ASAMNEWS

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Newsletter of The American Society of Addiction Medicine

Methamphetamine Use Spreading Across U.S., New Federal Studies Show

Neil Swan

Midwestern states such as Iowa, Nebraska and Missouri are experiencing a rapid increase in methamphetamine-related emergency room episodes, crimes and arrests, new data show. Federal officials link the growing abuse of the drug to its increasing availability and the fact that it can be easily manufactured from readily available chemical ingredients.

Also called "meth," methamphetamine is a particularly potent form of amphetamine. It is a synthetic, highly addictive stimulant that is cheaper and longer lasting than cocaine. Users can escalate quickly to larger and more frequent doses. Chronic abuse often is associated with violent behavior.

Methamphetamine comes in many forms and can be smoked, snorted, orally ingested, or injected. The drug is a white, odorless, crystalline powder that can be dissolved in water or alcohol. When made in clandestine labs, it often is in the form of a coarse powder or chunks that are off-white to yellow. Other nicknames include "speed," "crank" and "zip." The smokeable form of the drug may be called "ice" or "crystal."

The Community Epidemiology Work Group (CEWG), a network of epidemiologists and researchers from 20 major U.S. metropolitan areas that provides frontline surveillance of the nature and extent of drug abuse, confirms that methamphetamine use has been prevalent in west coast cities and in western and southwestern communities, including many rural areas. Abuse of the drug now is being reported in urban settings in widening areas of the West, Midwest, and elsewhere.

Animal studies show that high doses of methamphetamine damage nerve cells. In rats, one high dose of methamphetamine is enough to cause damage. Prolonged dosage seems to make it worse.

Methamphetamine is the dominant illicit drug problem in San Diego, according to CEWG data that include records of hospital emergency room admissions, drug-related deaths, and police drug seizures; and local observations of street buys and drug-trafficking patterns. Honolulu and San Francisco also have substantial methamphetamine-using populations, according to CEWG data. Recent reports indicate increasing patterns of methamphetamine use in Denver, Los Angeles, Minneapolis, Phoenix, Seattle, and Tucson as well.

Until recently, the drug's manufacture generally was dispersed so that small quantities were produced in rural areas. There are indications that methamphetamine now is being manufactured on a larger scale by organized groups operating out of Mexico and southern California. Methamphetamine of Mexican origin is now found along newly extended trafficking routes in several States, including Arizona, Colorado, Iowa, Missouri, Nebraska, and Texas, according to CEWG. Clandestine labs have produced the drug in rural and desert areas where the telltale odors of the production process are less likely to be detected. Mobile labs in campers and vans have been reported in Washington.

Mechanisms of Action Sought

Research has shown that methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, causing enhanced mood and increased body movement. Studies funded by the National Institute on Drug Abuse (NIDA) are examining the neurobiological mechanisms involved in methamphetamine's action in the brain, seeking knowledge necessary for long-term solutions to abuse of the drug. Another major research focus is on

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INSIDE

TO OUR READERS

You'll notice several changes in this issue of *ASAM News*. Most prominently, we're proud to show ASAM's new logo on the masthead. The other change is in response to reader requests: through the courtesy of our friends at the National Institute on Alcohol Abuse and Alcoholism, your copy of *Alcohol Alert* is now bound separately, but will continue to arrive with each issue of *ASAM News*. This change also gives us an additional four pages within *ASAM News* in which to bring you more updates about ASAM and the field of addiction medicine. We hope you'll continue to give us feedback; we like to hear from you!

Elizabeth F. Howell, M.D.
Chair, ASAM Communications Section

American Society
of
Addiction Medicine

ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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EXECUTIVE VICE PRESIDENT'S REPORT

OFFICE OF NATIONAL DRUG CONTROL POLICY REAUTHORIZATION

Dr. James F. Callahan


Dr. Callahan

The Office of National Drug Control Policy (ONDCP) Reauthorization legislation has been sent to Congress. In it, the term "drug control" is clarified to include underage use of alcohol and tobacco. ONDCP has included illegal alcohol and tobacco use in the Strategy over the years, even though it is not specifically authorized to do so.

This year's Strategy has taken the strongest stand yet. The first of five strategic goals is to "educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco." Its objectives include promoting zero tolerance policies for youth, encouraging the development of community coalitions, and creating a partnership with the media, entertainment industry and others to avoid the glamorization of alcohol, tobacco and other drug use.

Alcohol is by far the most popular drug among people under the age of 21 and is a leading cause of death, trauma and school problems. It makes sense for the country's top drug control office to have the imprimatur of Congress to address the illegal use of alcohol by underage individuals.

The House Government Reform and Oversight Committee held a hearing on ONDCP Reauthorization on May 1. The Senate is expected to take action soon.

WHAT YOU CAN DO: Write to your senators and representative and urge them to support the inclusion of underage drinking in the ONDCP mandate.

SAMPLE LETTER

The Honorable _____
United States Senate/House of Representatives
Washington, D.C. 20510/20515

Dear Senator/Representative _____:

I strongly urge you to endorse a priority of reducing underage drinking as a part of the mandate of the Office of National Drug Control Policy (ONDCP).

Alcohol is by far the most popular drug among people under the age of 21 and is a leading cause of death, trauma and school problems. The country's top drug control office should have the imprimatur of Congress to address the illegal use of alcohol by underage individuals.

Parents and teenagers agree that alcohol is a bigger problem than other drugs. A Washington Post/ABC News poll found that a majority of parents (71%) believe alcohol abuse is a bigger problem for young people than other drugs (24%). By a margin of 65% to 35%, teenagers agree.

Other studies support these figures. The federally funded annual Monitoring the Future Survey shows that 50% of twelfth graders in the class of 1995 used alcohol in the 30 days prior to being asked and 21% had used marijuana or hashish.

We certainly must not scale back our efforts to prevent the use of any illicit dugs. However, it is important to focus on the substance that causes more devastation than all the others—alcohol.

Thank you for your time and consideration.

Sincerely,

ASAM URGES FDA BE GIVEN STRONGER ROLE IN PROPOSED TOBACCO SETTLEMENT

In a July 28 letter to President Clinton, ASAM President G. Douglas Talbott, M.D., outlined the changes ASAM recommends in the draft settlement agreement negotiated with the major cigarette companies. John Slade, M.D., chair of the ASAM Committee on Nicotine Dependence, led the effort to develop the Society's position.

Dear President Clinton:

On behalf of the American Society of Addiction Medicine, I write to urge that the proposed tobacco settlement be changed in ways which provide genuine protection for public health. Unfortunately, as it is written, the proposal will do more harm than good. ASAM shares the concerns that many medical and public health groups have already expressed about many aspects of the proposal, but in this letter, I will focus exclusively on the issues surrounding the FDA and its role in this matter.

The overriding questions which guide the Society's approach to this are these: Is the public health being served? Is the tobacco industry being held accountable?

As written, the proposed settlement seriously hamstrings the FDA. If enacted as proposed, the public health would be worse off than it is today: we would have the appearance of accountability without its substance. The text grants the agency this or that authority with this or that limit. Many of these limits are unacceptable, there are ambiguities in the way things are presented, and there is an implication that if something is not specifically allowed, it is forbidden for the FDA to become involved. These features must be removed from any legislation that moves forward.

Instead, the FDA must have broad authority over tobacco products (including cigars and pipe tobacco). This authority should be as comprehensive and direct as its authority over any other product it regulates. Any exceptions to this should be narrowly drawn. The burden should be on the tobacco product manufacturers to justify any limits on the FDA; it should not be up to the agency to justify any grant of authority.

Specific examples of unacceptable provisions in the current proposal include:

■ The proposal would not permit the FDA to learn all it needs to know to intelligently regulate tobacco products. The FDA needs access to all information relevant to the design and manufacture of tobacco products so it can understand how these products are made and how they can be modified for the benefit of public health. The agency respects trade secrets. The public health is ill served by the industry keeping its knowledge of how and why tobacco products are made in the way they are (and not other ways) secret from the FDA.

■ The proposal limits the FDA's ability to regulate claims made for tobacco products. The proposal would permit the continued use of terms such as "Light", "Mild" and "Slim" as descriptors in brand names even though these claims, embedded in various products' names, impart a false health message as certainly as the brand name "HeartBeat" did. "HeartBeat" was, for a time, the name of a low fat margarine. The product's name changed when the FDA insisted on truth in health labeling for foods a few years ago.

■ The proposal limits FDA's ability to determine the size, shape, location and other characteristics of the warning label on packages of tobacco products.

■ The proposal limits the FDA's flexibility in setting performance standards. The FDA should be able to approach the opportunities to improve the public health through performance standards broadly (not merely through reduced direct toxicity) and with no additional administrative burdens than those it bears for far less dangerous products than cigarettes or snuff. The fact that the proposal would make it far more difficult for FDA to regulate tobacco products than, say, aspirin, codeine, eyewash or hand lotion is, simply, outrageous. (Setting a limit for a certain reasonable number of years on the removal of nicotine or the removal from the market of conventional tobacco products is acceptable, however.)

■ The section which deals with ingredients excludes tobacco and derivatives of tobacco from FDA oversight. This major concession is granted even though there might be tobacco-derived ingredients which contribute disproportionately to the toxicity of the finished product.

Ambiguities regarding FDA in the proposal include:

■ It is not clear whether the FDA's regulation of all public health aspects of advertising for tobacco products remains intact under the proposal. Under ordinary circumstances, the FDA would be expected to be able to deal with any false or misleading claim that affected the public health. In the proposed settlement, the FDA's advertising authority is only mentioned in the far more narrow connection with limits on advertising that reaches the young, and the FTC is described as only ceding its test of cigarette yields to the FDA. (The fact that the FTC, not the FDA, ordinarily regulates advertising for OTC drugs is not controlling here: a specific interagency agreement controls this particular area. There is no such agreement, for instance, regarding non-prescription devices.)

■ It is not clear whether manufacturers will be required to notify FDA of changes in ingredients or processes so that FDA can consider whether these changes are desirable and should be permitted from a public health perspective. For instance, we see nothing in the proposal that would require a company to tell the FDA of a change which could render a product more addictive, more appealing, easier to use or more toxic.

■ It is not clear to what extent the FDA could regulate the availability of tobacco products beyond the administrative structure which the proposal sets up. If the industry is to be given protection from liability, there must be iron-clad guarantees that the public health will be protected. The industry can only be held accountable by strong external agencies such as the courts and the FDA. If the courts are to bow out, the FDA must be unquestionably in charge of making sure the industry's products do the least possible amount of harm to the public.

The American Society of Addiction Medicine is a medical specialty society with more than 3,000 physician members dedicated to advancing research, education and clinical practice on behalf of patients addicted to alcohol, nicotine, or other drugs. The Society admires and supports the work your Administration has done for the public health on tobacco. We urge you to take the opportunity afforded by the proposed settlement to further assure the health of Americans. One of the key ways the proposal needs to be strengthened is for the FDA to have broad authority to severely limit the damage tobacco products inflict.

Respectfully submitted,
G. Douglas Talbott, M.D.
President

ASAM BOARD ADOPTS NEW POLICY STATEMENTS ON MARIJUANA, OPIOIDS, PAIN AND PATIENT SCREENING

G. Douglas Talbott, M.D.

At its April meeting, the ASAM Board of Directors approved four Public Policy Statements at the recommendation of the Public Policy Committee, chaired by Sheila Blume, M.D. With the Board's approval, these statements become the official policy of the Society.

The Public Policy Statement on Marijuana, first adopted in 1987, was revised by the Public Policy Committee to respond to issues recently raised in public ballots on the use of marijuana in medical care, as well as by the responses of federal and state law enforcement agencies to those ballot initiatives.

The Public Policy Statement on the Rights and Responsibilities of Physicians in the Use of Opioids for the Treatment of Pain was adopted to elucidate issues that have emerged in recent years in relation to the management of acute and chronic pain, for whom physicians specializing in addiction medicine increasingly are asked to provide expert consultation. A related statement on Definitions Related to the Use of Opioids in Pain Treatment clarifies concepts such as dependence and preoccupation as they relate to pain patients managed on opioids.

The Public Policy Statement on Screening for Addiction in Primary Care Settings responds to issues raised by the growing focus on use of primary caregivers to provide a majority of patient care.

The full text of the three policy statements follows.

Public Policy Statement on Marijuana

Marijuana is a mood-altering drug capable of producing dependency. Its chief active ingredient is delta-9-tetrahydrocannabinol.

Marijuana has been shown to have adverse effects on various organ systems, on perception, behavior and functioning, and on fetal development. Because of the widespread use of this drug, its effects on mind and body, and the increasing potency of available supplies, ASAM strongly recommends:

1. Education about drugs, beginning in the earliest grades of elementary school and continuing through university level. Drug education should contain scientifically accurate information on the dangers and harmful effects of marijuana, and on the disease of marijuana dependence.

2. Health and human service professionals should be educated about marijuana and marijuana dependence as a required part of their curriculum.

3. Persons suffering from alcoholism and other drug dependencies should be educated about the need for abstinence from marijuana and its role in precipitating relapse, even if their original drug of choice is other than marijuana.

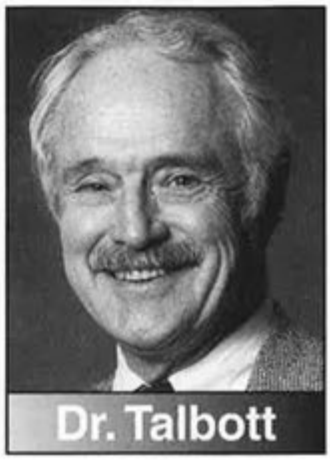
4. Marijuana dependent persons, like other drug dependent people, should be offered treatment rather than punishment for their illness. Treatment of marijuana dependence should be part of the plan for rehabilitation of any person convicted of a drug-related offense, including driving under the influence of alcohol and/or drugs, who is found to be marijuana dependent.

5. Approved medical use of marijuana or delta-9-tetrahydrocannabinol for the treatment of glaucoma, illnesses associated with wasting such as AIDS, the emesis associated with chemotherapy, or other uses should be carefully controlled. The drug should be administered only under the supervision of a knowledgeable physician.

6. Research on marijuana, including both basic science and applied clinical studies, should receive increased funding and appropriate access to marijuana for study. The mechanisms of action of marijuana, its effect on the human body, its addictive properties, and any appropriate medical applications should be investigated, and the results made known for clinical and policy applications. In addition, ASAM strongly encourages research related to the potential and actual effects of marijuana-related public policy.

7. ASAM encourages the study of the potential impact of making cannabis available for approved medical uses, and the consideration of what changes might result from moving cannabis from Schedule I to another Schedule.

8. Physicians should be free to discuss the risks and benefits of medical use of marijuana, as they are free to discuss any other health-related matters.


Dr. Talbott

Adopted by the ASAM Board of Directors in April 1987 and revised in April 1997.

Public Policy Statement on the Rights and Responsibilities of Physicians in the Use of Opioids for the Treatment of Pain

BACKGROUND: Physicians' concerns regarding possible legal, regulatory, licensing or other third party sanctions related to the prescription of opioids contribute significantly to the undertreatment of pain.

Physicians are obligated to relieve pain and suffering in their patients. Though many types of pain are best addressed by non-opioid interventions, opioids are often required as a component of effective pain treatment. In patients complaining of pain, which is a subjective phenomenon, it is often a difficult medical judgment as to whether opioid therapy is indicated. This may be a particularly difficult judgment in patients with concurrent addictive disorders for whom exposure to potentially intoxicating substances may present special risks. It is, nonetheless, a medical judgment which must be made by a physician in the context of the doctor-patient relationship based on knowledge of the patient, awareness of the patient's medical and psychiatric conditions and on observation of the patient's response to treatment. The selection of a particular opioid medication(s), and the determination of opioid dose and therapeutic schedule, similarly must be based on full clinical under-

Continued on next page

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standing of a particular situation and cannot be judged appropriate or inappropriate independent of such knowledge.

Despite appropriate medical practice, physicians who prescribe opioids for pain may occasionally be misled by skillful patients who wish to obtain medications for purposes other than pain treatment, such as diversion for profit, recreational abuse or maintenance of an addicted state. The physician who is never duped by such patients may be denying appropriate relief to patients with significant pain all too often. It must be recognized that physicians who are willing to provide compassionate, ongoing medical care to challenging, psychosocially stressed patients may more often be faced with deception than physicians who decline to treat this difficult population.

Addiction to opioids may occur in the course of opioid therapy of pain in susceptible individuals under some conditions. Persistent failure to recognize and provide appropriate medical treatment for the disease of addiction is poor medical practice and may become grounds for practice concern. Similarly, persistent failure to use opioids effectively when they are indicated for the treatment of pain is poor medical practice and may also become grounds for practice concern. It is important to distinguish, however, between physicians who profit from diversion or other illegal prescribing activities and physicians who may inappropriately prescribe opioids due to misunderstandings regarding addiction or pain.

Physicians traditionally have received little or no education on addiction or clinical pain treatment in the course of medical training. This omission is likely a basis for inadequate detection and management of addiction and inadequate assessment and treatment of pain.

RECOMMENDATIONS:

1. Physicians who prescribe opioids for the treatment of pain should use reasonable medical judgment to establish that a pain state exists and to determine whether opioids are an indicated component of treatment. Opioids should be prescribed in a legal and clinically sound manner, and patients should be followed at reasonable intervals for ongoing medical management and to confirm as nearly as is reasonable that the medications are used as prescribed. Such management should be appropriately documented.

2. Physicians who are practicing medicine in good faith and who use reasonable medical judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-medical purposes. It is the appropriate role of the DEA, pharmacy boards and other regulatory agencies to inform physicians of the behavior of such patients when it is detected.

3. Physicians who consistently fail to recognize addictive disorders in their patients should be offered education, not sanction, as a first intervention.

4. Physicians who consistently fail to appropriately evaluate and treat pain in their patients should be offered education as a first-line intervention.

5. For the purpose of performing regulatory, legal, quality assurance and other clinical case reviews, it should be recognized that judgment regarding a) the medical appropriateness of the prescription of opioids for pain in a specific context, b) the selection of a particular opioid drug or drugs, and c) the determination of indicated opioid dosage and interval of medication administration, can only be made properly with full and detailed understanding of a particular clinical case.

6. Regulatory, legal, quality assurance and other reviews of clinical cases involving the use of opioids for the treatment of pain should be performed, when they are indicated, by reviewers with a requisite level of understanding of pain medicine and addiction medicine.

7. Appropriate education in addiction medicine and pain medicine should be provided as part of the core curriculum at all medical schools.

8. Legal and/or licensing actions against physicians who are proven to profit from diversion of scheduled drugs or from other illegal prescribing activities are appropriate.

Adopted by the ASAM Board of Directors in April 1997.

Public Policy Statement on Definitions Related to the Use of Opioids in Pain Treatment

BACKGROUND: Opioid medications have an important role in the treatment of acute pain and cancer-related pain, and they are sometimes helpful as a component of the management of intractable pain of non-cancer origin. However, a number of issues of clinical concern may arise in the course of opioid therapy of pain. Physical dependence on opioids may occur with prolonged therapeutic use, and tolerance to the analgesic effects of opioids may occur under certain circumstances. Some individuals may develop addiction in association with the prolonged use of opioids.

The clinical implications and appropriate management of physical dependence, tolerance and addiction differ. It is therefore important that clear definitions be established to facilitate identification and appropriate management of these occurrences.

The standard DSM IV criteria for diagnosis of psychoactive substance use disorder cannot be used reliably to diagnose addiction in the presence of opioids prescribed for the treatment of pain. Many of the DSM IV criteria defining addiction refer either to physical dependency or tolerance which are physiologi-

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1998 ASAM CERTIFICATION EXAM ANNOUNCED

The next Certification/Recertification Examination for physicians in addiction medicine is to be offered Saturday, November 21, 1988, at three sites: Atlanta, GA; LaGuardia, NY; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. Applications are to be sent automatically to all ASAM members. Completed applications will be accepted on the following schedule: Early Registration, through Friday, October 31, 1997; Standard Registration, through Friday, January 30, 1998; Late Registration, through Thursday, April 30, 1998. All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination.

Physicians who pass the examination become ASAM Certified/Recertified in Addiction Medicine. Since the examinations first were offered in 1986, 2,939 physicians have passed the examination, including many of the nation's top addiction treatment professionals.

For more information on ASAM Certification and the examination, contact Chris Weirs at the ASAM office.

1997 ALCOHOL AND DRUG TREATMENT PARITY EFFORT BEGINS

Marc Galanter, M.D., FASAM

Last September, Congress passed a law ensuring that people covered under private health plans would not be subject to discriminatory annual or lifetime caps on their health care benefits. This was a first step toward equal coverage, or "parity," for mental illnesses with other medical illnesses. Alcoholism and drug addiction were specifically *excluded* from receiving equal coverage. Without substance abuse parity, many people will not receive needed, appropriate treatment for their addictions. Without access to treatment, thousands of individuals will remain addicted and be unable to lead productive lives.

Senator Paul Wellstone (D-MN) plans to introduce a new parity bill this year which will include substance abuse. However, Senator Wellstone needs our *strong* support. Last year, when Senator Wellstone tried to include substance abuse in the parity legislation, there were not enough Senators who would vote for it. In fact, although Senator Wellstone had received hundreds of letters in support of mental health parity, at the time of the vote, he only had received three letters supporting substance abuse parity. This year, we have the opportunity to lay the groundwork for a long-term effort to ensure that employers provide equal coverage for alcoholism and drug addiction treatment.

GET INVOLVED NOW. We must get involved with the parity effort and stay involved for as long as it takes to achieve equal coverage. We must provide constant support for Senator Wellstone's bill. Without support now, the bill will not go forward or substance abuse provisions will be dropped again.

WHAT YOU CAN DO:
Everyone should WRITE, CALL, FAX or E-MAIL your support for substance abuse parity to Senator Paul Wellstone. Let him know that you appreciate his efforts on our behalf and ask him to keep substance abuse parity in any parity bill he proposes. Include a return address on anything that you send. Senator Wellstone can be reached at:

The Honorable Paul Wellstone
The United States Senate
Washington DC 20510
phone 202/224-5641
fax 202/224-8438
senator@wellstone.senate.gov

WRITE, CALL, FAX or E-MAIL your support for substance abuse parity to the following Senators and Representatives if you reside in their state or district. Include a return address on anything that you send:

Sen. Spencer Abraham (R-MI)
phone: 202/224-4822 fax: 202/224-8834
michigan@abraham.senate.gov

Sen. John H. Chafee (R-RI)
phone: 202/224/2921 fax: n/avail.
senator_chafee@chafee.senate.gov

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phone: 202/224-3344 fax: 202/228-1264
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vermont@jeffords.senate.gov

Sen. Connie Mack (R-FL)
phone: 202/224-5274 fax: 202/224-8022
connie@mack.senate.gov

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phone: 202/224-5344 fax: 202/224-1946
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Rep. Jim Ramstad (R-MN)
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mn03@hr.house.gov

Rep. Marge Roukema (R-NJ)
phone: 202/225-4465 fax: 202/225-9048

The address for all Senators is:
The Honorable (Name)
The United States Senate
Washington DC 20510


Dr. Gallanter

The address for all Representatives is:
The Honorable (Name)
U.S. House of Representatives
Washington DC 20515

A written message is most likely to reach your legislator or receive a response.
- Let your legislators know who you are.
- Give one or two reasons to support treatment policy.
- Ask them to:
  - publicly support parity for substance abuse treatment
  - communicate their support to Senator Wellstone.
- Ask each Senator to co-sponsor Senator Wellstone's bill.
- Ask Representatives Roukema and Ramstad to sponsor a parity bill in the House.

Facts to communicate:
– The costs of untreated alcohol and drug abuse to the U.S. taxpayers is in the tens of millions of dollars. More than 70% of drug users are employed. Exclusion of substance abuse from parity ensures that thousands of workers with health care insurance will be forced to go without alcohol or addiction treatment or will use resources in the public treatment system.

– Providing parity for drug and alcohol treatment services will not significantly increase health insurance programs. In fact the actuarial firm of Milliman and Robertson, estimates that employers will face increases of less than 0.5% (April 1996).

– Substance abuse treatment is cost-effective. The drug and alcohol treatment gained through parity will significantly reduce the risk of HIV/AIDS, tuberculosis, Fetal Alcohol Syndrome, cirrhosis and more.

Please Act Now. If we do not make our voices heard, we will not achieve parity for substance abuse treatment.

NEW DEVELOPMENTS IN AIDS AND ADDICTION REPORTED AT CONFERENCE

Penelope P. Zeigler, M.D.

The 1997 Forum on AIDS and Addictions was held on April 17, 1997 in conjunction with the ASAM Annual Medical-Scientific Conference in San Diego. The Forum was co-sponsored by ASAM and the National Institute on Drug Abuse (NIDA). Melvin I. Pohl, M.D., Director of Substance Abuse Services, Behavioral Healthcare Options, Inc., Las Vegas and Chair of the ASAM HIV/AIDS Committee, and Larry Siegel, M.D., Senior HIV Consultant, Immune Care of Key West and Whitman Walker Clinic, Washington. DC, were co-facilitators. Other planning committee members were Kevin O'Brien, M.D., Melissa Warner, M.D. and Penelope Ziegler, M.D.

Harold Kessler, M.D., Professor of Medicine at Rush-Presbyterian-St. Luke's Medical Center in Chicago, opened the conference with an overview of developments in HIV/AIDS medicine, including clinical implications of new AIDS research, new drugs, and the latest strategies in antiretroviral therapy. He presented the epidemiology, biology, pathogenesis, natural history and treatment of HIV viral infection.

The topic of harm reduction through syringe exchange programs was explored by Don Des Jarlais, Ph.D., Professor of Epidemiology and Social Medicine at Albert Einstein College of Medicine, New York, who presented studies from Europe, North America, Australia and Asia. Fourteen of 16 studies showed a low rate of seroconversion among program participants. A New York study was associated with a reduction of two-thirds in the rate of new HIV infections.

Mark Katz, M.D., Regional HIV/AIDS Physician Coordinator for Kaiser Permanente of Southern California, discussed complementary therapies in HIV/AIDS, including nutritional, pharmaceutical, physical and spiritual approaches. Although none of these remedies is curative, they have demonstrated to have effectiveness in increasing well being, reducing stress and fear, stimulating weight gain, and in certain patients improving CD4 counts and reducing diarrhea and fever.

The epidemiology and immunology of AIDS and drugs of abuse were the focus of the presentation by Harry Haverkos, M.D., Special Assistant to the Deputy Director, Intermural Research Program, NIDA. He reviewed recent studies demonstrating modulation of immune function by THC and opiates in animal models. Both substances increased susceptibility to bacterial and fungal infections. Interestingly, opiate addiction maintained without withdrawal offered some protection against viral infection, while withdrawal appeared to disrupt host protection. At a recent NIDA symposium, the consensus was that treatment of addiction is a very important health objective in decreasing the spread of HIV and progression of HIV to AIDS.

Brenda Chabon, Ph.D., from the Montefiore Medical Center Adolescent AIDS Program, Bronx, NY, discussed HIV and adolescents, identifying groups of at-risk youth and emphasizing the role of alcohol and other drug use as a risk co-factor in this age group. She stated that 50% of HIV infections worldwide occur in people under 25; 25% of U.S. infections are in people under 22, and 19% of AIDS cases are among young people aged 20–29 who were infected during adolescence. HIV counseling and testing, linkage to care and treatment needs of HIV positive youth were explored. Dr. Chabon also spoke about risk reduction and prevention strategies for teens.

Andrea Barthwell, M.D., President of Encounter Medical Group and ASAM's Secretary, spoke on HIV in women and its relationship to addictive disease. She covered the epidemiology of HIV/AIDS in women of various ethnic and social groups, risk factors for women and both horizontal and vertical transmission factors. The special issues for pregnant women addicts and their treatment needs were reviewed.

A luncheon attended by Forum participants featured Nelba Chavez, Ph.D., Administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, as Keynote Speaker. She presented Clinton Administration goals regarding increased access to treatment for addicted patients as a primary strategy for decreasing the spread of HIV/AIDS.

With the support of grants from Merck and Company, Inc. and Glaxo-Wellcome, Forum organizers plan to publish the proceedings as a monograph to be distributed by ASAM.

Methamphetamine – Continued from page 1

methamphetamine's neurotoxicity, specifically its action in damaging brain cells that contain dopamine and serotonin, another neurotransmitter. Scientists think that methamphetamine abuse over time may cause reduced levels of dopamine, which can cause symptoms like those of Parkinson's disease, a severe movement disorder.

Animal studies going back more than 20 years show that high doses of methamphetamine damage neuron cell-endings, says Dr. Lewis S. Seiden of the University of Chicago, a NIDA-funded researcher who has studied methamphetamine for many years. "The damage is essentially permanent, although there may be some regrowth. The damage occurs in rats, guinea pigs, pigs, cats, and nonhuman primates. In rats, one high dose of methamphetamine is enough to cause damage. Prolonged dosage seems to make it worse," he says.

Another NIDA-funded researcher, Dr. Glen R. Hanson at the University of Utah, found evidence that dopamine-generated compounds called free radicals that appear following methamphetamine use can affect serotonin production in contrasting ways. He also reports that several neuropeptide systems linked to dopamine brain pathways are profoundly altered by administration of low to high doses of methamphetamine. "Our results suggest that high and low doses of methamphetamine affect a peptide called neurotensin in very different ways," says Dr. Hanson. High doses of methamphetamine limit neurotensin's function, perhaps resulting in exaggerated dopamine responses to the stimulant. Low doses of methamphetamine increase neurotensin levels and function, which in turn appear to counteract behavioral response to the drug. These findings suggest that neurotensin perhaps could be used to prevent excessive and damaging dopamine responses to methamphetamine, he adds.

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FACTS ABOUT METHAMPHETAMINE

Methamphetamine is a central nervous system stimulant with a high potential for abuse and dependence. A synthetic drug, methamphetamine is closely related chemically to amphetamine, but produces greater effects on the central nervous system. The drug's euphoric effects are similar to but longer lasting than those of cocaine.

Methamphetamine takes the form of a white, odorless, and bitter-tasting crystalline powder, readily soluble in water or alcohol. Street methamphetamine is referred to by many names including "meth," "speed," "zip," "go-fast," "cristy," "chalk," and "crank." Pure methamphetamine hydrochloride, the smokeable form of the drug, is called "L.A." or—because of its clear, chunky crystals—"ice," "crystal," "glass," or "quartz."

Methods and Effects of Use

Methamphetamine can be smoked, injected intravenously, snorted, or ingested orally. The drug alters mood in different ways, depending on how it is taken. Immediately after smoking or intravenous injection, the user experiences an intense "rush" or "flash" that lasts only a few minutes and is described as extremely pleasurable. Smoking or injecting produces effects fastest, within 5 to 10 seconds. Snorting or ingesting orally produces euphoria—a high but not an intense rush. Snorting produces effects within 3 to 5 minutes, and ingesting orally produces effects within 15 to 20 minutes.

Even small amounts of methamphetamine can produce euphoria, enhanced wakefulness, increased physical activity, decreased appetite, and increased respiration. Other central nervous system effects include athetosis (writhing, jerky, or flailing movements), irritability, insomnia, confusion, tremors, anxiety, aggression, hyperthermia, and convulsions. Hyperthermia and convulsions sometimes can result in death.

Cardiovascular side effects include chest pain and hypertension and sometimes can result in cardiovascular collapse and death. In addition, methamphetamine causes increased heart rate and blood pressure and sometimes can cause irreversible damage to blood vessels in the brain, producing strokes. Methamphetamine abuse during pregnancy may result in prenatal complications, increased rates of premature delivery, and altered neonatal behavioral patterns.

Psychological symptoms of prolonged methamphetamine abuse can resemble those of schizophrenia and are characterized by paranoia, hallucinations, repetitive behavior patterns, and formication (delusions of parasites or insects on the skin). Methamphetamine-induced paranoia can result in homicidal or suicidal thoughts., Although no characteristic physical signs of withdrawal are associated with methamphetamine abuse, users report drug craving, depressed mood, sleepiness, and hunger.

Extent of Use

NIDA's 1996 Monitoring the Future study, which assessed the extent of drug use among 8th-, 10th-, and 12th-graders across the country, reports that:

– When high school seniors were asked if they had used crystal methamphetamine at least once in their lifetimes, 4.4 percent said they had—an increase from 2.7 percent in 1990;

– In that same year, when high school seniors were asked if they had used crystal methamphetamine in the 12 months prior to the survey, 2.8 percent said they had—an increase from 1.3 percent in 1990.

The Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network reports that from 1991 to 1994, the number of methamphetamine-related visits to hospital emergency departments more than tripled, from 4,887 to 17,397.

LIKE METHAMPHETAMINE, "ECSTASY" MAY CAUSE LONG-TERM BRAIN DAMAGE

Robert Mathias

Heavy users of ecstasy, a synthetic drug that is structurally similar to methamphetamine and the hallucinogen mescaline, may be risking brain damage that remains long after the high has worn off, according to NIDA-supported research.

In a series of studies conducted with rats and nonhuman primates, Dr. George Ricaurte and his colleagues at Johns Hopkins Medical Institutions first determined that a single dose of MDMA (3,4-methylenedioxymeth-amphetamine), only slightly higher than the size of doses taken by humans, significantly damaged brain cells called neurons that produce serotonin. Serotonin is a major neurotransmitter, or chemical messenger, in the brain that is thought to influence mood, appetite, sleep, and other important functions. Then Dr. Ricaurte reported that 12 to 18 months after the brains of squirrel monkeys had been damaged by MDMA, serotonin-producing nerve fibers had regrown abnormally in some brain regions and failed to regrow at all in others.

Unlike methamphetamine, which damages brain neurons that produce both serotonin and another important chemical messenger called dopamine, "MDMA selectively damages serotonin neurons in virtually all species examined to date," Dr. Ricaurte said. He added that, "With MDMA, the doses that people take very closely approach the doses known to produce neurotoxic effects in animals. At this point, the major question is whether the neuronal changes we see in animals from methamphetamine and MDMA exposure occur in human beings who use these drugs."

To help answer that question, Dr. Ricaurte is conducting separate clinical studies using brain imaging techniques to evaluate the possibility of long-term brain damage in humans who have previously used either methamphetamine or MDMA. These studies also are assessing the potential functional consequences of such neuronal damage on aspects of mood, movement, memory, impulse control, aggression, and sleep cycles.

Determining the functional consequences of MDMA exposure may be more complex than previously thought, Dr. Ricaurte said. The long-term study with squirrel monkeys indicated that in some brain areas, such as those containing structures involved in memory and learning, damaged neurons failed to recover. However, in other brain areas, specifically those involved in regulating such functions as sleep and appetite, damaged neurons regrew nerve fiber excessively, resulting in an overabundance of serotonin being released. "This means that when we evaluate humans previously exposed to high doses of MDMA, we should be looking for loss of serotonin function in some brain regions, but perhaps normal or increased serotonin function in other regions," Dr. Ricaurte said.

Determining the possible damaging effects of ecstasy has become more important in recent years because the pattern of MDMA use has changed, points out Dr. Ricaurte. Although ecstasy has been available as a street drug since the 1980s, its use escalated in the 1990s among college students and young adults, particularly those who participate in all-night dance parties called "raves." In 1995, 2.3 percent of college students said they had used ecstasy at some time during the year, more than quadruple the 0.5 percent of students who reported using the drug in 1994, according to NIDA's Monitoring the Future study. The percentage of young adults, aged 19 to 28, who used ecstasy in the past year also jumped significantly to 1.6 percent in 1995 from 0.7 percent in 1994, according to the survey.

More Information

For more information about methamphetamine and MDMA, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847, or by phone at 800/729-6686. Information also is available at the NCADI Web site at **http://www.health.org** or at NIDA's Web site at **http://www.nida.nih.gov**.

Source

*Reported in **NIDA Notes** from Fischer C, Hatzidimitriou G, Wlos J, Katz J & Ricaurte G (1995). Reorganization of ascending 5-HT axon projections in animals previously exposed to recreational drug 3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy"). **Journal of Neuroscience** 15:5476–5485.*

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AMA HOUSE OF DELEGATES REPORT

Michael M. Miller, M.D. FASAM

The theme "150 Years of Caring for the Country" marked the June meeting of the American Medical Association's House of Delegates.

ASAM was represented at the meeting by Mike Miller, M.D., Delegate, and David E. Smith, M.D., Alternate Delegate to the AMA House; Stuart Gitlow, M.D., Delegate, and Dan Glatt, M.D., Alternate Delegate to the AMA's Young Physicians Section; and Chris De Los Reyes, M.D., Delegate to the AMA Resident Physicians Section. The official delegation was joined by Dr. James F. Callahan, ASAM Executive Vice President, and Manny Steindler, former AMA official, retired ASAM association executive and now ASAM's liaison to the AMA.

The House of Delegates' opening ceremony included the Presidents of the World Medical Association and of the national medical organizations of many countries, including Russia. In fact, a large delegation of Russian physicians were in attendance. Outgoing AMA President Daniel "Stormy" Johnson, of New Orleans, gave an inspiring address on the unique and sacred aspects of the physician-patient relationship and the need to preserve the nature of that relationship in all future revisions to the nation's health care delivery system. Dr. Johnson discussed the link between health care cost inflation and the past artificial insulation from the cost aspects of health care, and the AMA's belief that Medicare reform should place the patient in a position of choice. (Copies of his remarks, "Put the Patient in the Driver's Seat, with the Doctor Riding Shotgun!") are available from the ASAM office.)

A major event of the week for ASAM was the delegation's meeting with incoming AMA President Percy Wootten, M.D. (see adjoining story).

ASAM had four resolutions adopted by the House of Delegates. The first calls for national medical specialty societies to determine the desirability and feasibility of additional training in addiction medicine for members of those societies. Another directs the AMA to refocus some of its anti-tobacco activities on the health dangers of cigar smoking. (ASAM prompted AMA to "get out front" on this issue in light of recent marketing successes by the cigar manufacturers in convincing young adults—especially young women—that cigar smoking is glamorous, sexy and benign.

A third resolution places the AMA firmly in opposition to Congressional attempts to require public housing applicants to disclose their medical history of previous addiction treatment. (The reference committee that heard testimony on this resolution concluded that such a requirement is "completely contrary to Medicine's ethical tenets regarding confidentiality" and would have a "chilling effect" on such patients' likelihood of entering treatment.)

A final ASAM resolution sought to prohibit the alcohol beverage industry (particularly wine bottlers) from placing messages on their labels that would make claims of beneficial health effects for their products; this resolution was adopted by acclamation.

The AMA Council on Scientific Affairs' report on "Reducing the Medical and Public Health Consequences of Drug Use" was well-received by the Reference Committee on Public Health. The report was much improved over earlier drafts, which had deemphasized the disease nature of addiction, the efficacy of traditional abstinence-based treatment, and the need to maintain opposition to decriminalization of drugs, given the current environment in which addiction treatment is not as available, recognized and financially supported as it should be.

Continued on page 12

AMA ADOPTS RESOLUTION IN APPRECIATION OF JESS W. BROMLEY, M.D.

ASAM Member Emeritus Jess Bromley, M.D., who also is ASAM's Delegate Emeritus to the American Medical Association House of Delegates, is the subject of a special resolution of appreciation from the AMA Section Council on Preventive Medicine. The language of the resolution follows:

Resolution in Appreciation of Jess W. Bromley, M.D.

Whereas, Jess W. Bromley, M.D., served the American Medical Association, its House of Delegates and the Section Council on Preventive Medicine from 1988–1995; and

Whereas, He played a significant role in the work of the Section Council on Preventive Medicine as the representative of the American Society of Addiction Medicine; and

Whereas, As a result of his active involvement in the House and the Section Council, he was instrumental in formulating major AMA policy initiatives, including:

– identifying substance abuse as the nation's number one public health problem;

– characterizing alcohol and nicotine as addictive gateway drugs;

– recognizing that drug dependence in all of its forms is a disease and its treatment, a legitimate part of medical practice;

– urging that trauma patients be screened for alcohol and other drug use; and

– calling upon licensing and accreditation agencies and managed care entities not to exclude or discriminate against physicians solely because of a past history of substance abuse; Therefore, be it

Resolved, that the Section Council on Preventive Medicine formally express its appreciation to Dr. Bromley for his forthright and innovative contributions and for the depth and quality of understanding he brought to our deliberations. It produced not merely a greater appreciation of his own field of practice but a more profound realization of medicine's potential for enhancing the well-being of society.

AMA PRESIDENT AND ASAM DELEGATES AGREE ON JOINT STRATEGY

Increasing physician education in addiction medicine and achieving parity for health care coverage for the prevention and treatment of addictive disorders were at the top of the agenda when incoming AMA President Percy Wootton, M.D., met with ASAM Delegates Michael Miller, M.D. and David E. Smith, M.D., and ASAM Executive Vice President James F. Callahan, D.P.A., to map out a joint strategy.

Dr. Wootton invited the ASAM team to meet with him on the first day of his 1997-1998 term of office as AMA President, to seek ASAM's assistance in shaping and carrying his message on the need for parity to assure that addictive disorders are covered in a non-discriminatory manner (on the same basis as any other medical care), especially for the uninsured children of America.

Joining Dr. Wootton and the ASAM representatives were Emerson Moran, AMA's Director of Strategic Communications, Dr. Richard Yoast, Director of AMA's Office of Alcohol and Other Substances, and Patrick Scott, AMA Field Representative for Medical Specialty Societies.

After Dr. David Smith presented Dr. Wootton with a copy of ASAM's comprehensive textbook, *Principles of Addiction Medicine*, the group engaged in an hour-long discussion of how ASAM and the AMA could collaborate during Dr. Wootton's presidency. Dr. Smith brought greetings from ASAM Delegate Emeritus Jess Bromley, M.D., who is a long-time friend of Dr. Wootton.

Dr. Miller told Dr. Wootton that his interest in the problem of addiction among young people is timely, pointing out that at the same time the incidence of drug problems is increasing in this population, funding for addiction treatment is decreasing. Dr. Miller suggested to Dr. Wootton that he consider using the AMA's experience with its tobacco initiative as a model for helping the medical community and the American public understand all forms of chemical dependence (focusing on the similarities in terms of loss of control, preoccupation, and compulsive use that persists despite adverse consequences) and the steps that can be taken to prevent and treat such addictions.

The ASAM representatives told Dr. Wootton that research funded by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism has established that addiction is a disease of the brain, which can be successfully treated. They reviewed with him the literature on screening for addiction in primary care settings and the effectiveness of brief interventions for substance abuse problems that can be conducted by primary care physicians, citing the recent article in *JAMA* on this subject by ASAM member Michael Fleming, M.D. They also told him of the work done by Michael Mayo-Smith, M.D., Christine Kasser, M.D., and their colleagues on the ASAM Practice Guidelines Committee, whose guideline on the Pharmacological Management of Alcohol Withdrawal was published in the July 9 issue of *JAMA*.

AMA President Percy Wootton, M.D. (center), meets with (from left) ASAM consultant and former EVP Emanuel M. Steindler, ASAM Executive Vice President James F. Callahan, D.P.A., and Delegates David E. Smith, M.D., and Michael Miller, M.D., to discuss a joint AMA-ASAM strategy.

The ASAM group invited Dr.Wootton to avail himself of the resources represented by ASAM's 3,400 members and 28 state chapters to:

❑ urge physicians in state medical societies to learn more about how to prevent, diagnose and treat or refer alcohol, nicotine and other drug addictions.

❑ tell physicians about ASAM and ASAM-certified specialists in addiction medicine as resources for them in their own states and communities.

❑ ask physicians to get involved in community coalitions, as physicians, and to serve as the voice and public advocates for patients by promoting access to treatment and parity in its funding.

❑ draw attention to the ASAM *Patient Placement Criteria* as the most effective vehicle for determining the need for treatment and the appropriate level of care, while appropriately containing health care costs.

The ASAM representatives and AMA staff agreed to hold further talks to arrive at specific actions that would both facilitate Dr. Wootton's communication of his message and educate the medical community about the prevention, recognition and treatment of addictive disorders.

As a first step in such collaboration, ASAM agreed to continue to participate with the AMA and the American Bar Association in the National Substance Abuse Coalition, and to promote its action plan to (1) mobilize the memberships of the participating organizations to carry the message that substance use is a serious national public health problem that can be prevented and treated, (2) advocate for greater state and federal funding for treatment and prevention, and (3) campaign for parity in mental health and substance abuse health benefits.

REGULATORY UPDATE

CARISOPRODOL ADDICTION STUDIES REQUESTED

The Drug Abuse Advisory Committee of the U.S. Food and Drug Administration has requested addiction studies on carisoprodol, marketed under the trade-name Soma® by Carter-Wallace. The committee requested the studies in their evaluation of the Drug Enforcement Agency's request to schedule the muscle relaxant. According to the February 12, 1997 issue of Health News Daily, the committee will be reconvened to suggest a response to the DEA request.

Carter-Wallace is countering the scheduling effort by challenging the basis of the DEA petition. DEA's conclusions "at first glance appear to rest strongly on a major premise that carisoprodol is a pro-drug that is metabolized into meprobamate, a premise which has no valid scientific basis," according to Wallace Laboratories Vice President of Research & Development James Costin, M.D.

Carter-Wallace acknowledges that studies have "reported that meprobamate is a metabolite of carisoprodol." However, the firm maintains that "the issue of whether carisoprodol is metabolized to pharmacologically significant amounts of active meprobamate remains unresolved."

Costin also acknowledged that studies evaluating the addictive potential of Soma® are lacking. The drug has been on the market for more than 40 years, and the company has not pursued such studies. The company will carry out the evaluations if the FDA concludes that such data would be needed.

The DEA notes that the request is based on growing concerns over trafficking and abuse of carisoprodol. A DEA spokesman says that 224 reports of seizure or illegal purchase of the product have been reported in 27 states and the District of Columbia.

AMA Report — Continued from page 10

Testifying on the revised report, ASAM Delegate Dr. Miller offered the insight of ASAM's Delegate Emeritus Jess Bromley, M.D., that what may be called for is a "paradigm shift" in which the debate over criminalization versus legalization of drugs is replaced by a dialog on the medicalization of substance use problems, given that addiction is a medical disease and that substance use has clear public health ramifications. ASAM's testimony was that substance use should not be the focus only of police, judges and wardens, but should be addressed primarily by physicians, nurses and counselors.

Recommendations in the report that were adopted include:

❑ Encouraging a national policy under which the approach to problems associated with drug abuse are aimed at preventing the initiation of drug use, aiding those who wish to cease such use, and diminishing the adverse consequences of drug use;

❑ Expanding opioid maintenance programs to make them available to all patients for whom such treatment is appropriate;

❑ Broadening the application of needle exchange and distribution programs and the modification of laws and regulations concerning the availability of sterile syringes and needles; and

❑ Encouraging policymakers to recognize the importance of screening in a variety of settings and to broaden their concept of treatment to embrace a continuum of modalities and goals, including appropriate measures for harm reduction.

The House agreed with the reference committee that a further report should be presented to the House at its December 1998 meeting, outlining the research into potential effects—both positive and negative—of relaxing existing drug prohibitions and controls. During floor debate, there was an attempt to have AMA drop its policy of opposing decriminalization, even before the 1998 report is completed. Dr. Miller testified regarding the need to maintain current controls until there is an environment in which treatment is fully available and adequately funded, and attitudes toward substance abuse are "medicalized" rather than "criminalized."

In other business, the House heard several resolutions regarding the "medical use of marijuana," which proposed to move marijuana from federal Schedule I to a less restrictive schedule, and to make marijuana available for research into potential beneficial uses. Dr. Smith testified for ASAM on these resolutions, providing copies of the 1997 ASAM Public Policy Statement on the matter. The AMA Council on Scientific Affairs is preparing a report—due in December 1997—on medical uses of marijuana; pending receipt of that report, the House deferred further action.

The Tobacco Settlement kept this year's House meeting abuzz. Dr. Miller presented ASAM's Public Policy Statement on Nicotine Dependence, which encourages several items not included in the language of the proposed settlement, including elimination of all forms of tobacco advertising and regulation of cigars in addition to cigarettes and smokeless tobacco. The AMA will appoint a task force (which is expected to include ASAM member John Slade, M.D.) to help shape the AMA's ongoing advice on the Tobacco Settlement negotiations as they move through the national political process.

ASAM testified in favor of a resolution from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, which was passed, affirming AMA policy in opposition to prescription privileges for psychologists. ASAM's testimony on this issue afforded an opportunity to remind the House that pharmacotherapy is an increasingly important component of addiction medicine practice. Another resolution that was adopted encourages national medical specialty societies to develop guidelines and standards appropriate to their specialties for expert medical witnesses; ASAM is thus challenged to develop such documents.

The House referred for further study issues surrounding adequate pain medication, palliative therapy at the end of life, and undue regulatory scrutiny of physicians who prescribe opiates; these are expected to be reviewed again at the December 1997 House of Delegates meeting.

Overall, ASAM was active in this session of the House. In addition to floor activities, Dr. Gitlow ran for the post of Chair of the Governing Council of the Young Physicians Section, where we hope he will become Chair-Elect in 1998. His success in that section enhances ASAM's visibility and credibility in the AMA. Dr. Gitlow and the other members of the delegation continue to use the convening of the AMA's meetings as opportunities to network with leaders of other specialty societies and to enhance the visibility of addiction medicine within organized medicine.

MEMBER NEWS

Members in Service to ASAM

■ ASAM member Hoover Adger, M.D., has been appointed Deputy Director of the Office of National Drug Control Policy by Director Barry McCaffrey.

■ Drs. Andrea Barthwell and David Lewis have used the ASAM *Patient Placement Criteria, Second Edition (ASAM PPC-2)* and other materials in presentations to the Benefits Committee of the Robert Wood Johnson Foundation's Join Together program. In their presentations, Drs. Barthwell and Lewis have emphasized the cost-effectiveness of standardized criteria and the rationale for parity in coverage of addiction treatment.

In Memoriam

■ Roland E. Herrington, M.D., of Palm Springs, CA, died March 1, 1997. Dr. Herrington was a former member of ASAM's Board of Directors. At its April 16 meeting, the ASAM Board unanimously voted its condolences to Mrs. Herrington and its appreciation of the work of Dr. Herrington in laying the foundation for ASAM's work to advance the field of addiction medicine.

■ John P. Manges, M.D., of Boulder, CO and St. Johnsbury, VT, died June 1, 1997. Dr. Manges, 54, was an internist in private practice in Vermont and practiced addiction medicine as co-medical director of Founders Hall treatment program there. He also served in the U.S. Public Health Service on the Wind River Reservation in Wyoming and with the Indian Health Service in Santa Fe, NM.

■ James S. Todd, M.D., Executive Vice President of the American Medical Association from 1990 to 1996, died June 24, 1997. Dr. Todd, 65, had a long career in organized medicine. Trained as a surgeon, he was a member of the AMA's speakers bureau, of its House of Delegates, and of the Board of Trustees before joining the staff in 1986 as Deputy Executive Vice President. In announcing his death, AMA Past President Daniel H. Johnson said, "Jim was that rarest of human spirits; one who was able to lead with warmth and pursue life with a smile. He did not have to demand your respect because everything about him—from the sharpness of his mind to the twinkle in his eye—led you toward his ideas; and often his ideas helped lead medicine where it needed to be." The family has asked that the American Medical Association's Education and Research Foundation accept gifts to benefit the James S. Todd, M.D., Memorial Scholarship Fund at the Harvard Medical School.

ASAM CHAPTER UPDATE

California

Chapter President: William Brostoff, M.D.
Regional Director: Gail Shultz, M.D.

At a regional educational program in June in Orange County, Max Schneider, M.D., and Arnold Zepel discussed "Evaluating Physicians for California's Diversion Program for Physicians." The dinner meeting was one of a series of regional meetings designed to promote interaction among CSAM members.

CSAM's 12-member Executive Committee held its biennial retreat in July. The schedule included a business meeting, in-depth discussions about future directions, and social functions. In November, Gail Shultz, M.D., will succeed William Brostoff, M.D., as CSAM President.

Florida

Chapter President: Richard Keesal, M.D.
Reg. Dir.: Richard A. Beach, M.D., FASAM

The 11th Annual Conference of the Florida Society of Addiction Medicine has been scheduled for January 23-25, 1998, in Orlando. Agenda and registration information is available from Robert Donofrio at the FSAM office, 904/484-3560.

Illinois

Chapter President: Martin Doot, M.D.
Regional Director: Andrea Barthwell, M.D.

ISAM has scheduled its annual Medical-Scientific Meeting for November 21-22 in Chicago. Information on the program is available from Dorothy Freestrom at the Illinois Chapter office, 312/263-7150.

Michigan

Chapter President: Thomas Haynes, M.D.
Regional Director: Norman Miller, M.D.

New chapter officers were elected in June; results were to be announced at the chapter's business meeting in July. Chapter members are planning an educational conference for September.

New Jersey

Chapter President: John Verdon, M.D.
Regional Director: R. Jeffrey Goldsmith, M.D.

At its business meeting in San Diego, the New Jersey Chapter elected the following new officers: President, John Verdon, M.D.; President-Elect, Kenneth Bahrt, M.D.; Immediate Past President, David Canavan, M.D.; Secretary, Lance Gooberman, M.D.; Treasurer, Susan Neshin, M.D. Six at-large Directors also were chosen.

More detailed information is available in the meeting minutes, which can be obtained by calling Dr. Lance Gooberman at 609/663-4447.

New York

Chapter President: Merrill Herman, M.D.
Regional Director: Lawrence Brown, Jr., M.D.

Regional Director Lawrence Brown, Jr., M.D., reports that the New York Chapter has nearly completed its incorporation process.

Among the topics of discussion at the chapter's breakfast meeting during ASAM's annual Medical-Scientific Conference was how treatment of nicotine dependence should be integrated into an overall treatment plan for drugs of abuse.

North Carolina

Chapter President: Tom Lauer, M.D.
Regional Director: Richard Beach, M.D.

NCSAM held its annual meeting June 20 in Charlotte, with Dr. Anderson Spickard as featured speaker. A member of the medical school faculty at Vanderbilt University, Dr. Spickard also directs the national program office for the Robert Wood Johnson Foundation's national "Fighting Back" prevention initiative.

In policy developments, Chapter representatives have met with a committee of the North Carolina Medical Society in June to discuss the proposal to endorse the ASAM *Patient Placement Criteria, Second Edition* (*ASAM PPC-2*) for statewide use.

Region III

Reg. Dir.: Alan Wartenberg, M.D., FASAM

A Region III meeting is being planned for Fall 1997, probably in the Northern New England area. Region III members who have suggestions for topics and speakers are asked to contact Dr. Wartenberg.

All the New England states now have official State Chairs: Don Berland, M.D., in New Hampshire; George Dreher, M.D., in Maine; John Femino, M.D., in Rhode Island; John Hughes, M.D., in Vermont; Ron Pike, M.D., in Massachusetts; and Peter Rostenberg, M.D., in Connecticut.

Region VIII

Reg. Dir.: Richard Tremblay, M.D., FASAM

The First Annual Region VIII Conference will be held in Hawaii during President's Day weekend, February 12-13, 1998. Contact person for this event is Dr. Gerald McKenna, who can be reached at 808/246-0663.

INTERNATIONAL

Bangladesh

Representative: Talukder A. Razzaque, M.D.
Regional Director: Peter Mezciems, M.D.

Anti-Drug Consultancy Centers will be opened in each of five district headquarters. The goal of ASAM representatives there is to establish a clinical 100-bed hospital and vocational training programs in each of the districts. The Consultancy held a rally June 26, which included information on treatment, poster sessions, and a conference attended by young students and their guardians.

COMMITTEE REPORTS

NEW COMMITTEE ON GERIATRIC ALCOHOLISM AND SUBSTANCE USE SEEKS VOLUNTEERS

ASAM members interested in the prevention and treatment of alcohol and drug problems in older persons are invited to join a new committee on Geriatric Alcoholism and Substance Use, according to Barry Solof, M.D., chair.

The mission of the committee is:

❑ To heighten awareness of the magnitude of geriatric alcoholism and substance use within the medical and lay communities;
❑ To promote and support educational and outreach programs; and
❑ To improve the medical care provided to this burgeoning population.

For additional information, contact Dr. Solof at 8306 Wilshire Blvd., #311, Beverly Hills, CA 90211, or phone 213/874-9947 or fax 213/850-1415.

FROM THE LITERATURE

Businesses Reluctant to Offer Treatment Coverage

According to a study by Drug Strategies, a Washington, D.C. policy research institute, three out of four drug abusers hold down steady jobs, most with small businesses—companies that are least likely to offer drug treatment in their health plans, according to a private research group. Other findings include:

❑ Nearly 60% of drug-abusing employees work for companies with fewer than 500 employees.
❑ Many businesses find the cost of drug treatment prohibitive.
❑ Drug and alcohol abuse are everywhere, but employers hesitate to invest scarce resources in employees with substance abuse problems," the report said. "Many are skeptical that treatment can work."

Even employers who have seen lives change through treatment understand that recovery from addiction takes time and relapse is common," the report.said. "High turnover in some industries is another reason that business owners are reluctant to make long-term investments in treatment for individual workers."

Broadcast Ads Undermine Efforts to Stop Underage Drinking

According to the American Medical Association (AMA), the Federal Trade Commission recently launched an investigation into whether liquor distillers and beer brewers are inappropriately targeting underage viewers in their TV advertising. The action follows a decision by the Distilled Spirits Council of the United States to rescind the industry's 48-year-old voluntary ban on broadcast advertising. Beer and wine brands have continued to advertise on television, but now they, too, are targets of the FTC's intensified scrutiny of alcohol advertising in general. The AMA notes that broadcast ads undermine efforts to combat so-called "binge drinking" among college students. In a letter to the heads of the four major networks—ABC, NBC, CBS and FOX—AMA Past President Daniel H. Johnson, Jr., MD, urged that all alcoholic-beverage ads be banned. Dr. Johnson lauded the networks for displaying good corporate citizenship "for shunning liquor advertising."

Education Decreases Young Athletes' Intent to Use Steroids

Anabolic androgen steroid (AAS) prevention programs can help student athletes enhance healthy behaviors, lower their intent to use steroids, and reduce factors that encourage steroid use, according to an article in the November 19, 1996 issue of the *Journal of the American Medical Association*.

Linn Goldberg, M.D., from the Oregon Health Sciences University, Portland, and colleagues tested an anabolic steroid educational intervention program on thirty-seven high school football teams in the Portland area. According to the authors, the intervention was associated with:

❑ Significant reductions in adolescent intent to use AAS;
❑ Greater knowledge of AAS and other drug effects;
❑ Greater belief in personal vulnerability to the harmful effects of AAS use; and
❑ More negative attitudes about AAS users.

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cal and expected with the long-term opioid use (criteria 1 and 2) or to other occurrences which may be normal and expected in the course of opioid therapy of chronic pain (criteria 3 and 4). If DSM IV criteria are considered in diagnosing addiction in the context of pain treatment, only those criteria which reflect addictive behaviors (criteria 5, 6, and 7), rather than the physiologic phenomena of physical dependency and tolerance, should be used in formulating the diagnosis.

RECOMMENDATIONS: The American Society of Addiction Medicine recognizes the following definitions as appropriate and clinically useful definitions and recommends their use when assessing the use of opioids in the context of pain treatment.

Physical dependence: Physical dependence on an opioid is a physiologic state in which abrupt cessation of the opioid, or administration of an opioid antagonist, results in a withdrawal syndrome. Physical dependency on opioids is an expected occurrence in all individuals in the presence of continuous use of opioids for therapeutic or for non-therapeutic purposes. It does not, in and of itself, imply addiction.[1]

Tolerance: Tolerance is a form of neuroadaptation to the effects of chronically administered opioids (or other medications) which is indicated by the need for increasing or more frequent doses of the medication to achieve the initial effects of the drug. Tolerance may occur both to the analgesic effects of opioids and to some of the unwanted side effects, such as respiratory depression, sedation or nausea. The occurrence of tolerance is variable in occurrence, but it does not, in and of itself, imply addiction.

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[1] Physiologic rebound phenomena reflecting physical withdrawal from opioids may occur between doses of therapeutically prescribed opioids, particularly short-acting opioids, in individuals who have developed physical dependence on opioids in the course of pain treatment. Such phenomena may impel the individual to use opioids specifically to relieve these rebound symptoms, even when pain is resolved. In the context of long-term opioid prescription for the treatment of pain, such use of opioids should be interpreted as reflecting physical dependency, not addiction, unless other factors suggestion of addiction (see above) are present and persist following adaptation of the therapeutic regiment to avoid intermittent withdrawal. Physical dependency may perpetuate opioid use following resolution of pain; in such cases gradual withdrawal of medications is usually appropriate.

Addiction: Addiction in the context of pain treatment with opioids is characterized by a persistent pattern of dysfunctional opioid use that may involve any or all of the following:

- ❑ *adverse consequences* associated with the use of opioids;
- ❑ *loss of control* over the use of opioids;
- ❑ *preoccupation* with obtaining opioids, despite the presence of adequate analgesia.

These phenomena may be accompanied by distortions in thought, chiefly denial, and a tendency to relapse, once in recovery.

Adverse consequences suggestive of addiction in the context of pain treatment with opioids may include persistent oversedation or euphoria, deteriorating level of function despite relief of pain, or increase in pain-associated distresses such as anxiety, sleep disturbance or depressive symptoms. Common and expected side effects of the medications, such as constipation, should not be interpreted as adverse consequences in this context.

Loss of control over use might be reflected in prescriptions used up before the expected renewal time, obtaining multiple prescriptions or using street sources of opioids or other drugs.

Preoccupation with opioid use may be reflected in noncompliance with non-opioid components of pain treatment, inability to recognize non-physical components of pain, and the perception that no interventions other than opioids have any impact on pain whatsoever.

Individuals who have severe, unrelieved pain may become intensely focussed on finding relief for their pain. Sometimes such patients may appear to observers to be preoccupied with obtaining opioids, but the preoccupation is with finding relief of pain, rather than with using opioids *per se*. This phenomenon has been termed "pseudoaddiction" in the pain literature. Such therapeutic preoccupation can be distinguished from true addiction by observing that when effective analgesia is obtained, using either opioids or other pain treatment interventions, the previous behavior, which might have suggested addiction, resolves. If opioids are used for pain treatment, the patient does not use these in a manner which persistently causes sedation or euphoria, level of function is increased rather than decreased, and medications are used as prescribed without loss of control over use.

Adopted by the ASAM Board of Directors in April 1997.

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Public Policy Statement on Screening for Addiction in Primary Care Settings

BACKGROUND: Alcohol, nicotine, and other drug use are common behaviors: two thirds of American adults drink alcohol, and one quarter of adults smoke tobacco. Problems from use are also common, and diagnosable substance use disorders are highly prevalent: over 12% of adults exhibiting addiction to alcohol or another drug (exclusive of nicotine), and almost 24% of adults being regular nicotine users (most of these being addicted to the nicotine).

Given that alcoholism and other drug dependencies are progressive conditions, early detection and early intervention can be effective strategies in diminishing the duration, and thus the prevalence, of these conditions in the population. Furthermore, early intervention can diminish the pattern of problems resultant from substance use.

It is estimated that over two-thirds of persons with addiction see a primary care or urgent care physician every six months. Thus, physicians have an opportunity to recognize, diagnose, and intervene in cases of substance use problems and substance-related disorders. Proper training in detection and intervention techniques, and proper motivation on the part of physicians to utilize these techniques, are necessary for these techniques to be widely employed. Screening techniques comprise one process by which physicians and other primary health care providers can determine whether or not to intervene in the course of a substance-related disorder and whether and when to apply more specific diagnostic or therapeutic procedures on behalf of the patient.

A review of available literature by ASAM leads to the conclusion that screening for alcohol and other drug problems is a clinical process that is effective in enhancing health care outcomes, a cost-effective process that reduces overall healthcare expenditures, a preventive health care intervention that is of equivalent importance to other screening interventions, such as screening for breast or cervical cancer, and an activity that should be promoted so that it will become part of the public consciousness of health care consumers, providers, purchasers, administrators, quality managers, and public policy makers.

The quality and efficacy of routine health care services for any condition are compromised unless the patient's alcohol and other drug usage pattern and history are known to the clinician planning and providing primary health care interventions.

THEREFORE, ASAM RECOMMENDS:

1. That the *services of primary care physicians* and other primary health care providers should at a minimum include the provision of the following four elements of care:

– *assessment* of the nature and extent of alcohol, nicotine, and other drug use by patients, with consistency of data collection and documentation akin to the consistence of assessment and documentation of vital signs;

– *routine screening* for the presence of alcohol, nicotine or other drug use problems in patients, as well as screening for risk factors for development of alcohol, nicotine and other drug dependence;

– appropriate *intervention* by the primary care provider;

– the provision of ongoing *general medical care services* to persons who manifest alcohol, nicotine or other drug problems, including dependence.

2. That health care services to prevent, screen for, assess, and intervene regarding alcohol, nicotine and other drug problems should be considered to be a component of *general medical practice*.

3. That reimbursement policies and benefit structures for health care services should cover appropriate primary care and specialty provider *screening and treatment* activities regarding alcohol, nicotine and other drug problems, including dependence.

4. That benefits packages for health care services should address addictive diseases, including the diagnosable syndromes of substance use and dependence, equivalently to the way other chronic conditions are addressed.

5. That the interrelatedness of the biomedical and emotional-behavioral aspects of many chronic diseases, including alcohol, nicotine and other drug dependence, suggests that *an integrated approach to assessment and intervention will be preferable* to any approach that separates health care services, delivery system structures, and reimbursement policies and benefit structures for alcohol, nicotine, other drug, or mental disorders, from such services, structures, and policies for other health care conditions.

6. That *health care organizations* which provide, contract for, arrange, or purchase medical care, should assure that screening processes are designed and implemented effectively and routinely in primary care settings, in order to ascertain the presence of alcohol, nicotine and other drug problems, including dependence.

7. That purchasers of health care services should make it a *specification* of services provided, as well as a measure of the quality of services provided, that screening for alcohol, nicotine and other drug problems by primary care providers be a routine clinical function.

8. That contract language between purchasers (employers or governmental entities) and organized systems of health care delivery should follow a model which includes appropriate screening for chronic conditions, including alcohol, nicotine and other drug dependence, and which also includes data collection regarding health care outcomes and health care expenditures for patients/enrollees identified as having alcohol, nicotine or other drug dependence.

9. That the JCAHO, the NCQA, and other organizations which accredit, monitor and evaluate the performance of healthcare organizations should recognize that screening for alcohol, nicotine and other drug disorders is a fundamental function of primary health care service, and therefore should include such screening as a *standard* by which quality performance is measured.

10. That screening for alcohol, nicotine and other drug problems be included by the developers of HEDIS and other quality assurance and quality improvement standards as a "report card" item for evaluating the qual-

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ASAM MEMBERSHIP DIRECTORY NOW ON-LINE

William Hawthorne, M.D.

ASAM's web site at **http://www.asam.org** now has the most up-to-date copy of the ASAM membership directory. Only members will be able to access the site, since a password is requested. The directory is arranged alphabetically by state. If you do not know the state of a member whose address you seek, consult the cross-reference directory to find the correct location.

When you access the directory, you will be asked for your "user name" and "password." For each blank, enter "asam," using lower case letters.

Because of the ease of updating information in on-line format, we anticipate that the membership directory can be kept current more easily than in its print version.

Policy Statements – Continued from page 17

ity of services provided by an organized system of health care delivery.

11. That as states request waivers which may allow them to change the structure, processes, benefit structures, eligibilities, and policies of their Medicaid programs, the new structures, processes, etc., will include *requirements* for:

– screening of all patients in primary health care settings for alcohol, nicotine and other drug use problems;

– appropriate care for persons with alcohol, nicotine and other drug use disorders, in either primary care or specialized care settings.

12. That clinical practice guidelines should be developed and utilized which describe appropriate integration of screening, assessment, and intervention for alcohol, nicotine and other drug problems into routine primary medical care processes.

13. That health care organizations should be encouraged to assure that the assessment of potential alcohol, nicotine and other drug use problems should, when feasible, involve the patient's family members and other collateral sources of information.

14. That individuals served by organized systems of health care should be screened to determine the impact upon them of the alcohol, nicotine and other drug use problems of their family members.

15. That organized systems of health care delivery, such as health maintenance organizations, should be encouraged to assure that primary care providers will provide, or refer for, appropriate counseling and referral services for family members affected by an alcohol or other drug use problem in the family.

16. That implementation of screening procedures for substance use and/or addictive illness should preserve the special needs for confidentiality of patients with substance use conditions.

Adopted by the ASAM Board of Directors in April 1997.

RUTH FOX MEMORIAL ENDOWMENT FUND

Total Pledges: $2,185,022

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In Honor of the 75th Birthday of Max Schneider, M.D.
from Claire Osman

Dear Colleague:

Dr. Anthony Radcliffe received special acknowledgment at the major donors' breakfast during ASAM's Annual Medical-Scientific Conference in San Diego, in recognition of his very generous deferred gift which put the Endowment over the $2 million mark in December 1996.

Special thanks go to Max A. Schneider, M.D., for his very generous bequest to the Endowment Fund. We are forever grateful to him for his many contributions to ASAM. We look forward to his continued leadership as Chair of the Endowment Fund, and wish him all the best on his 75th birthday.

We are very grateful to Dr. and Mrs. Elmer H. Ratzlaff for their very major bequest to the Endowment Fund, in addition to their previous generous contributions. We thank them for their commitment and their continued support.

For contributions, pledges, or information about making a planned gift (bequests, insurance, stock, pensions), contact Ms. Claire Osman at 800/257-6776.

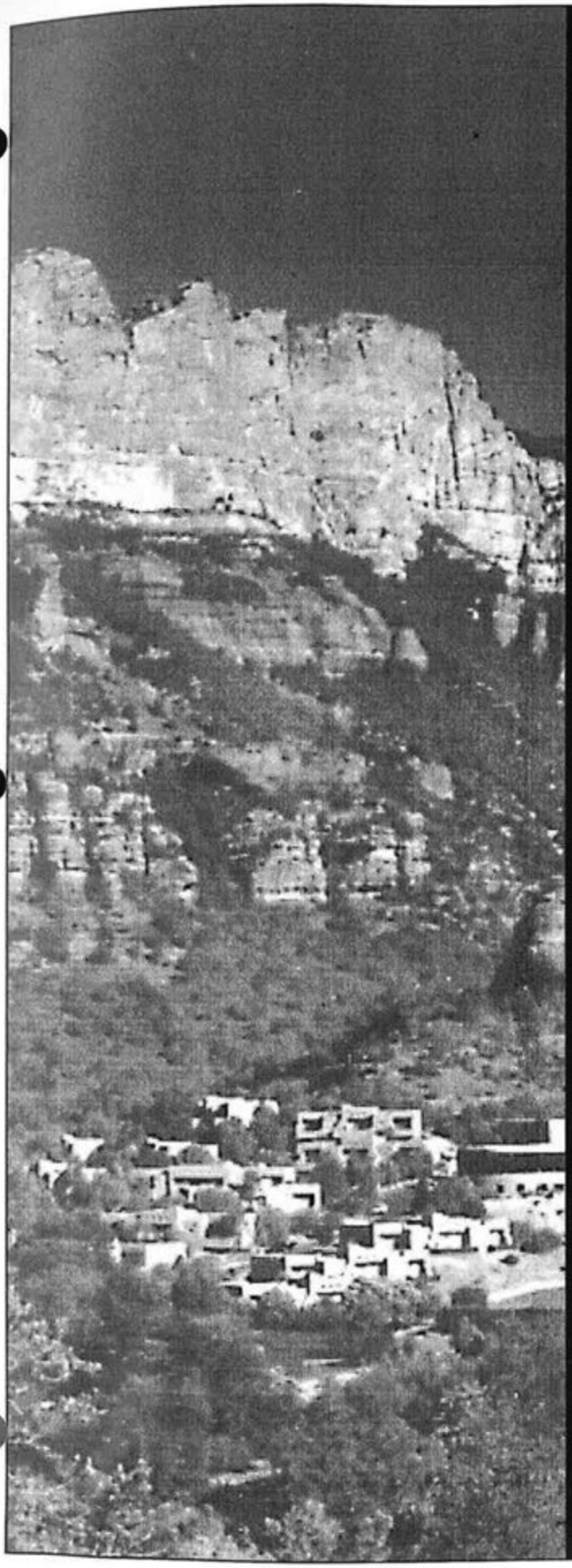
Jasper G. Chen See, M.D.
Chair, Emeritus, Endowment Fund

Claire Osman
Director of Development

NIDA PLANS CONFERENCE ON HEROIN

In response to recent increases in heroin use (particularly among young adolescents), new drug trafficking patterns, increased purity and decreased price, the National Institute on Drug Abuse will sponsor a conference on "Heroin Use and Addiction: A National Conference on Prevention, Treatment, and Research" September 29-30, 1997, at the Sheraton Washington Hotel, Washington, D.C.

Designed to provide new findings from the research that can help treatment professionals, prevention workers and others to respond to the changing problem of heroin addiction, conference sessions will focus on research-based prevention and treatment strategies. An early registration fee of $100 is available until August 29. For further information, contact Sally Marshall or Robyn Bowie of Capital Consulting at 301/468-6001.



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CONFERENCE CALENDAR

1997

September 6-21
South Africa People-to-People Conference
(jointly sponsored by ASAM)
Contact Max A. Schneider, M.D., FASAM
Fax: 714/639-0062
E-mail: Alexron@aol.com

September 28-30
The New York State Association for Alcoholism & Substance Abuse Providers
First Annual Statewide Conference
(jointly sponsored by ASAM)
Saratoga Springs, NY
Contact Todd N. Tate at 609/845-1720

October 16-19
ASAM 10th National Conference on Nicotine Dependence
Minneapolis, MN
22.5 Category 1 CME credits

October 17-19
Canadian Society of Addiction Medicine
9th Annual Scientific Meeting
"The Process of Addiction"
(cosponsored by ASAM)
Contact Raju Hajela, M.D. at 609/541-3951

1997

October 23-25
ASAM State of the Art in Addiction Medicine Conference
Washington, D.C.
20 Category 1 CME credits

October 26-28
First American-Italian Conference on Addiction Medicine
(jointly sponsored by ASAM)
Rome, Italy
Contact Cristiana Fiandra
011-39-40-368-808

November 5-8
CSAM State of the Art Conference
San Francisco, CA
Contact CSAM at 510/428-9091

November 14-16
ASAM MRO Conference
Seattle, WA
19 Category 1 CME credits

1998
ASAM 29th Annual
Medical-Scientific Conference
New Orleans, LA

1999
ASAM 30th Annual
Medical-Scientific Conference
New York, NY

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SAVE THESE DATES!

October 16-19, 1997
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Minneapolis, Minnesota

October 23-25, 1997
State of the Art in Addiction Medicine Conference
Washington, DC