Drug Strategy Pairs Treatment, Law Enforcement

BY DOUG BRUNK

Teenagers and young adults are targeted in a 5-year plan outlined in the Obama administration's National Drug Control Strategy to reduce illegal drug use by 15% and 10%, respectively.

The strategy, released last month by the Office of National Drug Control Policy (ONDCP), also sets goals for the reduction of drug-induced deaths and drug-related morbidity by 15% and the prevalence of drugged driving by 10% among all Americans over the same period.

Key to the success of attaining these goals is the focus on prevention, which would include screening and early intervention; treatment and recovery; and law enforcement, which would address the trafficking and production of illicit drugs and the related cycle of crime, delinquency, and imprisonment.

Dr. Robert L. DuPont, a psychiatrist who was the first director of the National Institute on Drug Abuse and founding president of the Rockville, Md.–based Institute for Behavior and Health, said the strategy is focused on the primary goal of reducing the demand for drugs. "Teaming law enforcement with treatment makes both work better."

President Obama had called for a policy rooted in "common sense, sound science, and practical evidence" guided by "sound principles of public health and public safety." As such, it will incorporate educating young people, who are most at-risk for substance abuse; the allocation of substantial funding for treatment, including recovery, and research; and a comprehensive crime strategy. Communities and community-based faith and civic organizations in particular will be better equipped to implement initiatives.

Access, Reimbursement Expanded

The plan also advocates situating addiction screening, intervention, treatment, and recovery firmly within mainstream health care settings by educating providers about screening and brief intervention techniques and expanding access to and reimbursement for those services. A trial of pay-for-performance contracting might be launched in some states. Such incentives are already in place in a few states where contracted programs that deliver prompt and effective service to addicted patients are rewarded.

Access-to-recovery programs, often run by faith- and community-based groups that provide recovering people with vouchers for things such as treatment or recovery services or transitional housing, will also receive a boost under the program.

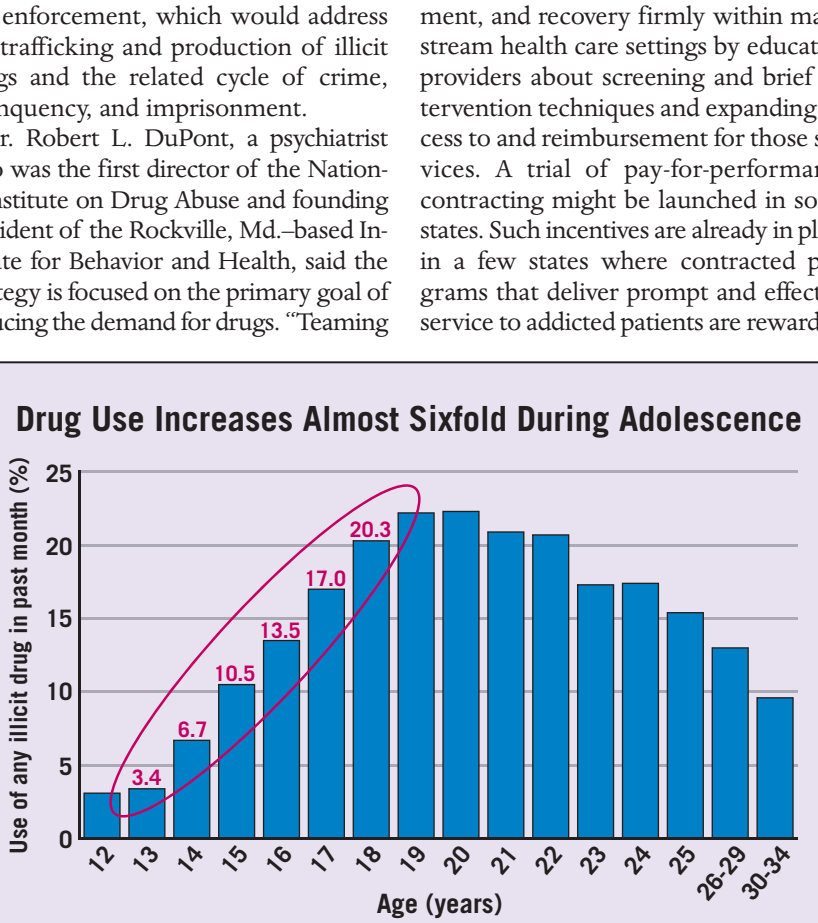
Dr. Mark S. Gold, chair of the department of psychiatry at the University of Florida, Gainesville, said the most important component of the drug control strategy is parity and access to treatment. "Physician addicts have 5-year outcomes proven by drug testing and return to work of greater than 80%. We would like to treat every addict like we treat physician addicts," he said.

Teenagers and young adults receive special attention under the strategy, because recent advances in prevention science show that this population is vulnerable to substance use. Research on the adolescent brain has shown there is an "at-risk period," before the age of 21 years, when people are more likely to develop substance abuse disorders. Other findings have shown that effective, evidence-based interventions for young people could protect against long- or short-term damage from substance abuse; risk factors of substance abuse in youth could predict problems such as bullying and depression; and youth prevention programs in a range of settings have a greater impact than those limited to a single setting.

Move to Reduce Drugged Driving

From a public safety perspective, the policy outlines an approach to reducing drugged driving through law enforcement and educating the public about the dangers. Gil Kerlikowske, ONDCP director, noted in a preface to the document that drugged driving is now at higher levels than alcohol-impaired driving.

With prescription drug abuse at record levels, the strategy outlines ways to curb their abuse while still facilitating their use for medical purposes. This includes expanding prescription drug monitoring programs, recommending disposal methods to remove unused medications from the home, and working with physicians to achieve consensus standards on opiate painkiller prescribing. Doctor shopping, pill mills, and illegal Internet pharmacies will be targeted from the law enforcement front, as will methamphetamine manufacturers and marijuana growers. ■



Note: Based on 67,870 responses to the 2008 National Survey on Drug Use and Health.
Source: Substance Abuse and Mental Health Services Administration

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MY TAKE

Synergy Exists Among Elements

The balance between prevention, treatment, and law enforcement in this strategy is very strong. It highlights President Obama's leadership in terms of a community-oriented, national prevention system that's focused on young children. He's enlisting communities to do something about this problem of substance abuse, and eliciting help from faith-based communities as well, which is absolutely the right thing to do.

The strategy differs from that of previous administrations in that there's a step up in paying attention to science-based evidence in public health as opposed to dogmatic morality. The president is bringing very smart people around him who understand science and not dogma. But at the same time, he has the faith-based community involved. He's creating synergy between the various elements of society to work on this problem.

CARL C. BELL, M.D., *is president and CEO of Community Mental Health Council Inc. in Chicago.*

Monitoring Helps Addicted Anesthesiologists on Naltrexone

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

SAN FRANCISCO — A monitoring program for physicians with substance use disorders greatly boosted the chances of anesthesiologists staying clean and returning to work after the program mandated 2 years of naltrexone therapy in addition to usual treatment, preliminary data suggest.

The study tracked 18 anesthesiologists and 4 anesthesiology residents with opiate abuse or dependence who entered the Florida Medical Association's Professionals Resource Network, the state-sanctioned "physician health program" that monitors impaired physicians. Half the cohort entered monitoring just before (and half after) a 2005 rule change requiring 2 years of naltrexone therapy in addition to usual program requirements.

In the group without naltrexone, 8 of the 11 physicians relapsed on opiates. Of the three who did not relapse, one left anesthesiology to become a consultant, one switched practice to pain medicine, and one successfully returned to anesthesiology.

In the group of 11 on naltrexone, only 1 anesthesiologist relapsed on opiates and another relapsed on nitrous oxide; 9 of 11 successfully returned to practice, Lisa J. Merlo, Ph.D., and her associates reported. The results with naltrexone might be more impressive, considering that 5 of the 11 physicians in the naltrexone group had a history of relapse on opiates or other drugs prior to starting naltrexone, added Dr. Merlo of the University of Florida, Gainesville.

These preliminary data suggest that adding naltrexone increased the chances of avoiding relapse ninefold and improved the chance of returning to work 11-fold.

Naltrexone is an opioid receptor antagonist used mainly in the management of alcohol or opioid dependence. If further research supports the small study's findings, naltrexone pharmacotherapy might be a useful addition to comprehensive treatment and monitoring contracts, but its potential advantages should be weighed against potential side effects when considering using naltrexone in specialists other than anesthesiologists, said Dr. Merlo, who received the society's 2010 Young Investigator Award for her study.

Naltrexone was taken orally as 50 mg 5 days per week or on 3 days per week in doses of 100 mg, 100 mg, and 150 mg, or by monthly injections. Ingestion was witnessed, with random urine testing to confirm the presence of naltrexone in urine.

Its use was added to the program's usual requirements for 2-5 years of monitoring for substance abuse or dependence, random urine drug screens, and attendance in monitoring groups and recovery programs.

The investigators said they have no pertinent conflicts of interest. The National Institute on Drug Abuse and the Florida Medical Association funded the study. ■