EXPERT COMMENTARY

Let's End Nonmedical Use of Stimulants

BY AMELIA M. ARRIA, PH.D.

AND ROBERT L. DUPONT, M.D.

We are intrigued by the work of investigators who recently reported a sharp increase in the number of calls to poison control centers related to attention-deficit/hyperactivity disorder medications, particularly amphetamine/dextroamphetamine–related compounds.

The investigators, led by Dr. Jennifer Setlik, an emergency physician at Cincinnati Children's Hospital Medical Center, investigated trends in calls related to ADHD medications for the years 1998-2005 (Pediatrics 2009 Aug. 24;doi:10.1542/ peds.2008-0931).

They provided a compelling argument that the increase in calls to poison control centers is related to the increased availability of prescriptions. Furthermore, they speculated that the increase in availability points to the increased misuse of these medications.

We believe that the findings of Dr. Setlik and her colleagues must be placed in context of an even larger problem: the ongoing escalation of nonmedical use of prescribed controlled substances.

There is a rapidly growing body of literature on the widespread nonmedical use of the medicines used to treat ADHD in adolescents and young adults who attend college. Evidence has documented the availability of these drugs, and research has consistently shown that most of the stimulants being used nonmedically originate from students being treated for ADHD, who then share and/or sell their medications to others who desire them for nonmedical use (J. of Drug Issues 2008;38:1045-60).

Because of their ability to increase wakefulness, these medications are sought out by many college students, especially those with high task demands who are experiencing academic difficulties (J. Am. Acad. Child Adolesc. Psychiatry 2008;47:21-31). Yet nonmedical prescription stimulant use is associated, on average, with lower academic performance (Addiction 2005;100:96-106).

The nonmedical use of prescription stimulants by lower-achieving students is also a marker for a set of related problems: excessive use of alcohol and use of illicit drugs such as marijuana and cocaine.

Reducing the problem will require the efforts of many parents, school administrators, the Food and Drug Administration, the pharmaceutical industry, and of course, adolescents and young adults themselves. Yet, in our view, physicians must shoulder an especially important set of roles and responsibilities in our collective response to this problem.

Physicians must become aware of the extent to which their patients—especially young patients—with legitimate prescriptions for controlled substances are sharing, selling, and trading their medications. It is important for physicians to be alert to the extent of nonmedical use occurring among their patients who do not have legitimate prescriptions.

With respect to students without ADHD, there are anecdotal reports of parents being concerned about their child in college "succeeding at any cost," and who, therefore, enable the problem by turning a blind eye to nonmedical use. The popular myth is that nonmedical use of prescription stimulants will help their child earn better grades, and that, at worst, it is harmless. Physicians should replace these myths with messages emphasizing that attending class and keeping up with schoolwork on a regular basis is the most likely strategy to achieve superior academic performance.

In managing patients with ADHD, it is important for physicians to emphasize the illegality of diversion of all prescribed medications, including ADHD medications. A recent study documented that about 60% of students with a prescription for an ADHD medication shared or sold the medication to someone for nonmedical use (J. Clin. Psychiarty, in press).

Students need to be made aware of the laws surrounding diversion and nonmedical use of prescription medication, and the sound public health reasons for these laws, so they can make responsible decisions regarding their own behavior.

Physicians should take steps to prevent diversion and nonmedical use by developing guidelines similar to those for prudent monitoring for misuse of prescription analgesics, such as establishing clear indications, screening out contraindications, using an informed consent form, and adopting a multifactorial monitoring strategy. The potential harm associated with sharing or selling their medications—which are controlled substances for good reason—with someone else should be spelled out clearly by the prescribing physician.

Physicians managing patients with ADHD need to be aware of the likelihood of diversion and discuss the issue directly with young patients and their parents. On routine checkups, physicians should monitor for compliance, diversion, and for other concomitant drug and alcohol use. When these problems are detected, they should be viewed as something requiring investigation.

We also support the development of "abuse-resistant" formulations of prescription stimulants. This could be a promising strategy that could reduce the nonmedical use without inhibiting appropriate medical treatment of ADHD and other serious medical disorders.

Abuse resistance is a feature that encompasses more than simply extended time release, although extended-release mechanisms certainly reduce the number of dosages that are available for distribution to others for nonmedical use. A new generation of abuse-resistant formulations of prescription stimulants, characterized by relatively slower onset of action and relatively stable blood levels, is becoming available. Abuse potential appears to be related to the rate of increase in plasma concentrations, rather than simply the concentration level or the level of dopamine transporter receptor occupancy (Am. J. Psychiatry 2006;163:387-95).

If nonmedical prescription stimulant use continues to escalate, the diagnosis and treatment of ADHD might become restricted or stigmatized because of increased suspicion about patients' motives for seeking prescription medication. Physicians—and patients—have important roles to play in ensuring that this situation does not occur, and that appropriate treatment for ADHD continues. ■

DR. ARRIA is affiliated with the Center for Substance Abuse Research, University of Maryland, College Park, and the Treatment Research Institute, Philadelphia.

DR. DUPONT is president of the Institute for Behavior and Health Inc., a nonprofit drug-policy research office in Rockville, Md., and served as the first director of the National Institute on Drug Abuse.

Both authors have received funding from Ortho-McNeil Janssen Scientific Affairs.

Multiple Early Interventions No Benefit for Some With PTSD

BY KERRI WACHTER

Multiple-session early psychological interventions are no better at reducing posttraumatic stress disorder symptoms than no intervention at all and might even increase symptoms in some individuals, a review of 11 randomized controlled studies shows.

"There was no evidence that a multiple session intervention aimed at everyone following a traumatic event was effective. There was a trend that just failed to reach significance for no intervention to result in less self-reported PTSD symptoms at 3 to 6-month follow-up than a multiple session intervention," wrote Neil P. Roberts, D.Clin.Psy., of the Traumatic Stress Service at Cardiff and Vale National Health Services (Wales), and coauthors. The results were published online in the Cochrane Database of Systemic Reviews (doi:10.1002/ 14651858.CD006869.pub2).

The researchers conducted searches of computerized databases and select journals, and they contacted key individuals in the field.

Any randomized controlled trial was eligible for the review. The researchers focused on multiple-session early psychologic interventions intended to prevent symptoms of traumatic stress that were initiated within 3 months of the event.

Potential intervention categories included cognitive-behavioral therapy (CBT), trauma-focused CBT, trauma-focused group CBT, nontrauma-focused group CBT, stress management/relaxation, eye movement desensitization and reprocessing, other psychological interventions, education, provision of information, stepped care, and interventions aimed at enhancing positive coping skills and improving overall well-being.

The researchers limited studies to those that compared a psychological intervention versus waiting list/usual care control or psychological intervention versus an other psychological intervention. The primary outcome was the rate of PTSD among those subjected to trauma, as measured by a standard classification system. Commonly used PTSD measures include the Impact of Event Scale and the Post-traumatic Diagnostic Scale.

The final review included 11 studies, involving 914 participants. Nine studies (775 participants)—two conducted in the United States, two in Australia, two in Sweden, and one each in Canada, France, and the Netherlands—provided data for the final analysis.

Traumatic events included traffic accidents, armed robbery/violence, traumatic childbirth, physical trauma, diagnosis of childhood cancer, and a range of other civilian traumatic experiences. The studies evaluated individual counseling, interpersonal counseling, adapted debriefing, CBT, counseling/collaborative care, and integrated CBT/family therapy. The average number of sessions attended by those who completed therapy was six.

The results "suggest that at this time there is little evidence to support the use of psychological intervention for routine use following traumatic events and that some multiple-session interventions … may have an adverse effect on some individuals," the researchers wrote. ■