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CSAM Leaders Meet With Governor Schwarzenegger's Office

by Donald J. Kurth, M.D., FASAM
President, California Society of Addiction Medicine

"Medicine is a social science, and politics is nothing else but medicine on a large scale."
–Rudolf Virchow, M.D. 1821-1902

On March 9, 2004 four CSAM physician leaders met with Governor Arnold Schwarzenegger's legislative staff to discuss addiction treatment in California. Led by CSAM's Immediate Past President and Chairman of the CSAM Public Policy Committee, Gary Jaeger, M.D., FASAM, the group met for an hour with Deputy Legislative Secretary Jennifer Fitzgerald in the Governor's Office in Sacramento, California.


DONALD J. KURTH, MD

In addition to Dr. Jaeger, attending the meeting were David Pating, M.D., CSAM President-Elect; Jack McCarthy, M.D., CSAM Committee member on Public Policy; Donald Kurth, M.D., FASAM, current CSAM President, and Kerry Parker, CSAM Executive Director. Robert Harris, Sacramento lobbyist from the office of Jim Gonzalez and Associates accompanied our group.

Our primary purpose was to educate the new administration about the disease of addiction. We began by covering three points, perhaps rudimentary to those of us

Continued on page two

Little-known Insurance Law Thwarts Screening in Emergency Rooms

In California new legislation – SB 1557 – has been introduced which would eliminate an outdated law, known as UPPL, which, in effect, prevents emergency room physicians from screening for alcohol abuse. CSAM has strongly supported this new legislation authored by Senator Romero. This article by Marlene Cimons and originally published by Ensuring Solutions to Alcohol Problems is excerpted here as background on this issue. For the full article go to the Ensuring Solutions web site: ***www.ensuringsolutions.org****.]*

The food was delicious and the champagne mellow when a 50-year-old woman and her husband celebrated their anniversary at an acclaimed Seattle restaurant. But it was raining as they left and the woman – wearing a pair of high-heeled shoes – slipped on a wet curb and badly broke her ankle.

If the mishap and its painful consequences weren't enough, the woman soon learned – to her shock and horror – that her insurance company would not pay the approximately $22,000 in medical bills for her treatment, which included two surgeries to repair her ankle.

This celebrant, whose name is being withheld due to privacy concerns, was the victim of little known state laws that not only allow insurance companies to cite alcohol use as a reason to avoid paying for care, but also help contribute to a cycle of inadequate treatment for people with alcohol problems.

Many emergency room physicians, aware that hospitals collectively could face billions in financial losses if insurance claims are denied, do not routinely screen their injured patients for alcohol. They worry that a Uniform Accident and Sickness Provision Law (UPPL) in their states will allow insurance companies to deny health coverage for emergency treatment to people who have been drinking.

The physicians' logic: if a patient's drinking does not appear in the medical records, insurers cannot use the law to deny coverage. By using this tactic to circumvent the measure, emergency room physicians believe they can protect both their patients and their hospitals from serious medical debt.

But as Eric Goplerud, director of Ensuring Solutions to Alcohol Problems (ESAP), points out this logic also discourages wider use of alcohol screening as a diagnostic procedure among emergency room patients, a group at high risk for serious alcohol problems. "Patients who could be helped by alcohol treatment will remain unidentified and won't receive the help they need," observes Goplerud.

UPPLs Have Not Reduced Insurance Costs

The UPPL laws have not reduced insurance costs, their original intent. By

Continued on page three

IN THIS ISSUE

CSAM Meets with Governor

Continued from page one

who work in the field of addiction treatment, but sometimes difficult to understand to those who do not work with this disease on a daily basis. First, addiction is a disease. Second, it is a treatable disease. Third, addiction treatment can be successful. Thankfully, the Deputy Secretary had had some experience with addiction public policy in the past so, this time, the educational curve was not too steep.

We also brought out the impact of substance abuse in the State. In 1998, California spent 16% of its budget, almost $11 billion, shoveling up the effects of substance abuse! But, less than 5 cents of every dollar spent on substance abuse goes to treatment and prevention. For every dollar spent on treatment, the state saves seven dollars in substance abuse related costs.

We emphasized that untreated chemical dependency is paid for by all of us. Employers pay in higher workers' compensation costs and lost productivity. Families pay through the ravages of substance abuse on their loved ones. All of us pay through rising crime and domestic violence, expanding criminal justice system costs, and a health care system that is staggering under the weight of substance abuse related care (trauma care, HIV, and Hepatitis C, just to name a few).

We then discussed four separate California bills that are just coming over the horizon for the new Schwarzenegger administration.

SB 1192 is the newly renamed California Parity Bill authored by Senator Wesley Chesbro. Full addiction treatment parity is very inexpensive. Insurance rates would rise by only 0.2% or about 43 cents per patient per month while saving the State many, many millions of dollars. The Deputy Secretary was familiar with the bill and told us that at their last meeting Senator Chesbro "looked me in the eye and told me he would keep bringing the Parity Bill back until it passed." And, she went on to say, "I believe him!"

Jack McCarthy, M.D., then explained prevention of Hepatitis C and HIV through the clean needle legalization bill, SB 1159 (Vasconcellos). As always, CSAM's public policy stand is evidence-based and the facts are undeniable. There is no evidence that providing clean needles increases the spread of addiction. Heroin dependent people seem to be quite adept at coming up with needles, clean or dirty.

However, the evidence is clear that clean needles can stop the Hepatitis C and HIV epidemics dead in their tracks. Sharing syringes accounts for 19% of all new AIDS cases in California and 60% of all Hepatitis C. There are 5,000 new needle related cases of Hepatitis C each year in California. Syringes cost 15 cents each. The cost of treating one person infected with HIV is $24,000 per year. You do the math.

Furthermore, it stands to reason that if hypodermic needles are no longer illegal, heroin dependent people will be less likely to feel that they have to hide them on their persons, and therefore law enforcement personnel will be less likely to be sustain dirty needle sticks while patting down detainees. Everybody wins, especially the taxpaying public who ends up paying for the medical care incurred by the spread of these deadly diseases.

Third, we discussed the omnibus legislation, AB 2136 (Goldberg), which provides a two-pronged attack on addiction in our society. It is based on the 2002 ASAM Public Policy on providing medical treatment for chemically dependent persons while incarcerated. First, AB 2136 clarifies existing law that requires medical care for any person incarcerated in the State of California. Persons suffering from addiction require medical evaluation and care, "based on available standards of care, such as the American Society of Addiction Medicine guidelines…"

It will no longer be acceptable to "throw the drunks into the drunk tank" on Friday night to have seizures or delirium tremens all weekend while awaiting arraignment on Monday morning. It will no longer be acceptable to leave heroin addicts or methadone maintenance patients to kick "cold turkey" in a jail cell simply because the jail personnel do not recognize the disease of addiction. Hopefully, passage of AB 2136 will help bring our society out of the dark ages when it comes to recognizing chemical dependency and addiction as a disease.

The second half of AB 2136 opens the doors to safe and sane methadone replacement treatment for indigent heroin dependent persons. Currently, federal law precludes methadone clinics from charging "cash" patients less than Medi-Cal (Medicaid) patients. The government does not want the government monies to support the care of patients who can pay their own way. However, for many heroin addicts, by the time they are ready to consider methadone maintenance, they have gone through all their resources and burned all their bridges. Often, they do not qualify for any sort of government support. Federal law is violated if the clinic charges them on a sliding scale.

But, how can we expect the heroin addict who is motivated for treatment to begin to turn his or her life around if we cannot make treatment available at a price they can afford? AB 2136 will correct this inequity by allowing the methadone clinics to charge on a sliding scale when the patient is indigent and no other funding source is available. Only by making treatment more available can we ever expect to turn around these destructive public health problems.

The final bill we discussed was SB 1157 (Romero). This bill will prevent insurance companies from denying payment to trauma centers for the treatment of injuries if the patient was intoxicated at the time of the injury. As a result of this insurance practice, many trauma center and emergency physicians will not test injured patients for the presence of alcohol or drugs.

When testing does not occur, this prevents the identification of patients with substance abuse disorders who might benefit from addiction treatment. Over 40% of injured patients treated in trauma centers are under the

Continued on page three

CSAM Meets with Governor

Continued from page two

influence of alcohol or drugs. Studies have demonstrated that the provision of alcohol counseling to these patients while they are in the trauma center significantly reduces the risk that these patients will reinjure themselves and return to the trauma centers by nearly 50%. Ending this outdated insurance practice reduces the burden to our trauma centers, and substantially reduces subsequent health care costs.

In a sense, Virchow's words still ring true, today. But, if politics is medicine, I also believe that good medicine is politics. If you are not involved in applying your medical knowledge and skills to educating your legislators to help make this world a better place, the time to start is right now. Call CSAM or ASAM today to see what you can do to make a difference in addiction treatment public policy.

Screening in Emergency Rooms

Continued from page one

limiting the number of patients who are screened and treated for alcohol problems, they indirectly contribute the $19 billion the nation pays in alcohol-related health care costs (by contrast, the nation spends only $5 billion to treat alcohol problems).

The Seattle woman's experience illustrates the dramatic and costly effect that UPPLs can have even on Americans when they have been drinking in moderation. Under the UPPLs, some insurers have denied coverage for injuries in cases where the patient wasn't legally drunk and drinking was not the cause of the injury. Moreover, few Americans even know that these laws exist – or how easily they can affect their own lives.

"If you're drinking beer while watching the Super Bowl at home in your own living room, and then trip – and require emergency medical treatment – you run the risk of not having the treatment for your injuries covered," warns Larry Gentilello, MD, a leading UPPL opponent.

"Many trauma centers are currently forced to treat the patient's injuries, while ignoring the underlying alcohol problem," says Gentilello, a trauma surgeon. "Doctors want to do what is right for their patients, but trauma centers that admit hundreds of intoxicated patients every year cannot afford to write off these costs," says Gentilello, who conducted a study of the problem while at Seattle Harborview Medical Center. "Surveys have shown that the vast majority of trauma surgeons believe that it is important to talk to their patients about alcohol use, and believe that a trauma center is an appropriate place to begin to address alcohol problems. However, UPPLs have prevented them from putting these potentially life-saving protocols into practice."

Brief Alcohol Counseling Can Reduce Emergency Room Visits

Gentilello, now chairman of the University of Texas Southwestern Medical School's surgery department division of burns, trauma and critical care, led a 3-year federally funded study published in 1999 in the *Annals of Surgery* that examined the impact of alcohol screening followed by brief counseling on trauma patients. The study followed 760 trauma patients between 1995 and 1998, comparing two groups. Members of one group received 30 minutes of alcohol counseling, while those in the second group did not.

The treatment group experienced a 48 percent reduction in hospital re-admissions and a 50 percent decrease in emergency room visits, compared to the controls. Also, control group patients did not reduce their drinking levels. Patients in the intervention group, on the other hand, reported drinking an average of 28 fewer drinks per person each week.[1] According to the Centers for Disease Control and Prevention (CDC), 20-30 percent of emergency room patients have alcohol problems.[2] However, Gentilello stresses that only a small fraction of these are alcohol dependent and require extended treatment. A life-threatening injury resulting from an accident after drinking can motivate people with less severe alcohol problems to change their behavior. These patients could benefit greatly from a counseling session delivered in the emergency room setting taking a half-hour or less.

Gentillelo, as head of a trauma department, is well positioned to see how the old UPPL law contributes to the $19 billion the nation pays in alcohol-related health care costs. By reducing the number of patients who receive alcohol screening and treatment, it indirectly increases insurance costs if patients continue to drink, become re-injured or develop costly alcohol-related medical problems such as cirrhosis of the liver, heart disease and some forms of cancer.

"The insurance companies are already paying because the doctors are not screening," he says. "The law has not reduced insurance costs at all."

Sources

[1]Gentilello L.M., Rivara F.P., Donovan D.M., Jurkovich, G.J., Daranciang, E., Dunn, C.W., Villaveces, A., Copass, M., and Ries, R.R. 1999. Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence. *Annals of Surgery* 230(4):473-483, 1999.

[2]Centers for Disease Control and Prevention. 2002. Injury Fact Book. Available on the World Wide Web at http://www.cdc.gov/ncipc/fact_book/09_Alcohol_%20Injuries_%20ED.htm.

Medical Students Launch Advocacy Initiative

Advocating for more training in the prevention and treatment of substance abuse in health professional schools is just a click away. A group of medical, nursing and physician assistant students at schools across the country have launched a student-run, student-created website, **www.hpssat.org**, as part of an advocacy effort to improve substance abuse training on their campuses.

The newly formed group, Health Professional Students for Substance Abuse Training (HPSSAT), has created the website as a tool for empowering students to advocate for more substance abuse training at their schools and increasing students' access to educational resources. The site serves as a one-stop shop for information about curriculum development, state and national news, and educational opportunities in the field of substance abuse.

"As medical students, we're taught to identify and treat diseases, but not always their underlying causes," stated Jennifer Lee, a second-year student at Brown Medical School and HPSSAT member. "By the time we graduate, we may know the treatment for acute pancreatitis, but we won't necessarily have been taught anything about treating the drinking problem that caused it. HPSSAT is taking the steps toward changing that."

Studies show that this change is needed. Currently, only 8% of U.S. medical schools include a substance abuse component in the curriculum. Additionally, the primary source of adolescent referrals for substance abuse treatment is the juvenile justice system; health care providers represent just 5% of referrals.

In addition to creating the website, HPSSAT members have initiated a range of activities on their campuses – hosting lectures, forming student interest groups and committees on substance abuse issues, piloting surveys, and developing a curriculum report card – to assess and improve substance abuse training in health professional programs.

Here in California, CSAM member and second-year medical student Brian Hurley has started a student group – Students for Training in Substance Use and Health Care – at his institution, the Keck School of Medicine at the University of Southern California. "Students training at the LAC+USC medical center need to be competent providers of care for substance users, as the majority of patients we see use drugs in one form or another," Hurley said. "Not taking adequate care of these patients has enormous public health consequences."

The group stems from an effort of the Physician Leadership on National Drug Policy (PLNDP), a group of national medical leaders that advocates for a public health approach to substance abuse, to promote the need for an expanded role of health professionals in the screening, diagnosis, intervention and referral of individuals with alcohol and other drug problems. In February 1998, the PLNDP conducted a national survey and found that 76% of medical students surveyed reported receiving little or no substance abuse training during medical school, and that 90% of all respondents felt physicians played an important role in the issue.

Last November, PLNDP selected 10 health professional students to participate in an advocacy workshop where the students formally created HPSSAT and discussed the need for building the website. Primary funding for this effort was provided by the Hanley Family Foundation with additional support from The Josiah Macy, Jr. Foundation and the Robert Wood Johnson Foundation (through the PLNDP project).

Jack Hanley, founder of Hanley-Hazelden, supports the initiative and met HPSSAT members at the advocacy workshop in Atlanta. He stated, "If they can stir up their schools so that there is a greater understanding of the disease, then that is a major step forward."

Although HPSSAT members currently hail from physician assistant, nursing and medical schools, the students plan to expand and diversify their membership nationwide to reach all health professional students including but not limited to those in the fields of dentistry, pharmacy, social work, and psychology.

NEW MEMBERS

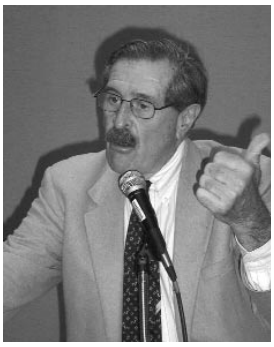
Jasdeep Aulakh, MD, Union City
Ronald P. Bangasser, MD, Sacramento
John P. Castro, MD, Modesto
Ronald J. Cavanagh, MD, MPH, Chico
Rick Chavez, MD, Redondo Beach
Warren B. Churg, MD, Glendale
Corazon Corpus-Elliott, MD, Camarillo
W. Kevin Costello, MD, Santa Rosa
Donna Ehlers, MD, Lomita
Sebastien C. Fromont, MD, San Francisco
James W. Golden, MD, San Gabriel
Randolph Holmes, MD, Whittier
Salma Samina Khan, MD, San Carlos
Aubrey A. King, MD, Upland
Mark Laty, MD, Bakersfield
Phillipp M. Lippe, MD, San Jose
Lenton Morrow, Sacramento
George C. Perdikis, MD, Lancaster
Thomas J. Prendergast, DO, Sausalito
Peter Przekop, DO, PhD, San Bernardino
Howard E. Richmond, MD, Encinitas
Katherine Ruiz-Mellott, MD, Los Angeles
Ian A. Shaffer, MD, Point Richmond
Richard Lee Stennes, MD, La Jolla
Naga Raja Thota, MD, San Diego
John W. Tsuang, MD, Torrance
Steven Valenti, MD, Redlands
Kevin L. Walsh, MD, Carmichael
Henrik Zakari, MD, Los Angeles

Legislative Day II: A Smashing Success!

by Donald J. Kurth, M.D., FASAM
President, California Society of Addiction Medicine

Make plans to join us in 2005. You will be enriched by the experience" – Gary Jaeger, MD, FASAM, Chairman, CSAM Committee on Public Policy.

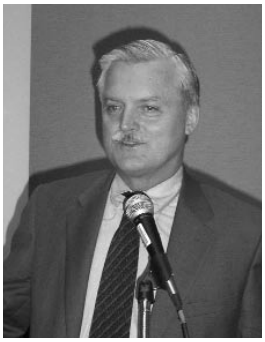
"My older brother died of a heroin overdose and my younger brother is in jail with Hepatitis C," began California Senator Debra Ortiz, "I know the disease of addiction as few of my fellow legislators do. That is why we need all of you to keep coming back to Sacramento to educate them about the disease of addiction." Senator Ortiz spoke to a group of 70 CSAM physicians and other health professionals at CSAM's Legislative Day II in Sacramento, California on January 28, 2004.


Senator John Vasconcellos

"I know it can be discouraging sometimes and I know you all have busy schedules back home," went on Senator Ortiz, "but if you don't take the time to teach my colleagues about addiction nobody else will." Six other members of the California Legislature took time out of their busy schedules to come speak to the CSAM Legislative Day participants. These included Senators Aanestad, Chesbro, and Vasconcellos and Assembly members Goldberg, Nakanishi, and Richman. Other speakers included Kathy Jett, Director of the Department of Alcohol and Drug Programs and Richard Figueroa representing the California Managed Risk Medical Insurance Board.


Assemblyman Alan Nakanishi

Public policy discussions on addiction treatment parity, Proposition 36 (treatment instead of incarceration), Hepatitis C, and opiate replacement therapy were presented. When CSAM's Past President Peter Banys led the charge for treatment instead of incarceration and wrote the ballot statement for Proposition 36, some people wondered how this would help those suffering from addiction and whether we, as physicians, should even be involved in such public policy activities.


Senator Wesley Chesbro

However, the hard data speaks for itself regarding the profound human impact of CSAM's public policy efforts. In its first year as law, Prop 36 provided treatment for 30,000 Californians who would not otherwise have received treatment for addiction. Fifty-five percent of these people had never had access to treatment before! Prop 36's second-year data looks equally promising.


Senator Gloria Romero

Following a full morning of public policy talks, the CSAM doctors broke into smaller groups for previously scheduled meetings with 30 more California legislators from our home districts. We explained who we were and why we had come all the way to Sacramento to talk about addiction. Reactions were mixed, to say the least. Some lawmakers had never heard of CSAM, ASAM, or treating addiction as a disease! Others told us we were preaching to the choir and pledged their dedication to our efforts. Still others, however, related poignant and sometimes tragic personal stories about their loved ones who had not been able to get help in time. Our CSAM debriefing session at the end of the day was filled with enthusiasm for our day's activities and we all redoubled our commitment to return next year to carry our message of recovery to our legislators.


Senator Samuel Aanestad

"We need to find a way to better educate our lawmakers," said David Pating, M.D., President-Elect of CSAM and Chairman of the CSAM Committee on Education. "It is simply a matter of education. We have to teach them about what we do to help people suffering from addiction."


Assemblyman Keith Richman

"Our efforts to educate our legislators," explained Dr. Jaeger, "and to learn more about their concerns and issues is one of the most significant things we, as Addiction Medicine specialists can do to help Californians who still suffer from the disease of addiction. Make plans to join us in January 2005. You will be enriched by the experience."

"So, please, don't give up," concluded Senator Ortiz. "Keep coming back to Sacramento and keep fighting the good fight. All those people across California who suffer from addiction need you to speak to our legislators for them. We need you to help us create better laws and better public policies so that they can someday get the help they need."

Death and Drugs in Oklahoma: An Addiction Medicine Perspective

By David E. Smith, MD

I was recently asked to participate in two death penalty appeal cases in the state of Oklahoma. This request was related to epidemiological and behavior research conducted out of the Haight Ashbury Free Clinics. The experience gave me a great deal more then I bargained for. Part of my motivation for participating was that both sides of my family were born in Oklahoma in the early part of the 20th Century and came to California during the great Oklahoma migration around 1930, in classic *Grapes of Wrath* fashion. (The maximum security prison for individuals on death row in Oklahoma was in McAllister, Oklahoma which is just one hour from where my mother was born in 1914, in Huglo, Oklahoma.)

What I learned in my Oklahoma travel was both illuminating and alarming. The rise of drug abuse in rural Oklahoma is substantially greater than in urban areas. The big increase in rural areas is methamphetamine abuse and methamphetamine manufacturing in illicit laboratories. This was validated not only by law enforcement in Oklahoma, Texas, Mississippi, and Arkansas, but also by such leading addiction experts as Dr. Lloyd Gordon, head of COPAC (Conducive Outpatient Addiction Center) in Jackson, Mississippi where I recently lectured at a medical school. He indicated that there has been a huge increase in methamphetamine labs in rural Mississippi. Law enforcement officials I interacted with confirmed that a good deal of the drugs and violence that they encounter is methamphetamine-related. In particularly this rise in speed in rural America is a growing major force in domestic violence.

There is a link between the rise in methamphetamine use, black market speed labs, and domestic terrorism. One of the memorable and chilling aspects of my travel through Oklahoma City was a visit to the Oklahoma City bombing site where Timothy McVey blew up the federal building which killed hundreds of men, women, and children. There is evidence that McVey, Nichols, and his cult of conspirators were both financed and deeply involved in methamphetamine. One only has to interact with "speed freaks" to learn where such bizarre and irrational ideas such as blowing up a Federal Building can come from.

Cemetary for prisoners who died at Huntsville Prison

Oklahoma law enforcement and public defender legal establishment confirm that the majority of the 150 people on death row in Oklahoma have a history of substantial substance abuse problems. In fact, up to 80% of the people in the criminal justice system in both Oklahoma and Texas have significent substance abuse problems, but very few get treatment. On a per capita basis, of all the states, Oklahoma is the number two death penalty state, surpassed only by Texas.

The death chamber at Huntsville Prison in Texas

In one of the cases that I was involved in, a vigorous public defender raised the accused killer's serious substance abuse history. It was a mitigating factor in her getting life with parole instead of the death penalty. However, in the second case despite the fact that the accused, a black man, was deeply involved in drinking over a fifth of alcohol a day, smoking two PCP joints, and using crack cocaine he was still convicted of first degree murder with the death penalty.

My involvement was to raise the substance abuse issues during both the appeal and clemency process. In the second case, the man who did the killing was a chronic substance abuser, intoxicated with alcohol and PCP at the time of the crime. The victims also had blood alcohol levels of .14 to .15 and blood PCP levels of .03 micrograms per liter at the time of the crime. The killer was operating under a very elaborate delusional system. The prosecution emphasized that some of the observers said he walked in a normal fashion, rejecting the whole concept of physical and behavioral tolerance. They said that this level of PCP would have minimal impact on the individuals' thought process and behavior.

By the time this is published he will have been executed in the state of Oklahoma, as I'm sure will several others who have had a history of substance abuse and committed heinous crimes. In my opinion, some who had substantial substance abuse problems should have gotten a lesser penalty or even an opportunity for diversion to treatment. As a result of their disease progressing and the resulting crime, they will get the death penalty. Some of those who are executed will be innocent.

The *New York Times* reported that Texas has executed 300 people since 1977. More defendants from Harris County near Houston, Texas have been executed than anywhere else in the country. If it were a state, Harris County would rank third behind Texas and Virginia in total executions since 1977. A review of the Houston forensic laboratory found that technicians had misinterpreted data, were poorly trained, and kept shoddy records. They mishandled all available evidence, while defense experts

Continued on page seven

Death and Drugs in Oklahoma: An Addiction Medicine Perspective

Continued from page six

were barred from refuting or verifying the results. The laboratory's building even had a leaky roof that contaminated evidence.

A recent retest of DNA found that an individual judged guilty was in fact innocent. William C. Thompson, a professor of criminology at the University of California at Irvine, who had studied the Houston police laboratory's work stated, "The likelihood that there were more innocent people convicted because of bad lab work is almost certain."

David Dowel, the University of Houston law professor who represents death row inmates in capital appeals, has indicated that these lab errors leading to convictions are probably the tip of the iceberg. He stated that there were two different problems in the crime lab: "scientific incompetence and corruption."

Professor Dowel said, "That's a deathly combination. Once you have corruption there is no reason to think that this is limited to DNA cases or any scientific evidence of any sort. Without appeal an individual in question may be executed by now."

It is clear that there is great variability in laboratory testing in the United States. Some are regulated by agencies such as the Department of Transportation that invokes a medical review officer with very high standards. Otherwise, particularly in the criminal justice system, unless the defendant has a good lawyer and an independent laboratory test, a medical expert is not required.

ASAM's Forensic Addiction Medicine Sciences Committee, chaired by Robert DuPont, MD has organized forensic science training seminars to raise the standards of addiction medicine physicians in forensic issues. The Medical Review Officer (MRO) Committee, chaired by Ian McDonald, MD, has organized MRO training courses which focus on the requirements of the Department of Transportation (DOT) and role of the medical review officer in that context, but have evolved as a laboratory urine testing course for doctors in addiction medicine.

Just as ASAM and the Department of Transportation have pushed to raise the standard of testing in safety sensitive positions, we should push to raise the standard for all substance abusers in the criminal justice systems. Each should have an adequate substance abuse evaluation. More importantly this would make available earlier intervention for such individuals and diversion from the criminal justice system. The lack of treatment of people's addictions prior to the progression of their disease, often results in costly and damaging crimes in our society.

Davis Smith is the Founder and Medical Director of the Haight Ashbury Free Clinics and is Medical Director of the California Department of Alcohol and Drug Programs. He is a member of both the ASAM Forensic Addiction Medicine Sciences Committee and the Medical Review Officer (MRO) Committee.

Retracted Study Raises Questions About Federal Research

A retracted ecstasy study has raised concerns about whether the dangers of the drug have been overstated for political reasons.

At issue is research conducted by George Ricaurte, associate professor of neurology at Johns Hopkins University and the nation's most prominent researcher on methylenedioxymethamphetamine (MDMA). Ricaurte's research was the first to suggest that ecstasy harmed the serotonin system, which regulates mood, sleep, appetite, and other functions.

In 2002, he released a study that purposted to uncover new dangers linked to ecstasy use, among them severe brain damage and neurological diseases such as Parkinson's. However, a year after the study was released Ricaurte issued a retraction, saying he erred in the research: the primates used in the study had been injected with methamphetamine, not ecstasy.

Over the last seven years, Ricaurte has received $10 million in federal funds, including support from the National Institute on Drug Abuse (NIDA), to conduct drug-related research that became key evidence in the development of the federal government's war on drugs.

Alan I. Leshner, chief executive officer of the American Association for the Advancement of Science and former NIDA head, said the retraction was "unfortunate" but shouldn't end Ricaurte's career. "I don't think he should be tarnished for a mistake that he very rapidly retracted," said Leshner.

But Marsha Rosenbaum, of the Drug Policy Alliance, which opposes current drug policy, said Ricaurte's studies have resulted in a flow of misinformation about ecstasy that has led to fear-driven legislation."

Nora Volkow, the new director of NIDA, is concerned that the retraction may lead people into falsely thinking that ecstasy is harmless. "The question that comes to light is, why has this attracted so much attention?" she said. "And I think perhaps it's because some people are exaggerating the adverse effects of drugs."

Source: Join Together Online 2/26/2004

SAMHSA: Deaths Not Linked to Misuse of Methadone from Treatment Centers

In February 2003, CSAM responded to inflammatory stories in the media, which blamed methadone maintenance programs for a apparent increase in methadone-related deaths on the East Coast (see *Letter to the New York Times* and *CSAM Defends Methadone Maintenance* by Judy Martin, MD in the Summer 2003 issue of CSAM News). Now, a panel of experts convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) has reported methadone-associated deaths are not being caused primarily by methadone diverted from methadone treatment programs.

The consensus report, *Methadone-Associated Mortality, Report of a National Assessment,* was released on February 6, 2004. The report concludes that "although the data remain incomplete, National Assessment meeting participants concurred that methadone tablets and/or diskettes distributed through channels other than opioid treatment programs most likely are the central factor in methadone-associated mortality."

SAMHSA convened the panel to determine whether its methadone regulations were allowing diversion of methadone from clinics or whether the rise of methadone mentions in hospital emergency rooms and reports of deaths were due to methadone coming from other sources. Hospital emergency department visits involving methadone rose 176 percent from 1995 to 2002. The rise from 2000 to 2002 was 50 percent, according to SAMHSA's Drug Abuse Warning Network. The panel of state and federal experts, researchers, epidemiologists, pathologists, toxicologists, medical examiners, coroners, pain management specialists, addiction medicine specialists and others was convened in May 2003.

"The participants in the meeting reviewed data on methadone formulation, distribution, patterns of prescribing and dispensing, as well as relevant data on drug toxicology and drug-associated morbidity and mortality, before concluding that the cases of overdosing individuals were not generally linked to methadone derived from opioid treatment programs," SAMHSA Administrator Charles Curie said. "SAMHSA will continue to monitor the situation to insure that SAMHSA's supervision of opioid treatment programs is always in the public interest."

"The Office of National Drug Control Policy (ONDCP) is pleased that the consensus report findings demonstrate that the controls on methadone are working," Dr. Andrea Barthwell, Deputy Director for Demand Reduction at the White House Office of National Drug Control Policy, said. "We applaud the diligence that the providers of methadone have shown in keeping this a safe modality for the patients they serve and the communities in which they reside."

The panel based it conclusion that methadone is coming from other sources on data showing that the greatest growth in methadone distribution in recent years is associated with its use as a prescription analgesic prescribed for pain, primarily in solid tablet or diskette form, and not in the liquid formulations that are the mainstay of opioid treatment programs that treat patients with methadone for abuse of heroin or prescription pain killers.

"Methadone continues to be a safe, effective treatment for addiction to heroin or prescription painkillers," Dr. Clark said. "While deaths involving methadone increased, experiences in several states show that addiction treatment programs are not the culprits."

The expert panel learned that in North Carolina only four percent of the decedents were participating in addiction treatment at or near the time of death, and in Washington State use of multiple drugs was reported in 92 percent of deaths involving methadone. In Texas, cases of overdose involving persons being treated in opioid treatment programs declined between 1999 and 2002.

The experts noted that the increasing numbers of prescriptions for methadone are paralleling the increase in prescriptions for oxycodone, hydrocodone, and morphine, as physicians prescribe to ameliorate chronic pain.

The panel recommended creation of case definitions that would make a distinction between deaths caused by methadone and deaths in which methadone is a contributing factor or merely present. They want health care curricula to train health care professionals in both "the diagnosis and treatment of addiction and appropriate pharmacotherapies for pain."

The experts surmise that current reports of methadone deaths involve one of three scenarios: illicitly obtained methadone used in excessive or repetitive doses in an attempt to achieve euphoric effects; methadone, either licitly or illicitly obtained, used in combination with other prescription medications, such as benzodiazepines (anti-anxiety medications), alcohol or other opioids; or an accumulation of methadone to harmful serum levels in the first few days of treatment for addiction or pain, before tolerance is developed.

Source: SAMHSA Press Release, February 6, 2004

Judith Martin on NPR

February 25, 2004. National Public Radio's "Talk of the Nation" has had a series on heroin addiction. A theme of the series is that heroin use is increasing among middleclass users and youth not traditionally associated with heroin. Dr. Judith Martin—medical director of the 14th Street Clinic and the East Bay Recovery Project, and Chair of the CSAM's Committee for the Treatment of Opiate Dependence—was a guest on a segment of the show focusing on treatment. Each of the three guests on that show was asked a brief opening question, followed by questions from listeners. Dr. Martin was first asked why heroin is so addictive. She briefly discussed dependence and tolerance in lay terms, and used her opening to emphasize that addiction treatment uses a holistic approach and that medical treatments with established efficacy are available for heroin addiction, such as methadone and buprenorphine.

JUDITH MARTIN, MD

The NPR interviewer, Neal Conan, was in Washington DC; Dr. Martin spoke from the studio of KPFA, a listener- supported radio station in Berkeley. Afterwards, she described her experience. "I was in a tiny room, a bit larger than a phone booth with a desk and a microphone. I was nervous, but once I started answering questions, my nervousness subsided."

"One caller asked me to explain why methadone or buprenorphine treatment wasn't just another addiction, and was concerned that the medical model, in which addiction is seen as an illness, was inappropriately lifting responsibility from the addicted person. I was glad he called because that is a very common concern. It gave me a chance to emphasize that addiction has many components, emotional, behavioral, spiritual, and medical, and that skilled addiction treatment addresses all aspects of addiction.

"There is a lot of hand-wringing and unwarranted hopelessness about opiate addiction. As professionals, we should use every opportunity to advocate for treatment and to get out the message that treatment works."

Dr. Martin's interview can be heard on the Internet at http://www.npr.org/rundowns/segment.php?wfId=1700681

Buprenorphine Clinical Guidelines Released

The "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction", SAMHSA's Treatment Improvement Protocol, number 40 (TIP 40) will be available in June. This TIP is a practical guide for physicians who wish to use Buprenorphine to treat patients who are addicted to opiate prescription pain medications or heroin.

The TIP covers screening, assessment and diagnosis of opioid dependence and its associated problems; determining when buprenorphine is an appropriate treatment option; and referrals to treatment professionals to provide the counseling and participation in self-help programs needed by most patients addicted to opiates. It contains detailed protocols for use of buprenorphine under a variety of clinical scenarios.

Along with providing general guidance for physicians who want to utilize buprenorphine in their practices, the TIP also provides guidance for physicians who need to know how to use buprenorphine with patients with co-occurring pain, psychological disorders or chemical dependency involving more than one substance.

TIPs are available free of charge and can be ordered by calling SAMHSA's clearinghouse at 1-800-729-6686.

Single-Dose Buprenorphine Shows Promise

The results of a small study indicate that a new, long-lasting formula of the drug buprenorphine may be effective in treating individuals addicted to heroin, Reuters reported Jan. 30.

Researchers at John Hopkins University School of Medicine in Baltimore, Md., found that the long-lasting form of the drug, known as a "depot" formulation, blocks the effect of opioid drugs, such as heroin and morphine, and prevents withdrawal symptoms for as long as six weeks.

"I believe the depot medication offers promise as a way to make effective treatment more accessible to opioid-addicted patients without the need to worry that the treatment medication itself might be misused or abused," said Dr. George E. Bigelow, lead author of the study.

Source: Join Together February 5, 2004

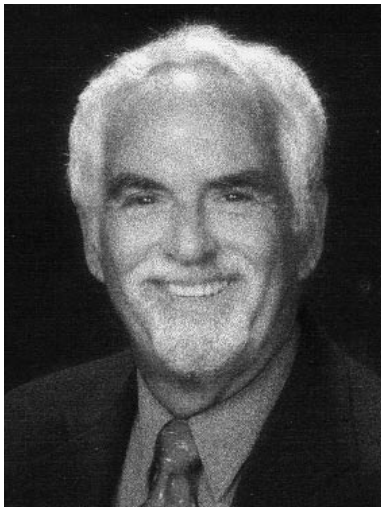
A TRIBUTE TO DR. TOM UNGERLEIDER

Addiction as a Brain Disease: What a Long Strange Trip It Has Been

By David E. Smith, MD

I was asked to give a J. Thomas Ungerleider lecture on Substance Abuse Prevention and Education on May 27, 2003 at the UCLA Neuropsychiatric Institute Grand Rounds. The title of my presentation was, "Addiction as a Brain Disease: What a Long Strange Trip It Has Been." I was honored to give this presentation on behalf of my good friend and esteemed colleague, Tom Ungerleider. Tom, currently a Professor Emeritus at the UCLA Department of Psychiatry, has been a pioneer in substance abuse education for health professionals and medicalization in the problem of addiction.

In addition to his important work in drug prevention Tom has emphasized the importance of having evidence-based approaches in clinical practice in the addiction area and has consistently warned of the dangers of ideologically backed approaches that are not based on science, but instead based on political agendas. In particular he has focused on the developing prison industrial complex that currently produces over 700,000 arrests per year for possession of marijuana. This has lead to a situation in which 80% of the prisoners in the criminal justice system have substance abuse problems, but only 5% get treatment for addiction. For the same drug offense, lower social economic non-whites have a ten times higher probability of getting a felony conviction than do the white middle class offenders. Since one dollar in treatment saves seven dollars in health and social costs, the current prison and drug policy can be seen as both racist and cost inefficient.



THOMAS UNGERLEIDER, MD

As a result of the political ideology and the prison industrial complex, criminalization has become the dominant mode of intervention. Criminalization has wasted a great deal of money and has harmed many more lives then it has helped. Addiction medicine is based on the study and treatment of addictive diseases. The paradigm of medicalization for all addicting substances isn't the same as a model of legalization for making drugs available to our society.

Tom has been a pioneer in emphasizing medicalization. The destructive direction of current U.S. drug policy has proved to be both inefficient, wasting hundreds of millions of dollars, and is inhumane, incarcerating instead of treating a large number of people with the problem of addiction. The concept of medicalization has been incorporated in the citizen's protest against current drug policy in California via Proposition 36.

I was introduced by Lew Yablonsky, a world famous sociologist, whose books have made major contributions to understanding of the drug culture. The first book I read of his was, *Synanon - the Tunnel Back*, and I met Lew in June of 1967. This was soon after I started the Haight Ashbury Free Clinics and he was doing a book titled the, *Hippy Trip*. He interviewed me relative to his book with particular emphasis on the psychedelic drug experience. At that time the Haight Ashbury Free Clinics was dealing with acute medical problems associated with people coming to the Summer of Love. We had a talk-down center for bad LSD trips. Interestingly enough, the talk-down procedure can still be seen today at Rock Medicine. Rock Medicine provides all the medical services for rock concerts in the San Francisco Bay Area. Around this time I met Tom Ungerleider for the first time. The beginnings of the Summer of Love revolved around psychedelic idealism, dominated by the "turn on, tune in, and drop out" philosophy of Timothy Leary, Richard Alpert, Alan Ginsburg, Ken Kesey's "Electric Kool-Aid Acid Test," and the Grateful Dead, led by Jerry Garcia. Many of the San Francisco rock bands did benefits for the Haight Ashbury Free Clinics including Big Brother and the Holding Company with Janis Joplin, the Grateful Dead, and the Jefferson Airplane, which was headed by Grace Slick (now in AA). Unfortunately the dream became a nightmare and we saw the methamphetamine epidemic. Our clinic coined the term "Speed Kills" in 1968 and we used media including posters and a film on amphetamine abuse in an attempt to intervene in the epidemic that had turned the Haight Ashbury into a scene of violence.

Also attending this lecture was my colleague Dr. Walter Ling, who I started working with in addiction research. Around 1968, while I was at San Francisco General Hospital, I developed a phenobarbital substitution and withdrawal technique with Dr. Donald Wesson, leading to thirty years of bad Smith & Wesson jokes. Don Wesson and I have worked closely with Walter Ling ever since, including developing medicational approaches revolving around buprenorphine, a partial agonist for the

Continued on page 11

Addiction as a Brain Disease

Continued from page ten

treatment of opiate addiction. The phenobarbital withdrawal technique set the stage for setting up our outpatient detox facility in 1969, since the drug is a long acting, low abuse potential drug which lent itself to outpatient detox as we started seeing the downer cycle of the upper downer cycle hit. That outpatient detox facility is still operative today at the Haight Ashbury Free Clinics in the form of our substance abuse treatment service programs. Initially, detox was supported by a benefit by Creedence Clearwater that was organized by the patron saint of the Haight Ashbury Free Clinics, Bill Graham. He is the one, through his Fillmore Auditorium, who organized most of the benefits for our clinic during the period of the 60's. Some were also done by enterprising physicians, such as Dr. David Breithaupt, who developed Dr. Sunday's Medicine Show with lead singer Janis Joplin.

The decade of the sixties ended and the heroin epidemic exploded, hitting the middle class and complicated by returning Vietnam Vets exposed to potent smokeable heroin in Vietnam. The outpatient detox facility, started by myself, was the only service that was available outside of the methadone maintance programs at county hospitals. We started seeing a large number of Vietnam Vets coming back strung out on heroin. As a result of the vets coming to our clinic, a dramatic change in public attitude towards addiction occurred. People took the view that we couldn't put our troops in jail for being strung out in a foreign unpopular war. We started seeing financial support for our clinic coming from public sources.

This was also the beginnings of the development of the California Society of Addiction Medicine. I received a call from Dr. Jeff Bromley, one of the founding fathers of CSAM, who indicated that in Southern California they had just arrested a doctor for detoxing a heroin addict on Valium. It turns out that under the Harrison Narcotic Act it was illegal for a doctor in his medical treatment program to use narcotics for detoxification. This became interpreted as being illegal to use scheduled drugs in the treatment of narcotic addiction outside of government regulated methadone clinics, putting community based addiction medicine doctors at risk for arrest.

Again, Tom Ungerleider was a key part of a new policy shift with his appointment to the National Commission on Marijuana and Drug Abuse. He emphasized the need for a policy shift towards demand reduction. That commission was appointed by President Nixon with a goal towards crime reduction that involved a policy that no addict should have to commit a crime because he can't get treatment. The decade of the 70s was the finest hour in drug policy. The Special Action Office on Drug Abuse Prevention headed by Dr. Jerome Jaffe was formed. A career teacher program was established, which brought addiction treatment education to medical schools throughout the country, including bringing important CSAM members such as Dr. John Chappel at the University of Nevada. The VA substance abuse fellowship, directed by Dr. Peter Banys, produced noteworthy CSAM graduates. The Center for Substance Abuse Treatment, with Dr. Wesley Clark as its head came into being.

Our knowledge of addiction as a brain disease has increased dramatically. I look with interest and nostalgia on those early dramatic shifts in public policy, in light of the current policy conflicts. It has indeed been a long strange trip, but one that I have shared with my dear friend and esteemed colleague, Tom Ungerleider, and his wonderful wife Dorothy Ungerleider.

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1. David E. Smith, M.D. & Alan J. Rose. The Group Marriage Commune: A Case Study. Journal of Psychedelic Drugs, Vol.3 (No.1)-September, 1970.

THOMAS UNGERLEIDER, MD SPEAKING FOR ACCESS TO MEDICAL MARIJUNA

CSAM news **CSAM NEWS** is published quarterly by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at: 74 New Montgomery Street, Suite 230, San Francisco, CA 94105; Phone: 415/927-5730; Fax: 415/927-5731; E-mail: csam@compuserve.com. The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

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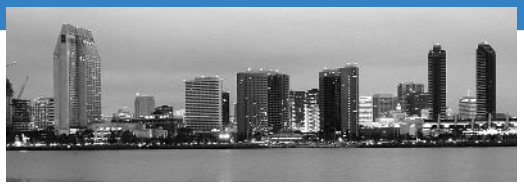

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