



To improve the care and treatment of people with the disease of addiction and advance the practice of Addiction Medicine.

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Atlanta to Host ASAM's 2012 Med-Sci Conference

Addiction medicine practitioners, educators and researchers will gather in Atlanta for ASAM's 43rd Annual Medical-Scientific Conference, scheduled for April 19-22, 2012. The conference welcomes ASAM members as well as non-member physicians, nurses, psychologists, counselors, students and residents. It features three full days of clinical and scientific offerings, as well as ASAM's annual Business Meeting on Friday morning, April 20th. Symposia and other special sessions will be sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Med-Sci Conference is preceded by the Ruth Fox Course for Physicians and ASAM's course on Pain and Addiction — Common Threads, both scheduled for Thursday, April 19th. The Exhibit Hall will host the Welcome Reception and will be open for two full days of the conference, with more than 70 exhibitors participating. All events take place at the Atlanta Hilton Hotel.

For additional information or to register, visit the ASAM website at WWW.ASAM.ORG or contact ASAM's Department of Conferences & Meetings at 1-301-656-3920, ext. 113.

ASAM Releases New Definition of Addiction

The American Society of Addiction Medicine has released a new definition of addiction that characterizes addiction as a chronic brain disorder, rather than a behavioral problem involving too much alcohol, drugs, gambling or sex. The release was widely reported in scientific publications and the popular media.

Led by former President Michael M. Miller, M.D., DFAPA, FASAM, the ASAM group that drafted the definition spent four years examining the literature and consulted more than 80 experts in the field. Dr. Miller says the definition reflects research studies funded by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, as well as related work by SAMHSA's Center for Substance Abuse Prevention and Center for Substance Abuse Treatment.

According to the new definition, "Addiction is a

primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours.

"Addiction is characterized by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death." (For a more detailed discussion and the full definition, see page 5 of this **ASAM NEWS**.)

Using Marijuana as Medicine — A FRESH LOOK

Robert L. DuPont, M.D.



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More is at stake in the drive to legalize marijuana for medical purposes than the use of a botanical alternative. Making marijuana widely available as a medicine threatens the Nation's century-long effort to separate medical from nonmedical drug use. It also threatens the commitment to science-based drug approval processes and the closed distribution system for the medical uses of drugs that have a potential for abuse — both foundations of the U.S. drug distribution system. Moreover, as it is now being implemented in the U.S., medical marijuana poses a serious threat to the Nation's public health.

Historical Perspective

For perspective, consider the late 19th century, when drugs of abuse were ordinary commodities of commerce. Heroin was sold to anyone as an effective cough remedy and Coca-Cola contained cocaine. At that time, opium was a scourge in Asia, where it was sold without restriction by British traders after being harvested on huge plantations in India. The public health disaster produced by widespread availability of dependence-producing chemicals led in the first two decades of the 20th Century to a U.S. commitment to limit the use of these drugs to approved medical uses. This meant drug were approved based on scientific evaluation, and it meant that approved drugs could be prescribed only by physicians and distributed only through a closed distribution system of licensed and regulated pharmacies and other health care institutions. These changes were adopted to protect the Nation's public health, to assure the medicines would be available for legitimate medical use, and to prevent their use for other than approved medical purposes.

Until the late 1960s, the world's drug problems were limited to one or two drugs, which usually were administered orally and were available to a relatively small part of the population. Since then, the U.S. has experienced the modern drug abuse epidemic, which is characterized by entire populations (especially the young) being exposed to many drugs of abuse that are ingested by highly potent routes of

administration, mostly by smoking and intravenous injection. At the leading edge of this epidemic, marijuana became the most widely used drug in the U.S. other than alcohol and tobacco. Today, 60% of Americans who meet diagnostic criteria for drug abuse or dependence do so as a result of their marijuana use.

The range of responses to the modern drug epidemic are clearly expressed by two leading thinkers. American sociologist Alfred Lindesmith advocated removal of the criminal law from drug policies. Instead, he proposed treating drug addiction as a medical disease. Swedish psychiatrist Nils Bejerot, working in the Stockholm prisons, observed first-hand the application of the Lindesmith approach — now called "harm reduction" — when Swedish physicians responded to the sudden dramatic emergence of an epidemic of intravenous use of amphetamines and opiates by medicalizing it. Swedish physicians prescribed these drugs to addicts in the expectation that they could wean them off the drugs to become drug-free and thus separate the addicts from the illegal drug sellers. Bejerot observed that Lindesmith's seemingly reasonable and compassionate approach did not wean addicts off drugs. Instead, the addicts continued using drugs at ever higher doses. Worse, these "patients" sold their medically prescribed drugs to others, thereby spreading the epidemic.

Bejerot's ideas about drug policy have dominated in both the U.S. and the U.N. until recently, when a new wave of support for Lindesmith's vision has begun to grow. Medical marijuana dominates this agenda in the United States.

Characteristics of Use

In thinking about medical marijuana, it is useful to consider how marijuana is used in the States that have legalized it through ballot initiatives or legislative actions. Medical marijuana is not produced as a standardized and pure product, as are all other medicines. Rather, the marijuana sold for medical uses is nothing other than illegal marijuana renamed. There is no quality control, no assessment of purity, and no dose control.

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ASAM Reaffirms Policy on Medical Marijuana

In view of the current debate and ballot initiatives, ASAM has reaffirmed its long-held policy in opposition to any changes in laws or regulations that would lead to a sudden significant increase

in the availability of any dependence-producing drug (outside of a medically-prescribed setting for therapeutic indications). This policy includes marijuana.

ASAM recognizes the therapeutic potential of cannabis and cannabinoids, including the recent discovery of the human endocannabinoid receptor system, and supports increased funding for research on marijuana that explores the mechanisms of its action, its effects on the human body, and the potential for its clinical applications. However, the Society believes that marijuana, like any other drug, must be subject to Federal standards for drug approval that establish a drug's safety, efficacy and purity, as well as methods of distribution that limit nonmedical use and diversion.

"ASAM supports continued research on certain cannabinoids, with the goal of identifying specific therapeutic applications in line with the 1999 Institute of Medicine study. Until sufficient research in this area exists, ASAM cannot endorse the legalization of the use of marijuana either as a 'medicine' or for any other sanctioned use," said ASAM Acting President Stuart Gitlow, M.D., M.P.H., M.B.A., adding that "smoking any drug is an unhealthy form of drug delivery."

To read the ASAM Public Policy Statement on Marijuana, the Public Policy Statement on Medical Marijuana, or the recent ASAM White Paper on the Role of the Physician in "Medical" Marijuana, visit WWW.ASAM.ORG.

FORMER NIAAA DIRECTOR MORRIS E. CHAFETZ, M.D.

Morris E. Chafetz, M.D., who played an important role in changing the public's perception of alcoholism from a moral failing to a disease requiring treatment, died October 14th at his home in Washington, DC. He was 87.

In 1970, Dr. Chafetz was invited by Elliot L. Richardson, then Secretary of Health, Education and Welfare, to work on alcoholism issues at the National Institute of Mental Health. He took the job and used it to lobby for the creation of a new Federal agency devoted to alcohol-related problems. When Congress approved legislation creating the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Dr. Chafetz was offered the post of director. He later said he jumped at the opportunity, asking "Who gets the chance to start a Federal agency in their area of expertise, the field they have studied for years?" adding: "It really was the greatest five years of my life."

NIAAA began in 1970 with an annual budget of \$6.5 million. By the time Dr. Chafetz left the agency in 1975, the budget was \$214 million. Dr. Chafetz was particularly interested in sponsoring programs in the U.S. and abroad to educate the public about alcoholism and its prevention and treatment. "I remember saying in one of my first speeches that alcoholism was America's most treatable untreated illness, and I still feel that way," he later recalled.

Dr. Chafetz wrote many books on alcoholism, including *"Alcoholism and Society"* (1962, written with Harold W. Demone), *"The Alcoholic Patient: Diagnosis and Management"* (1983) and *"The Encyclopedia of Alcoholism"* (1982, written with Robert O'Brien). He is survived by his sons Marc, of Washington, DC; Gary, of Cambridge, MA; and Adam, of Potomac, MD; a brother, Samuel, of Worcester, MA; and six grandchildren.

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The role of the recommending physician is at best marginal, with most recommendations being given by a few practitioners who sell their recommendations in the same way rogue doctors in pill mills sell prescriptions for opiates and other drugs. Patients consume large quantities of marijuana, and can purchase it at dispensaries that do not control how much is purchased or what is done with the drug once it has been purchased. This is completely unlike the way in which any other medicine — especially a medicine with abuse potential — is prescribed and dispensed.

The contrast becomes clear when we apply a four-part test to separate medical from nonmedical drug use by considering intent, pattern, consequences, and legality. Medical drug use has the **intent** to treat a recognized illness under the care of an informed and actively involved physician. In medical drug use, the **pattern** of use resembles the way patients take an antidepressant or a vitamin. Such medicines are not used in combination with other drugs of abuse, they are not taken to party or in social settings. In addition, no one smokes any medicine. Medical use of a drug typically has positive **consequences**: the patient's health is improved. Medical use is **legal** and can be honestly discussed not only with the prescribing physician but also with others who care about the patient, including family members.

Nonmedical drug use, in contrast, does not have these characteristics. It harms the user's life. It commonly includes other drugs of abuse, often alcohol, in social settings for recreational purposes. Nonmedical drug use is illegal and often concealed not only from physicians but also from family members and other concerned parties. Honesty is as common in medical use as dishonesty is in nonmedical drug use.

Four Questions

Given all of this, there are four questions that ought to be answered before marijuana is legalized and sold as a medicine:

1. Is it sound policy to approve any drug through a ballot initiative or legislative action?
2. Should a drug that is subject to widespread abuse be dispensed outside the current closed distribution system and without a

specific physician prescription, rather than a mere physician "recommendation"?

3. Is smoking a medically justifiable drug delivery system?
4. Should "medicines" be used as whole plants in uncontrolled doses of hundreds of separate chemicals, many of which are biologically active and known to be toxic?

It is difficult to see how anyone could answer even one of these questions "Yes," let alone answering all of four affirmatively. But if even one is answered "No," the current arguments for medical marijuana are rejected.

In summary, the current model of medical marijuana threatens the foundation of the U.S. drug approval and drug control systems. The current model of medical marijuana fails to distinguish between medical and nonmedical use. It also promises to vastly increase the use of marijuana — already the Nation's most widely abused drug, especially among our most vulnerable citizens: American youth, the disadvantaged, and the mentally ill.

The future of medical use of any chemical found in marijuana clearly involves the isolation of specific chemicals, which can be studied for safety and efficacy and — if shown to be safe and effective — can be produced in a pure form and consumed by nontoxic routes of administration. This conclusion was reached in the 1999 Institute of Medicine Report on the medical use of marijuana and has been affirmed in all other careful and balanced studies of this issue over the past 40 years.

The increase in use of medical marijuana following the California ballot initiative in 1996 has not only shown the dangers of bypassing the science-based approval system and the closed distribution system used for all other medicines: it also given new urgency to efforts to put this agent back on the track of all other medicines to prevent further damage to the Nation's public health.

Dr. DuPont is the founding Director of the National Institute on Drug Abuse and President of the Institute for Behavior and Health in Rockville, Maryland.