Incongruous approach to addictions?

Two recent articles about ketamine in Clinical Psychiatry News raise serious concerns about the attitude and approach of psychiatry and medicine toward this anesthetic.\textsuperscript{1,2} The first discusses the need to create a national ketamine registry to “collect data on dosage, treatment frequency, adverse events, and long-term outcomes in patients receiving the therapy for depression and other mental health conditions.”\textsuperscript{1} The article also describes how the “ketamine landscape” has changed over the last several years, with a large increase in ketamine prescribers, and approximately 500 to 750 ketamine clinics in the United States. They are not regulated by any federal agency and are supposedly “subject to oversight by individual states.” Many of these clinics “are staffed by individuals with no training in ketamine use and, in some cases, no formal mental health training at all.”\textsuperscript{1}

I am aware of one local clinic in Michigan run by an emergency medicine physician. While renewing an antidepressant prescription for one of my patients, I learned through the automated prescription program that she had completed a ketamine treatment at this clinic. When asked about it, the patient said she felt particularly “bad,” so she called one of “the ketamine places” and received a single dose that made her feel better. Neither the patient nor the ketamine clinic thought it necessary to inform me, the treating physician.

In addition to the rapid spread of ketamine clinics, there has also been a recent development of clinicians prescribing oral ketamine for home use via telemedicine without ever seeing the patient in person. This is coupled with signs of increasing illicit use of ketamine.\textsuperscript{1} Palamar et al\textsuperscript{3} found an 81% increase in ketamine poisonings between 2019 and 2021. The combination of ketamine with gamma hydroxybutyrate (GHB) or opioids could be a particular risk for more serious adverse effects.\textsuperscript{2}

These 2 articles, and a recent report by Hasin et al\textsuperscript{4} outlining how the enactment of medical and recreational cannabis laws have played a significant role in the increase in cannabis use disorder among US veterans,
made me think about the incongruous message and approach of our society and medicine toward addictions. At a time when we face an unprecedented rise of opioid abuse and drug overdoses, we also have some physicians who indiscriminately prescribe ketamine. Additionally, we have legislators who push for the legalization of cannabis/marijuana, business owners who advertise the numerous but poorly documented benefits of cannabis, and the anticipated FDA approval of psilocybin and 3.4-methylenedioxymethamphetamine (MDMA).

We know substance abuse is a serious public health problem. In 2021, there were >107,000 overdose deaths in the US, most of them from opioids, predominantly synthetic ones such as fentanyl.

Data on the increase of illicit cannabis abuse after the implementation of medical marijuana laws are nothing new. Hasin et al\textsuperscript{3} reported that from 1991 to 2013 the illicit use of cannabis increased more in states that passed these types of marijuana laws compared to those that did not. Some would argue that ketamine and cannabis/marijuana are “less serious substances of abuse” and that people do not die of cannabis or ketamine overdose. This argument misses the big picture. The cannabis of today is not the cannabis of the past; it is much more potent. Unfortunately, adolescents’ perception that marijuana is harmful has rapidly decreased.\textsuperscript{6} Cannabis is a gateway drug, namely for opioid use disorder.\textsuperscript{7-9} The touted benefits of cannabis are doubtful at best. Ketamine is a club drug that is mixed with other drugs. Cases of deaths after ketamine was self-administered (along with other drugs) have been reported.\textsuperscript{10} And cannabis and ketamine offer little in terms of efficacy as a treatment for substance use disorders.

Our patients and the public may get confused about the often subliminal messages that some substances may be safe or less harmful. Yet such substances are not necessarily less harmful, and pose different risks. Frequently, the risks include the introduction to other substances of abuse, including opioids.

The message our profession is sending about substance abuse is deficient and incomplete. Recently, we have seen strong campaigns addressing opioid abuse and overdoses. For example, the “One Pill Kills” campaign in Texas specifically focused on fentanyl. But that is not enough. Because substance abuse is such a serious public health problem that significantly contributes to the global burden of morbidity and mortality, we must have a strong public health campaign that includes all substances of abuse, not just opioids. Such an approach can work; we have seen such campaigns successfully decrease tobacco use. The medical profession must become more actively involved. Our involvement should include participation in public education campaigns that would explain the potential harm of cannabis and its lack of benefits, opposition to the legalization of substances of abuse, and abstaining from developing substances with clear abuse potential for treating mental disorders. We should also promote harm reduction practices, such as opioid agonist therapy, syringe exchange programs, and naloxone distribution. Naloxone should be free, akin to the free COVID-19 vaccines during the pandemic, as not many people are willing to pay $50 per dose. Naloxone is already free through the Veterans Health Administration. However, since we do not have any efficacious treatments for many substance use disorders, we should focus first and foremost on primary and secondary prevention, such as raising the minimum age for drinking alcohol and using cannabis.

REFERENCES