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The Evolution of Addiction Medicine: An Interview with Dr. David E. Smith

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Introduction

One of the modern pioneers of addiction medicine is Dr. David E. Smith, founder of the Haight Ashbury Free Medical Clinic in San Francisco and founder and Executive Editor of the *Journal of Psychoactive Drugs*. Dr. Smith's twin specialties of addiction medicine and clinical toxicology have placed him at the center of responses to evolving drug trends for nearly half a century. He is a prolific writer (more than 360 published articles) and has served on innumerable committees and boards that have advanced the practice of addiction treatment. Clinician, consultant, professor, author, editor, professional gadfly, recovery advocate: if one were to nominate candidates for the role of renaissance man or woman of modern addiction treatment, Dr. David Smith's name would be included among the top nominees.

In November of 2012, Dr. Smith graciously agreed to review his life's work and discuss some of the issues that are critical to the future of addiction treatment. Please join us in this conversation.

Early Career

***Bill White*:** You completed your medical education and an internship in the mid-1960s.

***Dr. David Smith*:** Yes, and such an education was not likely for a person of my background. My grandparents were farm workers from Oklahoma. I grew up in Bakersfield, California, and went to East Bakersfield High School and then did two years at Bakersfield College from 1956-1958. This was the era of public education in California so I went to the University of California (UC) Berkeley from 1958-1960. I then went to medical school thanks to access to public education for people of my background.

I was in medical school from 1960 to 1964 and at that same time also enrolled in graduate school in pharmacology and began studying psychoactive drugs. This was the

early days of psychedelic drug research. I then interned at San Francisco General Hospital and did a two-year post-doctoral fellowship in medical toxicology studying diseases caused by drugs. I also ran the alcohol and drug abuse screening unit and was on the clinical faculty at UC San Francisco. That was the era (1965-1967) of the hippies coming to the Haight Ashbury district of San Francisco, which borders the UC Med Center. I was doing clinical work treating addiction at San Francisco General and would then come home at night and see the whole hippie and psychedelic explosion—Ken Kesey, the Grateful Dead, and Jefferson Airplane—as described in Tom Wolfe's *Electric Acid Kool-Aid Test.*

At San Francisco General, I began to see the bad trips on LSD coming into the ER, but when I was out in the community, I would see how people within the street culture responded when somebody had a panic reaction to LSD. They did a better job of it than we were doing in the ER. That's when we began to refine talk down procedures as a response to adverse LSD reactions. Since those early days, we've seen literally thousands of bad trips on LSD, including following them up for 40 years. These supportive talk-down procedures came by observing the culture and translating it into a medical setting. This was also the civil rights era and "power to the people." I took LSD myself and stopped drinking and bought a green VW bus. It was in this turbulent context that I started a free medical clinic—24 hours a day, seven days a week, and without malpractice insurance. That was the beginnings of the Haight Ashbury Free Clinic. It was funded by rock and roll.

Initially, we saw bad LSD trips. Then it switched to speed and then to heroin and it got very violent following the speed epidemic. And then in the 1970s, the Vietnam vets started coming to our clinic, and that's when we started getting federal grants. This was interesting because in the 1960s, it was basically illegal for a physician to treat an addict with a prescription drug, but today it's very hard to get arrested in San Francisco unless you smoke a cigarette in a restaurant. So we were detoxing about a hundred addicts a day. Outside of San Francisco, they arrested a doctor for detoxing an addict on Valium. The physician was Dr. Jess Brown, who later became a delegate to the American Medical Association (AMA). I was an alternate delegate for addiction medicine and our early collaboration marked the beginnings of the California Society of Addiction Medicine. This was before there was a formal field of addiction medicine.

***Bill White*:** Could you describe what medical education physicians received about addiction during that pre-addiction medicine era?

***Dr. David Smith*:** There was nothing when I was in medical school. There was a Dr. Earl Marsh, an obstetrician/gynecologist who was in the Big Book of AA. He gave a lecture on alcoholism when he was a professor based on his own recovery experiences, but such lectures were the exception. Medical education on addiction was essentially non-existent, and addiction was not considered a disease within the medical community. When I started the Haight Ashbury Clinic, we started with the philosophy that healthcare was a right, not a privilege and that addiction was a disease. Our position was that an addict has a right to treatment. That basically came out of Narcotics Anonymous, which was very influential in California at that time.

But the Vietnam vets helped change that. The decade of the 1970s was the finest hour in terms of government addiction policy. That's when the career teacher program was initiated that began modern physician education on addiction. Before then, we were just seen as a bunch of radical hippie doctors treating addiction out on the west coast. In the 1970s, you saw Dr. Jerry Jaffe's ascendance to the Special Action Office on Drug Abuse Prevention, which later morphed into the White House Office on Drug Policy, NIAAA, and NIDA. Dr. Jaffe, Dr. Bob DuPont, Dr. Sidney Cohen, and other pioneers began to dominate public policy discussions. That was when we began to first come together as a field.

The Evolution of Addiction Medicine

***Bill White*:** You've now lived through more than four decades of addiction treatment. How would you describe the evolution of that treatment over the course of your career?

***Dr. David Smith*:** I think the overriding scientific point is how much we've learned about the brain and its role in addiction. My career began in 1962 when I was doing research in pharmacology as a student where I did drug trials where we administered Narcan to prison volunteers. Some of the subsequent top professors in pharmacology evolved out of these UCSF studies. The Department of Pharmacology was the big lead in clinical pharmacology and that was the first time I ever saw an addict. I remember him saying, "The rush of heroin is 100 times better than an orgasm and as soon as I get out of jail I'm gonna use again." That was my first exposure to the power of addiction.

To put this in a broader context, this was the time Narcotics Anonymous was beginning to first grow with its emphasis on addiction as a disease, and you could also read in AA literature about alcoholism being a condition of body and mind. These experiential understandings were the beginnings of what would become the brain science that has evolved so dramatically in recent years. In the 1960s, we didn't even know about opiate receptors or endorphins; we just knew there was something there. So, jump forward 30 years and you have the National Institute of Drug Abuse declaring that addiction is a brain disease. Now the whole treatment field is based on addiction as a brain disease. And the neuroscience of all brain diseases from Alzheimer's to Parkinson's to addiction is one of the most exciting areas of clinical research.

We were involved early in studying and treating addiction, but when I look back at our knowledge base, we were on the right track, but our understanding was very primitive.

AA should embrace these scientific changes because the first mentions of this really were allergy of body and compulsive of the mind. That's simplistic, primitive language but it's the right language. The Big Book of AA has the kernels of this whole addiction is a brain disease concept. And then all of science comes along and validates it.

***Bill White*:** Do you see the work you and others did on the west coast in the 1960s as part of the critical roots of modern addiction medicine?

***Dr. David Smith*:** Yes. The modern field of addiction medicine began in the 1960s. The forerunner to that was the alcoholism movement, of which AA and the National Council on Alcoholism were important parts. The beginnings of the modern field of addiction medicine go all the way back to the 1930s with AA.

***Bill White*:** What do you think are some of the major milestones in the evolution of addiction medicine since that early period?

***Dr. David Smith*:** Well, the most important was acceptance of addiction medicine by the mainstream medical community. That was the most important. Let me put this in context. I was just over at a Haight Ashbury Free Clinic meeting with the Medical Society and we were going over some historical notes. The fellow from the Medical Society reminded me what had happened when I started the Haight Ashbury clinic. I got a call from my malpractice insurer that said, "I didn't know that you were treating those weirdoes. I'm going to cancel your malpractice insurance." Similarly, my professor of medicine said, "David, where did you go wrong? You were always such a promising young medical student." In other words, I was a rising star in the academic community at UCSF and San Francisco General, but the perception was that I'd gone off the deep end because of my desire to treat addiction and to treat hippies having bad LSD trips. We were outside the realm of mainstream medicine. Ours was not a legitimate area of medical practice.

That starts shifting in the 1970s when Douglas Talbott started conceptualizing this

specialty, which was then called "addictionology"—an important but now out-of-date term— and the early work of the New York Society of Alcoholism. In 1980, we had a historic meeting. I've still got the photo on my wall of addiction medicine leaders from around the country coming together at the Kroc ranch to form this national society. It was funded by the Kroc Foundation. We conceptualized a national battle plan, and then they came up with a compromised name, which was "the American Society of Alcoholism and Other Drug Dependencies" because the people from New York had promised Marty Mann and Ruth Fox that alcoholism would remain in the organizational title.

We went to the AMA to present ourselves as the American Society of Alcohol and Other Drug Dependencies (AMSAODD). As it turns out, the 24th specialty approved by AMA was emergency medicine, so I suggested the term "addiction medicine," which would underscore its medical focus. That name was designed to get the mainstream of medicine to accept it and that clicked. In other words, the concept was the same. The evolution was the same. The science was the same, but changing the language helped addiction medicine's acceptance and its growth around the world. (We did have a lot of opposition from traditional psychiatry through that process since we were a multi-specialty society.)

The language shift set the stage for addiction medicine to evolve now to the American Board of Addiction Medicine—a board-certified specialty. So it was a very complex, long-term strategy—basically a lifetime of work—that is now manifested in healthcare reform and parity. You can't have parity for a disease that you don't believe is a disease; it all starts with the disease model of addiction. And you can't have parity for a specialty if you don't believe that specialty is legitimate. The American Society of Addiction Medicine has since become the big driver for all kinds of advancements, including the ASAM Patient Placement Criteria. We have all these young physicians and nursing students and health educators embracing this legacy who did not live through this radical period that created the field they are now entering.

***Bill White*:** I'm very interested in the fact that addiction medicine really began in the community outside of traditional medical institutions, and with the new healthcare reforms, it seems like there's a push to move medicine back into the community. Does that fulfill part of your early vision of how medicine should be practiced?

***Dr. David Smith*:** Oh yes. A community-based approach to medical and addiction treatment, that's what the Haight Ashbury Free Clinics was all about. We had a medical section. We had a drug detoxification section. We had psychological services. We still all do the medical services now at the Haight Ashbury Clinic—Walden House—they've recently merged to become the largest nonprofit in the state with about 4,000 client visits a day. This new entity is now known as HealthRIGHT 360. Now, it turns out that most of the patients are being diverted from the criminal justice system. I think we're seeing a paradigm shift toward diversion of addicts from the criminal justice system into the treatment system. This is a step toward medicalization after the era of criminalization in California that overcrowded the prisons. Now we are starting to see a diversion back to the community level with various types of rehab services. In this shift, addiction medicine needs to be available in every community.

***Bill White*:** You also extended addiction medicine far beyond traditional treatment services—I'm thinking of the pioneering work in rock medicine and all the other broader educational activities in the community, which really took medicine into the heart of the community.

***Dr. David Smith*:** Yes, we have our origins rooted in taking care of concert-goers and the hippies that came to the Summer of Love in 1967. That is why we received such early support from Bill Graham, the Fillmore Auditorium, and the musicians of that era. That early work evolved into this large Rock

Medicine service where we do medical support for 750 concerts a year with a thousand medical volunteers—a whole new generation of EMTs, nurses, pharmacists, physicians, residents. They get exposed to the free clinic philosophy and the free clinic way of delivering healthcare. We now do large event medicine. We did it for the San Francisco Giants World Series parade and the San Francisco 49er games. I have my picture with the Chief of Police and the Fire Department Chief. We've become part of the DNA of San Francisco because we take care of the medical and drug emergencies on site. They don't have to go to the emergency room unless it's very serious. We've saved the city millions of dollars through decreased emergency room visits.

The Role of Medications in Addiction Recovery

***Bill White*:** You talked earlier about the explosion in our understanding about neurobiology of addiction. Could you talk about the evolving role of medication in addiction treatment?

***Dr. David Smith*:** In the beginning, there were very few medications for addiction treatment. In the 1960s, we introduced the Smith and Wesson technique of phenobarbital substitution to manage opiate detoxification that is now widely used for outpatient detox. But then the new brain science spurred the evolution of new pharmacotherapies, beginning early with the debates between drug-free treatment and methadone maintenance, which is a very simplistic division. Now the trend is toward medication-assisted treatment and the integration of pharmacotherapy and psychosocial recovery support. These entrenched cultures have to modify their philosophies based on scientific evidence and the improved outcome for patients. I'm very committed to 12-step recovery, but there are a number of patients that require medication-assisted treatment, including buprenorphine, naltrexone, and all the new pharmacotherapies that are coming down the line. It's going to take a long time for the field to adjust because we're not talking about a medication or psychosocial recovery. We're talking about the integration of pharmacotherapy and psychosocial recovery based on the needs of the patient.

***Bill White*:** You mentioned earlier the recent merger between the Haight Ashbury Free Clinics and Walden House. If I remember right, Walden House was among the first of the early therapeutic communities to integrate methadone. Do you see such integration of medication and psychosocial support as the future of addiction treatment?

***Dr. David Smith*:** Yes, I do. That's what we presented at the last American Society of Addiction Medicine meeting. Ken Roy, head of the treatment program in New Orleans; Mike Miller, the past president of ASAM from Wisconsin; and I wrote an article suggesting that this type of integrated model is the future. I see this type of integrated, community-based care completely aligned with the future direction of health care reform. In fact, I think moving in that direction through the merger of the Haight Ashbury Free Clinics and Walden House saved both organizations.

Recovery Mutual Aid and Chronic Disease Management

***Bill White*:** Let me take you to another area of your expertise. You're one of the earliest addiction medicine specialists to get very interested in the role of mutual aid groups in long-term addiction recovery. Do you think physicians are becoming more supportive of such participation by patients with a history of addiction?

***Dr. David Smith*:** Well, medical groups like to focus on models that they understand and then try to integrate these models into the addiction and recovery areas. So, for example, I had prostate cancer surgery in 2006, and one of the things that my care team promoted was a prostate cancer support group. In the oncology unit, they have cancer support groups all over the place. Well, it turns out historically that such

groups were based on mutual self-help developed by AA. Promoting patient involvement in recovery support groups will increasingly be understood by physicians within the context of chronic disease management. That change is already underway. And you've got this whole obesity epidemic. Part of the treatment is pharmacotherapy and part of it is psychosocial. Management of any chronic disorder must have a psychosocial component of which mutual self-help is important. It's interesting that in this sense, AA has not just impacted management of alcoholism and addiction, but all of medicine.

Tracking Drug Trends for Half a Century

***Bill White*:** Your list of publications over the past 45 plus years constitutes a chronology of modern drug trends. Are there any principles you have found to make sense out of these ups and downs and cycles?

***Dr. David Smith*:** Well, one of the things we found early on was that people who just used psychedelics could function quite well for a very long time and still do today. The problem was when they got into speed and heroin and other drugs. We need a better understanding of why people do or do not migrate to this broader pattern of more destructive drug use. I find this out, interestingly enough, from AA groups, where someone says, "Yeah, I took LSD. It was good. It was great. No big deal" or the ones who say, "Well, I had this spiritual experience." Well then, the question is: "Why did you then get into speed and heroin and alcoholism?" This all seems to be a mix of cultural components, peer pressure, pharmacological optimism, and genetics. Many wish they could have stayed with that LSD experience and not gone further.

The other things that become clear looking back are these drug cycles repeat themselves.

You know, there has been great concern about the methamphetamine epidemic of recent years. Well, the speed epidemic happened a long time ago on the West Coast. But it also has become clear that politicians support particular concepts depending on the region of the country that it hits. It's when the speed epidemic hit the southeast, southwest, and the rural areas that they said, "Well, that's our constituency. We better get serious about it." And then it came off as a new thing. Well, it wasn't a new thing. It was a cycling of a terrible epidemic of amphetamine use in the 1960s and early 1970s.

***Bill White*:** I remember with that first epidemic that many migrated into heroin addiction and alcoholism, and we're seeing the same thing following this latest surge in methamphetamine use.

***Dr. David Smith*:** Exactly. There are these massive drug cycles. It's part of the brain, part of the person, and part of the social context of drug use. But the point of it is these cycles, the uppers and downers, are universal. And now that they're being legitimately studied, I think we need to return to an era of legitimate study of psychedelics. Because all the psychedelic drug research that was good happened in the early 1960s.

***Bill White*:** The drug surges you've witnessed were often accompanied by public panic, and you were often called in by the media in the midst of that panic. Do you have any thoughts for others about the media in the context of public hysteria?

***Dr. David Smith*:** Well, you can tell I'm a firm believer in understanding the cycles and the history and not panicking while trying to stay focused on meaningful public policy. If you think that this is the first time something has happened, you tend to get overwhelmed and think that there is nothing that you can do about it. But that's the value of the field of addiction medicine. It's like infectious disease. A new infectious disease comes along. There may be new parts of it that you have to deal with, but you have a history of dealing with infectious disease and public health approaches and you know all sorts of policy and treatment options that are based on sound scientific evidence that will best respond to it.

I'm hoping we are moving out of the criminalization era in addiction. Throwing everybody in jail didn't work. It didn't help much, and it hurt a lot. We have to have a balance between incarceration and public safety and treatment and rehabilitation, and we now have models for understanding that, which is going to be crucial for vets coming home and people coming out of the criminal justice system.

The Journal of Psychoactive Drugs

***Bill White*:** One of the many contributions you've made in terms of influencing public policy and the practice of addiction treatment was founding *The Journal of Psychoactive Drugs*. Could you talk a bit about the journal and the role you feel it's played in modern addiction treatment?

***Dr. David Smith*:** Well, again, that also came out of that 1960s era. We had formed a psychopharmacology study group to conduct objective studies of psychoactive drugs because of all that was happening in the Haight. At the same time, we were seeing all this hysteria nationwide, particularly about marijuana. You know, I'm in recovery myself, and I'm a grandparent so I'm not a big advocate of marijuana, but I would see this just total nonsense being presented about marijuana and LSD. It was just not scientifically sound and the drug consumer population was viewing all of it like it was a Reefer Madness campaign designed to scare but not inform. They didn't believe anything. We became an objective source of information, and that was the beginning basis of the *Journal of Psychedelic Drug*s. It was around psychedelic drugs because that was where most of the misinformation was and then as the drug culture changed, we evolved into the *Journal of Psychoactive Drugs*. It still fulfills that function. It is a very small operation and remains the oldest addiction-related journal focused on drugs other than alcohol.

We're all getting old and it's now published by Taylor and Francis. We're interviewing some younger people from the university here to take it on as a scholarly activity, just like we are trying to preserve the spirit of the free clinic movement here in the medical school. There seems to be growing interest in our early work and I hope some of the spirit of that work can be renewed. What we went through in San Francisco was such a microcosm of the country that there is much that can be learned from it. I get interviewed so frequently about this that we have actually created a frequently asked questions document.

Leadership of the Field

***Bill White*:** You have referenced passing the torch to a new generation, which reminds me that a lot of those early names you mentioned as pioneers have left the field or passed on. What concerns do you have about the coming loss of the field's modern pioneers?

***Dr. David Smith*:** Well, that's the key. I was just over at the clinic with a lot of these young people and I bring over the history, and they tell me they really like this free clinic and the free clinic philosophy and I told them, "You're the forerunners of the future." They're very interested in seeing the history. You want to carry the torch if you believe there's a torch to be passed on. This field will not continue unless we can imbue the next generation with a clear sense of mission. I am finding so many of the new people are not like we were: you know, recovering, civil rights activists, or whatever. They're involved just because it's an interesting field that has now become a legitimate area of study. Nobody says, "Where did you go wrong" for wanting to study in this area.

***Bill White*:** If you look back over what has been such a long and eminent career, what aspects of this work do you feel best about?

***Dr. David Smith*:** I feel best when somebody says to me, "You helped me and I got on the right path" or those who say, "You know, you saved my life." Well, that's very gratifying. Many other activities have been gratifying, but nothing more so than the recoveries I

have witnessed. There is still a lot of stigma around this disease, but I'm starting to see that culture shift with recovery becoming much more visible. We have to create an environment in which recovery can flourish. I'm hoping to see that more. This is going to be particularly important for the veterans returning from Iraq and Afghanistan who I hope will face greater acceptance and a far better rehab and recovery environment than the Vietnam veterans faced.

***Bill White*:** Let me ask you one final question: what advice or counsel would you offer a young physician or a young counselor who's considering dedicating his or her life to addiction treatment?

***Dr. David Smith*:** I would advise volunteering or interning at a community clinic just to see if you like it. You have to find a comfortable fit. I'd also advise them to study the area. Study the brain science and recognize that this is a very interesting, scientific, and legitimate field. Then, set your training dependent on what you want to do. In other words, if you want to go in to the medical aspect of it, which is desperately needed as a primary care physician, you go one way. If you want to go into the psychiatric aspect, you go in another way. If you're more into the emergency aspect of it, you go another way. If you're more interested in the long-term recovery aspect, you go yet another way. There are a lot of possibilities. A lot of students that are talking to me now are not interested in the clinical side and the health policy side. Another one that talked to me today is interested in the health education part. I'm the old guy who goes down and shares the history, and then I say, "Well, how did you get here?" I just love it! All I do is talk about history and then listen to them.

***Bill White*:** Maybe there is a chance for us to come full circle. [Laughing] Dr. Smith, this has been wonderful, thank you so much.

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