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COORDINATOR COMMENTS

Lieutenant Dale A. Rutledge

The Oregon Drug Evaluation Classification (DEC) Program is entering into a new era on the occasion of the retirement of Captain Chuck Hayes. Through his leadership and insight he has formed the Oregon DEC Program into a highly respected program. With his retirement from the Oregon State Police, Captain Hayes will continue to be involved in the program on a national level by accepting a position with the International Association of Chiefs of Police (IACP) as the Assistant Program Coordinator. We are fortunate that Captain Hayes will remain involved in the DEC Program and I look forward to his help and guidance. Chuck, a hearty congratulations on your retirement and thank you for all that you have done for the Oregon DEC Program.

As the State Coordinator I would like to recognize that the Oregon DEC Program is made up of many men and women who are willing to work hard and become recognized as experts in the area of impaired driving. It is the dedication of the DRE's, DRE Instructors, people like Dr. Yolton, Dr. Karl Citek, Dr. Richard Smith, DDA Mary Anderson, DDA Jody Vaughan and Captain Hayes who are willing to share their experience and wisdom in order to make the Oregon DEC Program the success that it is today. My job is to "coordinate" the efforts of those who are involved in the DEC Program. As we move forward into this new era I will work to insure the Oregon DEC Program maintains the highest standards of training and performance so that we will continue to enjoy the success of our hard work. I will need help from everyone in the DEC Program. All of us working together will keep the Oregon DEC Program strong. To everyone involved in the Oregon DEC Program I want to thank you for your support. I look forward to working with each of you.

METHADONE DEATHS ON THE RISE

The Oregon Medical Examiner's (ME) office recently noted an increase in the number of deaths related to methadone among ME cases. To determine if an increase in deaths related to methadone had occurred in the population as a whole, and to better characterize methadone-related deaths in Oregon we reviewed the ME records for 1999-2002. Over this period there were 245 methadone-related deaths of which 103 (45%) occurred in 2002 alone. The number of methadone-related deaths has increased annually at least since 1999, with a 4-fold rise in these deaths since 1999.

Among the 245 people who died a methadone-related death between 1999-2002, 58% were male, 91% were white, the mean age was 45 years (range 15-72), and the median year of school completed was 12th grade. Methadone deaths were not just an urban phenomenon; 46% of these deaths occurred outside of Multnomah and Lane counties. According to the ME report 43% of the decedents reported chronic pain (e.g., backache, headache, fibromyalgia), 38% had a history of using heroin (60% had a history of abusing illegal drugs or alcohol) and 37% had a history of mental illness (note that a single decedent could be counted in more than one category). Although we were not able to quantify this factor reliably, many of these decedents were reported to have been snoring loudly or difficult to arouse before their deaths, suggesting that excessive sedation contributed to their demise.

We classified the reasons that decedents had access to methadone into four categories: pain treatment (28%), addiction treatment (34%), illicit use (8%), and unknown (30%). The increase in methadone deaths appears to be related primarily to deaths among those receiving pain and addiction treatment rather than those using methadone illicitly. The proportion of deaths among those treated for pain increased from 18% to 33%. Since we do not know how many persons use methadone for either of these indications, so we cannot calculate the risks attendant to different uses of methadone.

Polypharmacy was common among these decedents, and may have contributed to these deaths by exacerbating the arrhythmagenic or respiratory depressant effects of methadone. The majority (87%) of decedents had toxicology tests positive for at least one other drug in addition to methadone. Other drugs most commonly present were benzodiazepines (50% of decedents), other opiates (25%), and alcohol (14%).

Summary

Although methadone benefits many, the number of methadone-related deaths has recently been increasing in Oregon, in step with the amount of methadone distributed to the state. The increase in deaths has occurred primarily both among those receiving methadone for addiction to heroin or other opiates and among those taking the drug for chronic pain. The majority of decedents had also taken other drugs that can increase the side effects of methadone. Many of these decedents were reported to be difficult to arouse or somnolent before their deaths.

What Now?

Should you stop prescribing methadone because of these deaths? As for all medical treatments, risks need to be balanced with potential benefits. Methadone is an important treatment modality for heroin addiction, and probably prevents many deaths from heroin overdose as well as attendant problems such as criminal activity undertaken to finance a drug habit, and the suffering of family members related to addicts. It is also an important tool with some unique properties for the treatment of chronic pain. Untreated chronic pain continues to afflict millions in the US, diminishing their quality of life and causing suffering that could be prevented with proper treatment.

However, when prescribing methadone, particularly for chronic pain, be sure to take steps to educate your patients. The Oregon Board of Medical Examiners requires that you discuss the risks associated with use of a controlled substance, and that you have patients sign a written notice about these risks.

Patients should be forewarned that this medication needs time to build to an effective level and that taking too much of this medication or taking it too often can be lethal.

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Methadone does not produce the same "high" as many other opiates, and also typically does not produce the same peak in analgesia soon after ingestion that other opiates produce. Also, the half-life can be as long as 150 hours. These qualities mean that methadone can accumulate insidiously to a fatal level. Similarly, the combination of methadone with other opiates, benzodiazepines, tricyclics, or barbiturates can be fatal.

In terms of dosing, providers should "start low and go slow." Experts advise that 5-10 mg/day may be surprisingly effective for chronic pain, and they caution against increasing the dose of methadone more often than weekly.

Providers should assess the history of substance abuse, and incorporate this information into the treatment plan. Also, they should advise family members and others caring for these patients of the need to monitor the patient for somnolence as an early warning sign of toxicity.

This investigation does not support the contention that the increase in methadone deaths can be solely attributed to formulary changes restricting the use of OxyContin, since the increase in deaths began long before those changes were made. However, health systems might consider addressing the problem of methadone deaths through policy changes, such as developing systems that automatically remind pharmacists or providers about the danger of polypharmacy when methadone is prescribed. Since the effectiveness of these policy approaches is unknown, careful evaluation of their effect might help guide future policy changes.

Additional information on methadone dosing and conversion is available from the May 2003 Drug Utilization Review Board Newsletter at http://pharmacy.oregonstate.edu/drug_policy/newsletter_email.html

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Our Nation's Best Chance for Reducing Impaired Driving

By Jeffrey W. Runge, M.D.
Administrator for National Highway Traffic Safety Administration, Washington D.C.

The numbers—if not American Drivers—are sobering. During 2002 there were 42,850 motor vehicle crash fatalities on our nation's roads. While we were making great progress in certain areas—nonfatal injuries, for instance, are declining—traffic deaths related to alcohol are increasing. A total of 17,970 Americans died in alcohol-related crashes in 2002, and 87 percent of the drivers in these crashes had a BAC over .08.

Every family in America should be alarmed at the increase in alcohol-related fatalities, as they are at risk for being broken and changed forever every time they leave the home. No one is immune from this rampant disease or, indeed, from being victimized by this pervasive crime. American lives are being lost even as the remedy is within our reach. This is not a mysterious virus without a known cure. We have the cure for this disease: safety belt use and eliminating impaired driving. If this were an infectious disease with a cure, our nation would spare no resource to deliver that cure to the American people.

Wearing a safety belt and driving only when sober is a choice that people must make. It is an act of personal responsibility, but society as a whole pays for it when individuals are irresponsible. We pay for it with the loss of our loved ones and coworkers, and we pay for it with our pocketbooks. Failure to use safety belts costs our nation $20 billion annually, and impaired driving costs us $51 billion (in 2000 dollars).

As a result of this scourge on our society, law enforcement professionals are stepping forward in huge numbers to address the problem through the work they do every single day. In the past, our agency has seen tremendous results from periodic campaigns to increase belt use and arrest impaired drivers. These are proven programs that involve highly publicized waves of enforcement of impaired driving and safety belt use laws. In the future, more and more police

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officers will come to appreciate that creating sustained changes in driver behavior occurs only with sustained enforcement of safety belt laws and the complete intolerance of alcohol- and drug-impaired driving every day, on every shift, 365 days per year. When the public has an expectation that the law is enforced, then behavior changes and lives are saved.

There is no one who can apply these proven tools, and reverse the fatality trend, more effectively than our nation's law enforcement officers. Enforcement of science-based laws is the foundation of highway safety. Vehicles have never been safer, and road and highway design has never been better. The missing piece is the modification of the behavior of a minority of drivers who still behave as if the roads were theirs alone, and as if the government existed to make their fellow citizens pay for their irresponsibility.

After a 20-year decline, the number of impaired driving deaths leveled off in the mid-1990s and has since increased. The reasons are complex. The number of vehicle miles driven each year has increased. The citizens who are sensitive to education and social norms have changed their behavior. But high BAC drivers are increasing, and they are not getting into the system to receive appropriate help or punishment. There are two portals into the system to keep problem drinkers from driving impaired. One is through the health care system, and the other is through prosecution. Prosecution is a problem as resources for police and courts are squeezed. Indeed, there has been a documented decrease in impaired driving enforcement activity over the last decade. The 2001 FBI Uniform Crime Report estimates that impaired driving arrests decreased by about 15 percent between 1992 and 2001. The nation needs law enforcement professionals to redouble their efforts to get impaired drivers off the road. There is no alternative.

Thank you for the work you do every day in your communities to keep America's families safe. There is much that remains to be done. You have the commitment of NHTSA and US Department of Transportation to help you. There is nothing more rewarding than saving a life, and you have the opportunity to save thousands. Please join me in our commitment to make America a safer and better place to live.

Methamphetamine Abuse Linked to Human Brain Damage

A new magnetic resonance imaging technology (pMRI) has allowed researchers to study the affects of long term methamphetamine abuse on the human brain in a new way. It should not be a surprise that the researchers have been able to document brain abnormalities caused by methamphetamine abuse.

Dr. Chang together with Dr. Nora Volkow and researchers at Brookhaven National Laboratory in Upton, New York used the new pMRI to document blood flow abnormalities to various regions of the brain in test subjects who abused methamphetamine. The methamphetamine abusers had a history of using 2.8 g or more a day of methamphetamine for 8 years. Researchers were able to show that the increased blood flow to the parietal brain regions of the methamphetamine users indicated that the brain tissue had suffered an injury and was attempting to repair itself. Animal experiments have demonstrated similar responses by the brain to repair drug induced injury. Dr. Chang’s study also showed that in some cases there was a decrease in blood flow in the parietal region, the frontal and basal ganglia regions. The decreased blood flow might indicate that the brain tissue is already damaged beyond the ability of the body to repair itself.

The research correlated these abnormalities with slower response time during cognitive testing. People who abused methamphetamine consistently reacted more slowly on computerized tasks than did closely matched non-methamphetamine users. The slower reaction times were evident even after months of abstinence by the methamphetamine abusers and are considered to be evidence of brain damage.

The methamphetamine abusers were between 21% and 30% slower than their counterparts

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while performing simple tests. They were particularly slower when performing tasks that required working memory and mental concentration.

Information obtained from the National Institute on Drug Abuse (NIDA) NIDA NOTES Volume 18, Number 2.

2002 SAMHSA SURVEY

In 2002, an estimated 19.5 million Americans, or 8.3 percent of the population aged 12 or older, were current illicit drug users. Current drug use means use of an illicit drug during the month prior to the survey interview.

In 2002, an estimated 11.0 million persons reported driving under the influence of an illicit drug during the past year. This corresponds to 4.7 percent of the population aged 12 or older. The rate was 10 percent or greater for each age from 17-25, with 21 year olds reporting the highest rate of any age (18.0 percent). Among adult's aged 26 or older, the rate was 3.0 percent.

Marijuana is the most commonly used illicit drug, with a rate of 6.2 percent. Of the 14.6 million past month marijuana users in 2002, about one third, or 4.8 million persons, used it on 20 or more days in the past month.

In 2002, an estimated 2.0 million persons (0.9 percent) were current users of cocaine, 567,000 of whom used crack. Hallucinogens were used by 1.2 million persons, including 676,000 users of Ecstacy. There were estimated 166,000 heroin users.

An estimated 6.2 million persons, or 2.6 percent of the population aged 12 or older, were current users of psychotherapeutic drugs taken non-medically. An estimated 4.4 million used pain relievers, 1.8 million used tranquilizers, 1.2 million used stimulants, and 0.4 million used sedatives.

In 2002, approximately 1.9 million persons aged 12 or older had used Oxycontin non-medically at least once in their lifetime.

Because of changes to the survey in 2002, estimates from the 2002 NSDUH should not be compared with estimates from 2001 and earlier. The estimates are presented in terms of lifetime and first-time substance abuse.

LAW CHANGES

HIPAA

The United States Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Congress called for regulations promoting administrative simplification of healthcare transactions as well as regulations ensuring the privacy and security of patient information. The privacy regulations required Health Care providers to comply by April 14, 2003. HealthCare Providers have a duty to protect the privacy of patients they are treating with some exceptions. A law enforcement officer may obtain limited information on suspects in order to identify them.

Under the HIPAA regulations, health care providers can release the information if it is required by state statute. On May 24, 2003 Oregon Revised Statute (ORS) 676.260 was amended to comply with HIPPA. This law requires health care providers that treat a driver involved in a crash to report to law enforcement within 5 days if a blood test or other evidence reveals that the driver had a blood alcohol content of .08% or more. This was amended to comply with the new HIPAA regulations.

The following bills were enacted by the Oregon Legislature in 2003. The bills are on Governor Kulongoski's desk for signature. If signed they would take affect on January 1, 2004.

OREGON DUII DIVERSION

Senate Bill 302. This law requires a guilty or a no contest plea to the charge of DUII in order to enter into diversion. The filing of pre-trial motions does not constitute "good cause" for extending the time of filing for diversion.

BREATH TEST REFUSAL

House Bill 2900 creates the traffic offense of refusal to take a breath test if the person was requested by a police officer to take a test in accordance with ORS 813.100.

HABITUAL OFFENDER REVOCATION

House Bill 2885 provides for the permanent revocation of the offender's driving privileges upon conviction of misdemeanor DUII for the third time or upon conviction of Felony DUII.

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