporation, invites viewers to examine the variance among marijuana laws and the complex consequences of marijuana decriminalization or legalization.

MEDICAL USE *(Coming Soon)*: Controversy over the use of cannabis as a "medicine" continues, with researchers, policymakers, the medical community, and the public all debating the pros and cons. In this video, Dr. Thomas E. Freese, Director of the Pacific Southwest ATTC, explains what is meant by "medical" marijuana, who uses it and why, and the difference between medical marijuana and medications containing tetrahydrocannabinol (THC).

For questions or to request information about the Marijuana Lit series, contact Susan Garrett of the ATTC Network Coordinating Office at: susan.garrett@attcnetworkoffice.org.

SAMHSA Offers Assistance with Transition to ICD-10, DSM-5

October 1, 2015, is the deadline for physicians to transition to the International Classification of Diseases,10th Edition, Clinical Modification (ICD-10-CM) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

ICD-10-CM codes are reported to insurance companies for reimbursement for clinical services. DSM-5 is the compendium of mental disorder criteria and diagnostic codes used by clinicians in the U.S. health care system. Clinicians need to understand and appropriately use DSM-5 codes to avoid barriers to or delays in treatment.

Working in concert with the American Psychiatric Association, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has developed resources to ease the transition, including fact sheets on:

- DSM-5's approach to diagnostic coding
- How to better understand the coding changes in DSM-5
- How DSM-5's approach is similar to and differs from that in DSM IV TR
- Rationale behind the revisions
- Specific clinical implications.

The new resources include an ICD-10 fact sheet and a webinar on "Transitioning to DSM-5 and ICD-10-CM." Resources can be accessed at: http://www.apaeducation.org/ihtml/application/student/interface.apa/index.htm.

Resources *(continued)*

American College of Physicians Develops Safe Prescribing Program

The American College of Physicians (ACP) and its curriculum partner, Pri-Med, are offering an online training program to help primary care physicians safely and effectively manage patients with chronic pain. The program is available at no cost through the Pri-Med website. Session titles include:

- ER/LA Opioids — Perspectives on Patient Assessment and Therapy Management
- Goals of Therapy, Monitoring and Patient Education of ER/LA Opioids
- Assessing ER/LA Opioid products: Similarities and Differences Prescribers Need to Know

On completion of the three one-hour webcasts, participants can receive a SAFE Opioid Prescribing Certificate and 3.5 AMA PRA Category 1 Credits™. For more information or to register, go to: http://www.acponline.org/acp_news/misc/emails/mde4075.htm.

Richard K. Ries, M.D.

PCSS Offers Online Education on Recognizing SUDs in Primary Care, More

A newly posted online webinar from the Providers' Clinical Support System for Opioid Therapies (PCSS-O) focuses on "Advances in Recognition and Treatment of Substance Use Disorders in Primary Care." Presented by Richard K. Ries, M.D., Professor of Psychiatry and Director of the Addictions Division at the University of Washington School of Medicine, and Harborview Medical Center, the webinar focuses on practical issues of brief screening, assessment, intervention, and pharmacotherapy for substance use disorders, all of which can be undertaken in the primary care setting.

Originally presented May 8, 2015, the webinar was organized by the American Academy of Addiction Psychiatry (AAAP) and is eligible for free CME credit.

Other recently posted modules from the PCSS-O and PCSS-MAT include the following:

Guide to Aberrant Drug-Related Behavior When Prescribing Opioids for Pain Management. Presented by Lynn R. Webster, M.D., Vice President of Scientific Affairs, PRA Health Sciences, Salt Lake City, Utah. (Live webinar sponsored May 8, 2015, by the American Academy of Pain Medicine; eligible for free CME credit.) *DESCRIPTION:* A diverse range of aberrant drug-related behaviors (ADRBs) are related to prescribed opioid analgesics. These behaviors can lead to opioid misuse, abuse, addiction, and overdose, which are serious public health concerns, as well as drug diversion, which is a criminal activity. This can result in potentially tragic consequences for individuals, their families, and their communities. This webinar will articulate the distinction between drug misuse, abuse, dependence, and addiction; describe the risk factors for ADRBs; and explain how to assess patients for and interpret these behaviors, and subsequently stratify individuals' risk for harming themselves or the community, by utilizing patient screening tools in all practice settings.

Responsible Prescribing of Opioids for Pain Management: Safety First. Presented by Lynn R. Webster, M.D., Vice President of Scientific Affairs, PRA Health Sciences, Salt Lake City, Utah. (Live webinar sponsored April 14, 2015, by the American Academy of Pain Medicine; eligible for free CME credit.) *DESCRIPTION:* The use of methadone as an analgesic for severe chronic pain has expanded in recent years. While it is effective for some patients and belongs in the armamentarium of pain medications, it has unimque pharmacologic properties that call for caution and expertise in prescribing it. More than 30% of prescription opioid deaths involve methadone, even though only 2% of opioid prescriptions are for methadone. Therefore, methadone should not be considered a drug of first choice for chronic pain, and specific education is necessary for health care professionals to prescribe it safely. This webinar will describe the unique pharmacologic properties and toxicities associated with methadone, provide recommended practices to use when prescribing methadone, and outline assessment, management, patient education, and monitoring practices to minimize the risk of adverse outcomes when utilizing methadone.

Opioid-Associated Drug-Drug Interactions: What We Don't Know is Hurting Us. Presented by Andrew J. Saxon, M.D., University of Washington, Seattle. (Live webinar sponsored May 7, 2015, by the American Academy of Addiction Psychiatry; eligible for free CME credit.) *DESCRIPTION:* This webinar reviews the current epidemiologic data on drug-drug interactions between opioids and other medications, reviews possible explanations for increases in drug-drug interactions, reviews physiological and pharmacokinetic basis for adverse drug interactions, and strategies for reducing risk.

PTSD and TBI Comorbid Opioid Abuse Risk. Presented by Anthony Dekker, D.O., Primary Care and Telemedicine Physician, Primary Care Service Line, Northern Arizona Veteran's Administration Healthcare System. (Live webinar sponsored April 29, 2015, by the American Osteopathic Academy of Addiction Medicine.) *DESCRIPTION:* This course will review the causes and symptoms of post traumatic stress syndrome (PTSD) and traumatic brain injury (TBI). There will be an emphasis on military experiences but these can be extrapolated to the general population with PTSD and TBI. The relationship of opioid use, misuse, and abuse in patients with PTSD and/or TBI will be reviewed.

The PCSS is a collaboration of the American Academy of Addiction Psychiatry (which is the lead organization), the American Psychiatric Association, the American Osteopathic Academy of Addiction Medicine, the American Society of Addiction Medicine and a number of other organizations, including COPE. Funding support for the PCSS is provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

For a complete schedule of upcoming webinars, a list of all archived webinars and online modules, and to explore the mentoring program and other resources offered through the PCSS, visit http://www.pcssmat.org or http://www.pcss-o.org.

In the Literature

Feature: Study Measures Alcohol, Tobacco and Drug Use by Medical Students

This study involved a cross-sectional survey of 255 randomly selected French medical students in their second- to sixth-year of training. It employed self-administered questionnaires featuring items on sociodemographic characteristics and mental health, as well as questions about alcohol use (using the Alcohol Use Disorders Identification Test [AUDIT]), tobacco use (through the Fagerstrom test), and consumption of illicit substances (using the Cannabis Abuse Screening Test [CAST]).

AUDIT scores indicated that 11% of the study participants were at risk for alcohol addiction, while 21% were rated as high-risk users. Tobacco dependence was assessed as strong or very strong for 12% of the participants. The CAST score showed that 5% of cannabis users needed health care services. Also, the cannabis users were more likely than non-users to fail their medical school examinations (89% vs. 39%, $p < .01$).

A quarter of the participating students (n = 41) had used other illegal drugs. One in 10 study participants reported that he or she had considered committing suicide during the preceding 12 months.

On the basis of these findings, the investigators concluded that the problems identified in the study — which may be representative of problems in other nations' medical schools — require more aggressive measures to prevent, screen for, and provide appropriate interventions for substance use and behavioral disorders in medical students.

Source: Gignon M, Havet E, Ammirati C, Traullé S, Manaouil C, Balcaen T, Loas G, Dubois G, Ganry O. Alcohol, cigarette, and illegal substance consumption among medical students: A cross-sectional survey. *Workplace Health Saf.* 2015 Feb;63(2):54-63.

Academic Medicine

Brown R, Griggs M, Cummins J, Nittler J, Gordy-Panhorst K, Hoffman KG. What can a brief narrative exercise reveal about medical students' development as patient-centered physicians and their attitudes toward patients with mental illness? *Acad Psychiatry.* 2015 Jun;39(3):324-328.

Folan PA, Juster HR, Lennon SE, Briest PJ, Gero CB. Improving tobacco dependence treatment delivery: Medical student training and assessment. *Am J Prev Med.* 2015 Jun 16. [Epub ahead of print]

Jin H, Earnshaw VA, Wickersham JA, Kamarulzaman A, Desai MM, John J, Altice FL. An assessment of health-care students' attitudes toward patients with or at high risk for HIV: Implications for education and cultural competency. *AIDS Care.* 2014;26(10):1223-1228.

Kirch DG, Gusic MD, Ast C. Undergraduate medical education and the foundation of physician professionalism. *JAMA.* 2015;313(18):1797.

Lanken PN, Novack DH, Daetwyler C, Gallop R, Landis JR, Lapin J, Subramaniam GA, Schindler BA. Efficacy of an internet-based learning module and small-group debriefing on trainees' attitudes and communication skills toward patients with substance use disorders: results of a cluster randomized controlled trial. *Acad Med.* 2015 Mar;90(3):345-354.

Raupach T, Al-Harbi G, McNeill A, Bobak A, McEwen A. Smoking cessation education and training in U.K. medical schools: A national survey. *Nicotine Tob Res.* 2015 Mar;17(3):372-375.

Addiction Medicine

Clemow DB, Walker DJ. The potential for misuse and abuse of medications in ADHD: A review. Postgrad Med. 2014 Sep;126(5):64-81. Review.

Cui C, Noronha A, Warren KR, Koob GF, Sinha R, Thakkar M, Matochik J, Crews FT, Chandler LJ, Pfefferbaum A, Becker HC, Lovinger D, Everitt BJ, Egli M, Mandyam CD, Fein G, Potenza MN, Harris RA, Grant KA, Roberto M, Meyerhoff DJ, Sullivan EV. Brain pathways to recovery from alcohol dependence. Alcohol. 2015 Aug;49(5):435-452

Hoeppner BB, Hoeppner SS, Seaboyer L, Schick MR, Wu GW, Bergman BG, Kelly JF. How smart are smartphone apps for smoking cessation? A content analysis. *Nicotine Tob Res.* 2015 Jun 4. [Epub ahead of print]

Oslin DW, Leong SH, Lynch KG et al. Naltrexone vs. placebo for the treatment of alcohol dependence: A randomized clinical trial. *JAMA Psychiatry.* 2015;72(5):430.

Park TW, Samet JH, Cheng DM, Winter MR, Kim TW, Fitzgerald A, Saitz R.The prescription of addiction medications after implementation of chronic care management for substance dependence in primary care. *J Sub Abuse Treat.* 2015 May;52:17-23.

In the Literature *(continued)*

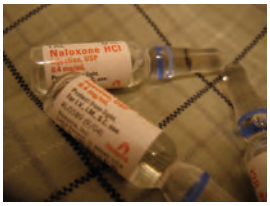
Adolescent Medicine/Pediatrics

Bidwell LC, Knopik VS, Audrain-McGovern J, Glynn TR, Spillane NS, Ray LA, Riggs NR, Guillot CR, Pang RD, Leventhal AM. Novelty seeking as a phenotypic marker of adolescent substance use. *Subst Abuse*. 2015 Jun 17;9(Suppl 1):1-10.

Glass JE, Grant JD, Yoon HY, Bucholz KK. Alcohol problem recognition and help seeking in adolescents and young adults at varying genetic and environmental risk. *Drug Alcohol Depend*. 2015 May 18. [Epub ahead of print]

Smith RF, McDonald CG, Bergstrom HC, Ehlinger DG, Brielmaier JM. Adolescent nicotine [use] induces persisting changes in development of neural connectivity. *Neurosci Biobehav Rev*. 2015 Jun 3;55:432-443.

Zaman T, Malowney M, Knight J, Boyd JW. Co-occurrence of substance-related and other mental health disorders among adolescent cannabis users. *J Addict Med*. 2015 Jun 16. [Epub ahead of print]



Emergency Medicine

D'Onofrio G, O'Connor PG, Pantalon MV et al. Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*. 2015;313(16):1636.

Epidemiology

Grant BF, Goldstein RB, Saha TD, Chou SP, Jung J, Zhang H, Pickering RP, Ruan WJ, Smith SM, Huang B, Hasin DS. Epidemiology of DSM-5 alcohol use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA Psychiatry*. 2015 Jun 3. [Epub ahead of print]

Jones CM, Campopiano M, Baldwin G, McCance-Katz EF. National and state treatment need and capacity for opioid agonist medication-assisted treatment. *Am J Public Health*. 2015 Jun 11. [Epub ahead of print]

Karila L, Megarbane B, Cottencin O, Lejoyeux M. Synthetic cathinones: A new public health problem. *Curr Neuropharmacol*. 2015 Jan;13(1):12-20.

Lundin A, Mortensen LH, Halldin J, Theobald H. The relationship of alcoholism and alcohol consumption to all-cause mortality in forty-one-year follow-up of the Swedish REBUS Sample. *J Stud Alcohol Drugs*. 2015 Jul;76(4):544-551.

Neurology

Djamshidian A. Neurobehavioral sequelae of psychostimulant abuse. *Int Rev Neurobiol*. 2015;120:161-177.

Goodman J, Packard MG. The influence of cannabinoids on learning and memory processes of the dorsal striatum. *Neurobiol Learn Mem*. 2015 Jun 17. [Epub ahead of print] Review.

Obstetrics

Todd ES. Missed Fetal Alcohol Spectrum Disorders diagnosis. *AAP Grand Rounds.* 2015;33(5):51.

Pain Medicine

Compton P, Weaver MF. Responsible opioid use. *J Pain Palliat Care Pharmacother*. 2015 Jun;29(2):166-168.

Krashin D, Murinova N, Jumelle P, Ballantyne J. Opioid risk assessment in palliative medicine. *Expert Opin Drug Saf.* 2015 Jul;14(7):1023-1033.

In the Literature *(continued)*

Pharmacology

Alpert HR, Agaku IT, Connolly GN. A study of pyrazines in cigarettes and how additives might be used to enhance tobacco addiction. *Tob Control*. 2015 Jun 10. [Epub ahead of print]

McCreary AC, Müller CP, Filip M. Psychostimulants: Basic and clinical pharmacology. *Int Rev Neurobiol*. 2015;120:41-83.

Physician, Resident and Student Health

Goldman ML, Shah RN, Bernstein CN. Depression and suicide among physician trainees: Recommendations for a national response. *JAMA Psychiatry.* 2015 Jun 24;72(5):411.

Riesenberg LA, Berg K, Berg D, Morgan CJ, Davis J, Davis R, Schaeffer A, Hargraves R, Little BW. Resident and attending physician perception of maladaptive response to stress in residents. *Med Educ Online*. 2014 Nov 17;19:25041.

Rothstein L. Impaired physicians and the ADA. *JAMA*. 2015 Jun 9;313(22):2219-2220.

Sayburn A. Why medical students' mental health is a taboo subject. *Student BMJ*. 2015 Feb 24;23:h722.

Prescribing Practices and Prescription Drug Abuse

Cicero TJ, Ellis MS. Abuse-deterrent formulations and the prescription opioid abuse epidemic in the United States: Lessons learned from OxyContin. *JAMA Psychiatry*. 2015;72(5):424.

Kavukcu E, Akdeniz M, Avci HH, Altuğ M, Öner M. Chronic noncancer pain management in primary care: Family medicine physicians' risk assessment of opioid misuse. *Postgrad Med*. 2015 Jan;127(1):22-26

Peacock A, Bruno R, Cama E, Kihas I, Larance B, Lintzeris N, Hordern A, White N, Ali R, Degenhardt L. Jurisdictional differences in opioid use, other licit and illicit drug use, and harms associated with substance use among people who tamper with pharmaceutical opioids. *Drug Alcohol Rev*. 2015 Jun 18. [Epub ahead of print]

Scott IA, Hilmer SN, Reeve E, Potter K, Le Couteur D, Rigby D, Gnjidic D, Del Mar CB, Roughead EE, Page A, Jansen J, Martin JH. Reducing inappropriate polypharmacy: the process of de-prescribing. *JAMA Intern Med*. 2015;175(5):827-834.

Scott K, Nelson L, Meisel Z, Perrone J. Opportunities for exploring and reducing prescription drug abuse through social media. *J Addict Dis*. 2015 Jun 15:0. [Epub ahead of print]

Smith RJ, Kilaru AS, Perrone J, Paciotti B, Barg FK, Gadsden SM, Meisel ZF. How, why, and for whom do emergency medicine providers use Prescription Drug Monitoring Programs? *Pain Med*. 2015 Jun;16(6):1122-1131.

Primary Care

Park TW, Cheng DM, Lloyd-Travaglini CA, Bernstein J, Palfai T, Saitz R. Changes in health outcomes as a function of abstinence and reduction in illicit psychoactive drug use: A prospective study in primary care. *Addiction*. 2015 Jun 15. [Epub ahead of print]

Psychiatry

Gardner DM. Competent psychopharmacology. *Can J Psychiatry.* 2014 Aug;59(8):406-411. *Review*.

Screening and Diagnosis

Loheswaran G, Soklaridis S, Selby P, Le Foll B. Screening and treatment for alcohol, tobacco and opioid use disorders: A survey of family physicians across Ontario. *PLoS One*. 2015 Apr 29;10(4):e0124402.

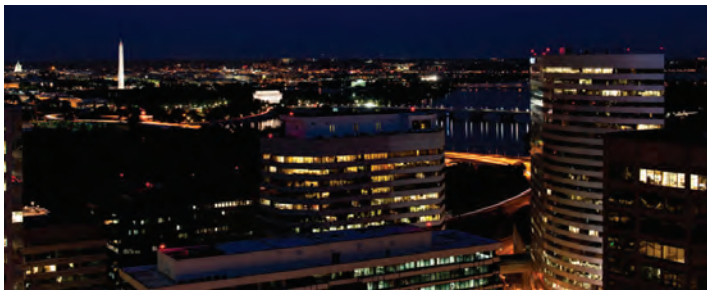
Treatment

Graziani M, Nisticò R. Gender differences in pharmacokinetics and pharmacodynamics of methadone substitution therapy. *Front Pharmacol*. 2015 Jun 9;6:122.

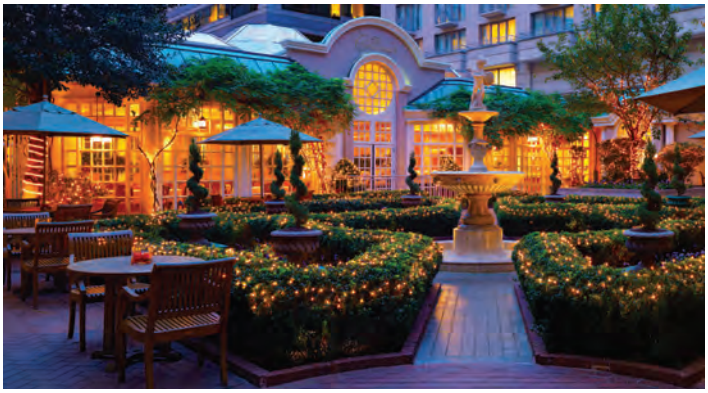
Young S, Wood E, Ahamad K. Pharmacotherapy for alcohol addiction in a patient with alcoholic cirrhosis and massive upper gastrointestinal bleed: A case study. *Drug Alcohol Rev*. 2015 Jun 18. [Epub ahead of print]

Meetings and Training Events

September 24-26, 2015
Appalachian Addiction & Prescription Drug Abuse Conference
Embassy Suites
Charleston, West Virginia
http://www.wvsma.com/Portals/0/AppAddic_Schedule.pdf



October 4-6, 2015
Agency for HealthCare Research and Quality (AHRQ)
Annual Research Conference
Crystal City, Virginia
http://www.ahrq.gov



November 5-7, 2015
Association for Medical Education and Research
in Substance Abuse (AMERSA)
39th Annual National Conference
The Fairmont Hotel Georgetown
Washington, DC
http://www.amersa.org/

November 10-12, 2015
Association of American Medical Colleges (AAMC)
Medical Education Meeting:
Accelerating Learning. Fostering Connections
Baltimore, Maryland
https://www.aamc.org/meetings/421328/2015medicaleducationmeeting.html

December 3-4, 2015
Addiction Medicine for the Primary Care Provider
Second Annual Education Conference by
Hazelden Betty Ford Foundation's
Professionals in Residence Program
University of Minnesota McNamara Alumni Center
Minneapolis, Minnesota
pir@hazeldenbettyford.org

December 3-6, 2015
American Academy of Addiction Psychiatry (AAAP)
26th Annual Meeting & Symposium
Hyatt Regency Huntington Beach Resort and Spa
Huntington Beach, California
(Medical students, residents, and Addiction Psychiatry Fellows may apply for Travel Awards through September 1, 2015; email Isabel@aaap.org)
http://www.aaap.org/annual-meeting/

About COPE

COPE — the Coalition on Physician Education in Substance Use Disorders, LLC — was formed in 2010 to sustain and enlarge on the accomplishments of a series of White House Conferences on Medical Education in Substance Abuse, sponsored in 2003, 2006, and 2009 by the Office of National Drug Control Policy in the Executive Office of the President. COPE is incorporated in the State of Connecticut as a 501(c)3 not-for-profit organization.

COPE's overarching goal is to support and assist medical school faculty in their efforts to teach medical students about the nature of alcohol, tobacco and other drug use disorders — ranging from problematic or risky use to addiction — and to ensure that medical students receive appropriate training in the skills they will need to prevent, screen for, diagnose and treat substance use disorders in their future patients, regardless of their medical specialty, practice type, or location.

Achieving this goal is important for many reasons. For example, educating all medical students about SUDs ensures that patients who are at risk for or experiencing problems with alcohol, tobacco or other drugs benefit from early identification and intervention, regardless of where they connect with the health care system (e.g., in routine visits to their primary care physician, during a consultation with a specialist, in a hospital emergency department, or while being treated for another medical or mental disorder.)

Teaching all medical students how to identify and care for patients with SUDs is both good public policy and a sound financial investment, because multiple studies have shown that early recognition of and intervention for alcohol, tobacco or other drug problems reduces overall health care costs and provides significant economic benefits to the individual and society.

In pursuit of this goal, COPE is developing a range of resources to assist faculty in teaching about substance use disorders, and is working with deans and curriculum designers to encourage them to expand the time and attention devoted to such teaching. In doing so, COPE does not endorse a "one size fits all" approach. Instead, through surveys and meetings, we ask medical school faculty and administrators what resources and models they need if they are to expand the attention given to alcohol, tobacco and other drug problems at their medical schools. Their responses are reflected throughout COPE's programs.

In all of its activities, COPE supports and complements the work of organizations whose goal is to prepare the next generation of addiction specialists, such as the American Board of Addiction Medicine (ABAM) and the American Psychiatric Association (APA), as well as addiction specialty organizations such as the American Academy of Addiction Psychiatry (AAAP), the American Academy of Osteopathic Addiction Medicine (AAOAM), the American Society of Addiction Medicine (ASAM) and the Association for Medical Education and Research in Substance Abuse (AMERSA). We do so by working toward the day when all medical students know how to seek consultation from, or refer a patient to, an addiction specialist whenever the patient would benefit from the specialized knowledge and skills such an expert can provide.

COPE's current activities include administration of a medical school survey, sponsorship of regional Medical Education Summits — which are designed to identify specific needs and respond to opportunities for enhancing teaching about SUDs in the undergraduate years — and development of an online resource center. COPE also produces this newsletter, which is distributed monthly to more than 3,600 readers, and maintains a website that offers information and resources relevant to the needs and interests of medical educators.

There is no fee to join COPE, and all of the resources developed by COPE are provided at no cost to the user. For more information, visit the COPE website at www.cope-assn.org or contact the COPE National Office.

Join COPE

To join COPE, register at the COPE website (www.cope-assn.org). There is no membership fee.

Receive *Addiction Education News* Every Month

To receive COPE's monthly newsletter, register at the COPE website (www.cope-assn.org), or email MedEdGroup@aol.com.

About COPE *(continued)*

Donate to COPE

Donations in support of COPE's Medical Education Summits and other educational activities are most welcome and, with the permission of the donor, will be acknowledged in *Addiction Education News* and other appropriate venues. Such donations are tax deductible to the full extent allowed by law. Contact the COPE National Office for further information.

Contact the COPE National Office at

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210 Marlboro Ave., Suite 31, PMB 287
Easton, MD 21601
Phone: 410-770-4866
Fax: 410-770-3505
Email: MedEdGroup@aol.com

Addiction Education News

Newsletter of the Coalition On Physician Education in Substance Use Disorders (COPE)

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Medical school affiliation, if any_____

About COPE

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