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News for policy and program decision-makers

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Sheriffs and police tell Trump: More treatment needed

When President Trump met with the National Sheriffs' Association in Washington on Feb. 7, many attendees pointed to the opioid problem in their communities — a topic the president himself broached in his initial remarks. "Stop the opioid epidemic. We've got to do it. It's a new thing," he said. "And, honestly, people aren't talking about it enough. It's a new thing, and it's a new problem for you folks. It's probably a vast majority of your crimes — or at least a very big portion of your crimes are caused by drugs."

"I'm averaging 12, 15 overdoses a week in my community," said Sheriff David Mahoney from Dane County, Wisconsin. Asked by President Trump how much crime was caused by drugs, Mahoney responded, "80 percent." And it's not only drugs, he said. "I have a jail, over 1,000 beds. Eighty percent suffer from chronic drug and alcohol addiction," Mahoney said. Without addiction, crime would be a "whole different ballgame," responded President Trump.

Bottom Line...
President Trump is getting pushback from law enforcement on his tough-on-crime stance, with police, sheriffs and prosecutors calling for a focus on treatment and urging the administration not to repeat the mistakes of the past.

President Trump did focus on the need to keep drugs from coming into the country, something sheriffs hoped would help stem the tide of overdoses.

Sheriff Richard Stanek of Hennepin County, Minnesota, said 144

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Iceland's activity-heavy prevention approach scarce in United States

In a perfect world, the ways in which a European nation influenced a steep drop in past-month intoxication rates among 15- and 16-year-olds in less than two decades would be the talk of every community in the United States. Yet Iceland's strategies, recently called the world's most promising approach to youth prevention by a U.S. prevention researcher, remain largely unknown here, and likely difficult to duplicate.

Bottom Line...
Iceland has used an aggressive approach to substance use prevention that brought significant results over a 20-year period, especially in underage drinking.

In recent months, Iceland's efforts have received significant media attention, including in a 2016 *Huffington Post* article written by former Metropolitan State University scholar-in-residence Harvey B. Milkman, Ph.D., as well as in an article published last month in *The Atlantic*. The efforts were presented by researchers in Iceland, led by Inga Dora Sigfusdottir, at the United Na-

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people in his jurisdiction died from opioid overdoses last year — a 31 percent increase over 2015.

Insurance and the ACA

Treatment providers can work with law enforcement to help that 80 percent of jail occupants who have chronic addiction, sources told *ADAW* last week. A key concern of sheriffs and police officers now is the possible loss of the Affordable Care Act (ACA), which has helped many people with addictions gain access to health insurance — insurance that pays for treatment for people in the criminal justice system.

As the overseers of jails, county sheriffs have the opportunity to utilize medical insurance to treat people with addictions — a priority of the Center for Lawful Access and Abuse Deterrence (CLAAD), which works with sheriffs to reduce jail bed days, costs and recidivism.

"Individuals with substance use disorders are often caught in the cycle of arrest and incarceration," said Shruti Kulkarni, CLAAD policy director. "Treatment providers and law enforcement work together to break this cycle by treating individuals with substance use disorders immediately when the medical need is identified, thereby improving the chances of success, instead of waiting to treat the individual prior to release," Kulkarni told *ADAW*.

Federal law bans the use of Medicaid to pay for treatment for those who are incarcerated. But often, private insurance and marketplace plans are not cut off until the individual is convicted and sentenced, said Kulkarni. "Jails can utilize insurance as long as possible to help individuals receive treatment before shifting to their own budget," she said. However, jails can re-enroll individuals in Medicaid prior to release, helping them access treatment immediately, she said.

Incarceration costs are much higher than treatment costs, added Kulkarni. "Treating individuals with substance use disorders can reduce recidivism and incarceration rates, resulting in significant savings to jails and communities," she said.

Some corrections officials have expressed concern about the possibility of diversion of methadone or buprenorphine — two treatment medications that are available in oral form. Kulkarni said the availability of Probuphine — the buprenorphine implant — and Vivitrol — extended-release naltrexone — there would be no diversion concerns.

Law Enforcement Leaders

Last week, a coalition of almost 200 police chiefs and prosecutors from all 50 states released a five-part agenda underscoring the importance of the criminal justice reform that had been in progress under the Obama administration. The group, Law Enforcement Leaders to Reduce Crime and Incarceration, prepared the agenda in response to President Trump's executive order this month creating a task force on crime reduction.

The police/prosecutor group urged President Trump to focus on "smart policing." The concrete steps that should be taken, according to the group, whose agenda was portrayed as an "open letter" to the administration, are:

- Prioritize fighting violent crime, targeting toward preventing it and not putting resources in fighting lower-level drug crimes and nonviolent crimes.
- Enact federal sentencing reform, reducing mandatory minimum sentences for nonviolent crime — an initiative expected to come from Senate Judiciary Committee Chair Charles Grassley and House Speaker Paul Ryan in reintroducing the Sentencing Reform and Corrections Act in coming weeks.
- Increase mental health and drug treatment. Republican governors have already made treatment programs a key to public safety efforts. Support for treatment will address un-

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derlying causes of crime, removing undue burdens on police and reducing future crime.

- Bolster community policing. Via grants from the Justice Department, local and state law enforcement have funded community policing initiatives that reduce crime while improving trust between police and communities. Police say that trust improves their safety as well as the safety of the neighborhoods.
- Expand recidivism reduction in prison programs. Law enforcement officials urge President Trump to support and expand in-prison job training and education to help prisoners stay away from crime when they are released.

"We urge the administration to embrace the lessons of recent successful policies," said Ronal Serpas, former New Orleans police superintendent and founding chairman of Law Enforcement Leaders. "A focus on violent crime works when it replaces a focus on low-level or nonviolent offenses. We've learned that incarceration and more prisons is not the answer. It's important that as we address the crime scene in 2017, we do not repeat the mistakes of the past. Law and order comes best when we have smart policing. It need not be a synonym for unnecessary arrests, prosecutions and imprisonment. We know that doesn't make us safer." David Brown, former Dallas police chief, is the new co-chairman of Law Enforcement Leaders.

PAARI

An early adopter of the belief that law enforcement should help facilitate treatment instead of arrest and prosecution is the Police Assisted Addiction and Recovery Initiative (PAARI). First begun in Gloucester, Massachusetts, in 2015, the program now has members throughout the country.

Police departments are also very concerned about the loss of the ACA, said David Rosenbloom, co-founder of PAARI. Last month, more than 100 police chiefs in PAARI co-signed a letter to members of Congress urging them to take no action that will make access to treatment more difficult, Rosenbloom told *ADAW* last week. "In states that expanded Medicaid, many individuals with addiction are now getting care," said Rosenbloom. "The [police] chiefs are appropriately concerned that reducing access to Medicaid through repeal or changes in the ACA will make the opioid epidemic worse than it already is."

> **'We've learned that incarceration and more prisons is not the answer.'**
>
> Ronal Serpas

Treatment providers also need to be responsive to police departments, especially in their admissions hours, said Rosenbloom. "If an individual is told to wait because the treatment provider schedules new admissions only at a particular time or day, the person is usually back on the street," said Rosenbloom. "Police departments operating non-arrest programs are unwilling to send people back to the street, where they are at risk of overdose death," he said. Treatment centers should also make their admissions hours more responsive to emergency departments and to the individuals with addiction, said Rosenbloom.

All treatment organizations should offer the full range of evidence-based treatments, added Rosenbloom. "Medication treatment for opioid disease is so effective for many people that every patient should be routinely assessed for and offered this alternative," he said.

Despite the voices expressed here, there are still concerns that not all police departments — or prosecutors — agree with the concept of treatment instead of arrest. "The fact is that police departments and prosecutors have broad discretion in setting enforcement priorities," said Rosenbloom. "These priorities vary from city to city now." •

For the Law Enforcement Leaders agenda, released Feb. 13, go to http://bit.ly/2kXil2m.

For a transcript of President Trump's Feb. 7 meeting with sheriffs, go to http://bit.ly/2kFtcw9.

For the letter from PAARI police chiefs to members of Congress written Jan. 19, go to http://bit.ly/2jN90tx.

Opioid use among women of childbearing age detailed

The Substance Abuse and Mental Health Services Administration (SAMHSA) last month quietly released a data-based report on the nonmedical use of opioids among women of childbearing age (15–44). Key findings include that younger pregnant women and pregnant women living below the federal poverty level are the most likely to be past-month opioid users. In addition, the health insurance gap suggests that both categories of women need help accessing insurance opportunities provided by the Affordable Care Act (ACA) to ensure care.

The report was issued Jan. 17, three days before the inauguration of President Trump, who has vowed to repeal the ACA — a process that is already underway. Nevertheless, the research presented, which relies on three of the country's strongest datasets of substance use information, can inform current policymaking.

Overall, about 21,000 pregnant

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women have misused opioids in the past month, according to the report. Of the pregnant women admitted to treatment, 22.9 percent reported heroin use, and 28.1 percent reported nonheroin opioid misuse.

The report was based on the National Surveys on Drug Use and Health (NSDUH), combining the 2007 to 2012 surveys; the 2012 Treatment Episode Data Set (TEDS); and the 2012 National Survey of Substance Abuse Treatment Services (N-SSATS).

Methadone and buprenorphine

The report stresses throughout that the best treatments for opioid use disorder if a woman is pregnant are methadone or buprenorphine maintenance. The effects of this recommendation on women of childbearing age with opioid use disorders who may become pregnant are significant.

If there's any group for whom methadone and buprenorphine are clearly the best treatment for opioid use disorders, it's pregnant women. The risks to the fetus of opioid withdrawal in utero are clear: low birth weight, miscarriage, death. Yet, many pregnant women in the United States are not getting these treatments, according to the report.

The treatment provided to these women was not always the gold standard. Only half of the women who reported heroin misuse received methadone or buprenorphine as treatment, and even fewer of those who had misused nonheroin opioids received methadone or buprenorphine as treatment.

Finally, not all facilities accepted Medicaid as a form of payment.

"It is critical that pregnant women of all ages have access to prevention, treatment and recovery services that meet their specialized needs," said Deputy Assistant Secretary for Mental Health and Substance Use Kana Enomoto. "Programs that provide pregnant women with access to opioid use disorder treatment and reproductive health services can help ensure that these future mothers and their children live healthier, happier and more productive lives."

The report was issued around the same time as the report to Congress on neonatal abstinence syndrome, in which one controversial recommendation was the possibility of using Vivitrol in pregnant women with opioid use disorders (see *ADAW*, Feb. 6). There is no evidence base to support the safety of Vivitrol during pregnancy.

'It is critical that pregnant women of all ages have access to prevention, treatment and recovery services that meet their specialized needs.'

Kana Enomoto

Data limitations

The report found that 21,553 female substance abuse treatment admissions aged 15 to 44 were pregnant at treatment entry. Younger age was associated with past-month misuse of opioids by pregnant women: 18-to-25-year-olds were three times more likely to have misused opioids, and 15-to-17-year-olds were four times more likely. Overall, 1.5 percent of pregnant women age 18 to 25 misused opioids during the past month, compared to 2.8 percent of 15-to-17-year-olds; 0.5 percent of women ages 26–44 misused opioids in the past month.

Between 2000 and 2009, in the United States, the number of infants born to women who had used opioids increased nearly fivefold annually, from 1.19 to 5.63 per 1,000 hospital births.

H. Westley Clark, M.D., former director of SAMHSA's Center for Substance Abuse Treatment (CSAT) — and, for a short period, director of the Center for Behavioral Health Statistics and Quality — pointed out the limitations of the data. First of all, the data by definition have different approaches. NSDUH data provide information on opioid misuse among women of childbearing age in the general population, whereas TEDS data focus on women of childbearing age who have been admitted to substance use treatment for opioid misuse. N-SSATS data describe specialized, relevant services offered to women within the nation's substance use treatment facilities.

"I want to stress that the findings are interesting, but the TEDS data and N-SSATS data may be incomplete," said Clark. In particular, the data do not take into account proprietary programs or private physicians prescribing buprenorphine. Almost half of all methadone clinics are proprietary (private for-profit).

According to SAMHSA, neither TEDS nor N-SSATS data include private physicians. "TEDS data are administrative data that SAMHSA receives directly from states," explained Bradford Stone, acting director of SAMHSA's Office of Communications. States receive TEDS data from facilities that receive some public funding, including the federal Substance Abuse Prevention and Treatment Block Grant funds and/or are licensed or certified by the SSA to provide substance abuse treatment, said Stone. TEDS is admission-based data where SAMHSA receive treatment information on an admission of a client. "Some facilities report all clients; some report only publicly funded clients," he said. "To the extent that an OTP receives public funding, it would report to TEDS. If an OTP does not receive public funding, it most likely would not report to TEDS. We have no way to determine which specific facilities would be in this category. TEDS data do not include admissions data from private practitioners."

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N-SSATS is an annual survey of substance use treatment facilities, added Stone. N-SSATS surveys certified opioid treatment programs (OTPs), both public and private, but does not survey private doctors prescribing buprenorphine.

"Some SSAs regulate private facilities and methadone clinics and require them to report TEDS data," said Stone. "Others do not because of the difficulty in obtaining data from these facilities, although these facilities may report voluntarily."

Facilities operated by federal agencies (e.g., the Bureau of Prisons, the Department of Defense and the Department of Veterans Affairs) generally do not report TEDS data to the SSA, although some facilities operated by the Indian Health Service are included. Hospital-based substance abuse treatment facilities are frequently not licensed through the SSA and do not report TEDS data. Correctional facilities (state prisons and local jails) are monitored by the SSA and report TEDS data in some states but not in others. Generally, individual practitioners do not report TEDS data.

The NSDUH surveys the general population, but TEDS and N-SSATS, because they rely heavily on information from treatment providers in the public system (Medicaid and block grant), are more linked to the low-income population. If indeed the frequency of the opioid problem among pregnant women is so low that SAMHSA needed to use data from five years of surveys, then this low-frequency, low-occurrence event is being sensationalized, said Clark, who is now Dean's Professor at Santa Clara University.

"There is no question that NAS and opioid use are problems that must be addressed," said Clark. "However, annual NSDUH data suggest that as soon as most women using drugs discover that they are pregnant, their substance use decreases." For the few who continue to use opioids, there may be unique clinical needs that affect their babies and themselves, said Clark. "Mental health issues, physical issues and other issues may be operating and should be explored," he said.

"It is unclear, and cannot be substantiated, that TEDS and N-SSATS are only capturing information germane to low-income clients," said SAMHSA's Stone. •

For the report, go to https://www.samhsa.gov/data/sites/default/files/report_2724/ShortReport-2724.html.

Protecting Our Infants Act draft report: Key recommendations

Below are the key recommendations in the draft report prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) in response to the Protecting Our Infants Act (see related story, *ADAW*, February 6).

Data and evaluation

- Standardize data collection and survey activities to ensure consistency and a more systematic approach to building a fuller and more nuanced picture of prenatal substance exposure, the multiple social and environmental variables involved in access to treatment for pregnant and parenting women with OUD [opioid use disorder], disparities in access, and differences in prenatal opioid use and use disorders in pregnant women between demographic groups.
- Expand implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to allow hazardous and harmful substance use to be addressed and SUD [substance use disorder] to be treated prior to conception, and to provide women at risk with access to the full range of contraceptive options.
- Place greater emphasis on collecting high-quality data, as well as developing and adopting strong, validated screening instruments for substance use among pregnant women and NAS [neonatal abstinence syndrome] in infants.
- Establish a clear definition of NAS and NOWS [neonatal opioid withdrawal syndrome] and more consistent use of this terminology.
- Increase the likelihood that women who use opioids will obtain needed prenatal care and be comfortable disclosing opioid misuse to their health care providers.

Research and evaluation

- Improve data collection so that the differences and scope of prenatal substance exposure, access to treatment, barriers to access, and disparities in access can be fully understood and inform the development of targeted and effective research agendas.
- Conduct further research to define and understand the elements of an effective risk–benefit assessment in order to counsel pregnant women with pain about the use of opioids for pain versus other pharmacotherapies, nonpharmacologic interventions, and the use of these interventions for themselves, their pregnancy, and their infants.
- Conduct studies to examine the extent and impact of polysubstance use on the outcomes of opioid exposure in pregnancy and NAS/NOWS, and the effects of prenatal opioid exposure through childhood.
- Facilitate and coordinate data sharing and data analysis activities across HHS agencies so that findings will be more comprehensive and bring a more robust understanding to substance use and its impact on children/youth

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and families.

- Undertake research to identify behaviors that can mitigate the risk of NAS for infants of women who, for medical reasons, receive prescription opioid therapy or MAT [medication-assisted treatment] during pregnancy.
- Undertake research to distinguish between the needs and outcomes of women of different ages, and between women who become pregnant while being treated with an opioid for pain, women on MAT and women with untreated SUD.
- Undertake research on how best to make NAS and NOWS assessment more objective and reliable.
- Conduct policy analysis and implementation studies to determine how to overcome institutional, social, legal, and other system barriers to the adoption of MAT and determine the most effective means of delivering MAT to women who are pregnant or parenting.
- Improve access to the full range of contraceptive options for women who receive opioids.
- Improve access to early intervention services for substance-exposed infants.

Programs and service delivery

- Improve data collection so that the scope of the prenatal substance exposure, access to treatment, barriers to access, and disparities in access can be fully understood and inform the development of targeted and accessible programs and services for pregnant and parenting women with OUD and substance-exposed infants.
- Expand services for women with opioid use and their children and ensure more consistent evidence-based resource allocation.
- Develop more family-friendly OUD treatment programs providing appropriate services for women during pregnancy and for mothers and infants following childbirth.
- Work to remove deterrents to treatment for women and promote the adoption of evidence-based practices, including MAT.

Education

- Promote improved public and health professional understanding of OUD as a brain disease responsive to treatment, and of NAS/NOWS as a medical condition that can be prevented, minimized, and effectively treated with available interventions.
- Increase efforts to train obstetricians, emergency department personnel, and community-based primary care providers on the need to take the cultural and social perspectives of at-risk and pregnant women into account when providing them with SUD treatment guidance, with special consideration for reducing the potential impact of NAS. Ensure prescribing providers, in particular obstetrician-gynecologists, family physicians, orthopedists, general surgeons, and dentists, are well trained in appropriate pain management during pregnancy, including the appropriate prescribing practices for opioids when needed.

HHS recommendations to prevent opioid-exposed pregnancy and NAS/NOWS

- Improve and expand the use of SBIRT to identify women in need of intervention or treatment.
- Better define the elements of an effective risk–benefit assessment in order to counsel pregnant women with pain regarding the appropriate use of opioids.
- Research the consequences of unrelieved pain and the safety and effectiveness of naltrexone use for OUD in pregnancy.
- Increase access to the full range of contraceptive options and SUD treatment for women at risk of experiencing a substance-exposed pregnancy.
- Develop family-friendly services.
- Promote public awareness of SUD as a disease and the effectiveness of treatment.

HHS recommendations to prevent prenatal opioid exposure

- Standardize terminology and promote a unified approach to data collection and reporting.
- Conduct research on effective and safe non-opioid pharmacotherapy and non-pharmacologic pain relief strategies during pregnancy and breastfeeding.
- Improve access to parental support and early intervention services.

HHS recommendations to meet the treatment needs of women

- Develop valid screening instruments.
- Collect substance- and diagnosis-specific data.
- Conduct research on maternal risk and protective factors, prenatal prescription opioid use for pain relief, effective and safe non-opioid pharmacotherapy and non-pharmacologic pain relief strategies during pregnancy and breastfeeding, and the safety and effectiveness of naltrexone, which has not been studied for use during pregnancy or breastfeeding and so has uncertain safety and efficacy.
- Support the continuation of treatment for SUD postpartum.
- Develop effective strategies to support informed decision making around pain management or SUD treatment.
- Promote breastfeeding, if no contraindications exist.
- Provide continuing medical education for providers.

HHS recommendations to meet the treatment needs of children

- Establish clear definitions of NAS and NOWS.
- Standardize the use of relevant ICD [International Classification

of Diseases] codes.
- Establish evidence-based protocols to identify and manage NAS and NOWS. Determine optimal toxicology screening of infants.
- Promote nonpharmacologic interventions.
- Promote breastfeeding, if no contraindications exist.
- Provide continuing medical education for providers.

HHS recommendations to meet the service-delivery needs of women

- Collect substance- and diagnosis-specific data.
- Provide family-friendly SUD treatment.
- Promote public and health-professional awareness of OUD and strategies to meet the unique needs of women who required SUD treatment.

HHS recommendations to meet the service-delivery needs of children

- Identify a history of prenatal opioid exposure and NAS or NOWS during developmental assessments, early interventions, or entrance into the child welfare system.
- Determine and promote optimal family and developmental support services.
- Conduct research on the long-term developmental effects of prenatal substance exposure.
- Provide developmental assessment and early intervention services.
- Promote nonpharmacologic interventions, such as rooming in, for managing mild to moderate NAS/NOWS. •

For the full draft report, including information on how to comment, go to https://www.regulations.gov/document?D=SAMHSA-2016-0004-0001. Comments are due by Feb. 21.

Buprenorphine initiation in ED shows benefits at 2 months follow-up

A second study by Yale researchers supports initiating treatment with buprenorphine in the emergency department (ED). The study, "Emergency Department-Initiated Buprenorphine for Opioid Dependence With Continuation in Primary Care: Outcomes During and After Intervention" was published online Feb. 13 in the *Journal of General Internal Medicine*.

A study published in the *Journal of the American Medical Association* in 2015 by the same researchers showed that patients with opioid use disorders are much more likely to be treated if the treatment starts in the ED than if they are referred elsewhere (see *ADAW*, May 11, 2015).

The study published this month is a follow-up from the randomized trial. Both studies were led by David Fiellin, M.D., Yale University professor of medicine and the principal investigator in the clinical trials that established buprenorphine as a treatment for opioid use disorder, and Gail D'Onofrio, M.D., chair of emergency medicine at Yale.

In the original randomized trial, 290 individuals with opioid use disorder were given one of three interventions when they visited the ED: a referral to treatment; a brief interview, including discussion of treatment; or a brief interview and buprenorphine induction (with continued medication provided by primary care).

The researchers evaluated patients at two, six and 12 months following the ED interventions, assessing participation in treatment, opioid use and HIV risk. Patients were also given urine tests.

At the end of two months, patients who received buprenorphine from the ED were more likely to be in formal addiction treatment, and also to report reduced opioid use, compared to the other two groups.

However, outcomes at six and 12 months were the same across all three groups.

Overall, the study showed that the ED visit is a good place to initiate treatment, the researchers said. "The ED visit is an ideal opportunity to identify patients with opioid use disorder and initiate treatment and direct referral, similar to best practices for other diseases, such as high blood pressure and diabetes," said D'Onofrio.

The researchers are currently leading a study funded by the National Institute on Drug Abuse on disseminating the model in four cities.

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tions General Assembly Special Session on the World Drug Problem last April in New York City.

Milkman, who has lectured frequently in Iceland, was an architect of a Denver program that in the 1990s received federal funding to offer appealing activities and life-skills training to youths at risk for substance use problems. Efforts resembling Project Self-Discovery can be found only in limited pockets of the country today.

"To generalize my program is not an easy thing to do," Milkman said.

Foundation of approach

Milkman said that in the early 1990s he became interested in how the substance-affected brain works, theorizing that individuals were actively seeking to change their brain chemistry. For those individuals who were motivated by feelings of arousal (others pursued relaxation, or fantasy), risk-taking activities and drug-using behavior were common.

This got Milkman to thinking, "Why not create a social movement for natural highs?", in place of the

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high that could be generated from higher-risk behaviors.

Partnering with a renowned local African-American dance company in Denver, Milkman wrote a grant for an initiative that would receive $1.2 million from the federal Center for Substance Abuse Prevention (CSAP). Targeting at-risk youths ages 14 to 18, Project Self-Discovery gave these young people a three-month dose of whatever activities they wanted, from dance classes to wilderness adventures. The offerings were tailored to the individual's interests. The results of the initiative included reduced drug use and less criminal conduct, Milkman said.

The Office of Juvenile Justice and Delinquency Prevention would later take up the funding of the program from CSAP. "I ran it for 10 years, and those who went through it are still talking to me today," Milkman said. One of these youths, who formerly was gang-involved and now is a Georgia tattoo artist, helped coin the phrase that became a motto for Project Self-Discovery: "Better Than Dope."

Milkman was invited to Iceland in the early 1990s to discuss his work and ended up consulting on the first residential treatment center for adolescents in the sparsely populated country of around 330,000. Iceland ultimately would craft a nationwide prevention approach that, unlike Milkman's tertiary prevention effort, would serve as a primary prevention initiative for all young people.

The effort in Iceland was highly data-driven, as annual school-based surveys of teens identified substance use trends and the factors that either exacerbated or protected against risk. Some of the strongest protective factors included participation in sports or other organized activities several times a week, as well as not being outside late at night.

Government officials in Iceland responded on several fronts, including increased public funding for youth sports and clubs, tighter restrictions on alcohol and tobacco sales and advertising, and a mandatory curfew for youths ages 13 to 16. Milkman admits that it would be difficult to see top-down mandates such as curfews imposed in the United States.

More generally, "What the Icelanders have been able to demonstrate is that in order to make changes, you need a community-by-community approach," Milkman said. "They present what kinds of problems each community has, and what kinds of resources each community has." In essence, the effort therefore has both nationally driven and community-controlled components.

Milkman cites what he termed "truly phenomenal" numbers in his *Huffington Post* article, as the percentage of Iceland youths ages 15 and 16 who reported being drunk in the last 30 days dropped from 42 percent in 1998 to 5 percent in 2016. Daily cigarette smoking fell from 23 percent to 3 percent in the same period, he reported.

The size of Iceland's population offers government officials there an advantage that strategists in the United States don't hold. In addition, Iceland is a country where everyone has health insurance, and youth are well-cared for, drinking mainly out of boredom. What works there is not likely to work here — and certainly not without research proving it is effective here.

Pockets of effort

Milkman is quoted in the article in *The Atlantic* as saying, "With Project Self-Discovery, it seemed like we had the best program in the world. I was invited to the White House twice. It won national awards. I was thinking: this will be replicated in every town and village. But it wasn't."

He cited in his interview with *ADAW* a small handful of places where similar efforts that are built on creating natural highs and that de-emphasize standard drug education continue. A natural-highs program in Boulder, Colorado, has 200 teens going into the schools to meet with peers. In three locations on the Hawaiian island of Oahu, a full-blown version of Project Self-Discovery flourishes, thanks largely to significant funding support from the state, according to Milkman.

ADAW asked the Substance Abuse and Mental Health Services Administration for comments about Iceland's approach and received this statement from agency spokesperson Bradford W. Stone: "We are familiar with certain aspects of this approach and hope to learn more about it, just as we are eager to hear of any approach that can help promote substance use prevention among young people. We are particularly interested in evidence-based practices that hold promise in working in a wide variety of diverse communities throughout the U.S." •

Coming up…

The **National Association of Addiction Treatment Providers** National Addiction Leadership Conference will be held **May 21–23** in **Austin, Texas**. Go to **https://www.naatp.org/training/national-addiction-leadership-conference** for more information.

In case you haven't heard…

Last week, Politico White House reporter Tara Palmeri, in an in-depth look at Kellyanne Conway, said the president's counselor has taken over the "opioid abuse portfolio." We asked Palmeri how she knew this. "She told me," she said. For the story, go to http://politi.co/2lYjTGW.