

Library Watch

substance use
policy issues

www.project cork.org

winter 2012

"But my doctor recommended pot": Medical marijuana and the patient-physician relationship.

Nussbaum AM; Boyer JA; Kondrad EC. *Journal of General Internal Medicine* 26(11): 1364-1367, 2011. (16 refs.)

As the use of medical marijuana expands, it is important to consider its implications for the patient-physician relationship. In Colorado, a small cohort of physicians is recommending marijuana, with 15 physicians registering 49% of all medical marijuana patients and a single physician registering 10% of all patients. Together, they have registered more than 2% of the state to use medical marijuana in the last three years. We are concerned that this dramatic expansion is occurring in a setting rife with conflicts of interest despite insufficient scientific knowledge about marijuana. This system diminishes the patient-physician relationship to the recommendation of a single substance while unburdening physicians of their usual responsibilities to the welfare of their patients. Copyright 2011, Springer.

Are prescription stimulants "smart pills"? The epidemiology and cognitive neuroscience of prescription stimulant use by normal healthy individuals.

Smith ME; Farah MJ. *Psychological Bulletin* 137(5): 717-741, 2011. (137 refs.)

Use of prescription stimulants by normal healthy individuals to enhance cognition is said to be on the rise. Who is using these medications for cognitive enhancement, and how prevalent is this practice? Do prescription stimulants in fact enhance cognition for normal healthy people? We review the epidemiological and cognitive neuroscience literatures in search of answers to these questions. Epidemiological issues addressed include the prevalence of nonmedical stimulant use, user demographics, methods by which users obtain prescription stimulants, and motivations for use. Cognitive neuroscience issues addressed include the effects of prescription stimulants on learning and executive function, as well as the task and individual variables associated with these effects. Little is known about the prevalence of prescription stimulant use for cognitive enhancement outside of student populations.

Among college students, estimates of use vary widely but, taken together, suggest that the practice is commonplace. The cognitive effects of stimulants on normal healthy people cannot yet be characterized definitively, despite the volume of research that has been carried out on these issues. Published evidence suggests that declarative memory can be improved by stimulants, with some evidence consistent with enhanced consolidation of memories. Effects on the executive functions of working memory and cognitive control are less reliable but have been found for at least some individuals on some tasks. In closing, we enumerate the many outstanding questions that remain to be addressed by future research and also identify obstacles facing this research. Copyright 2011, American Psychological Association.

Association of substance use and VA service-connected disability benefits with risk of homelessness among veterans.

Edens EL; Kaspro W; Tsai J; Rosenheck RA. *American Journal on Addictions* 20(5): 412-419, 2011. (38 refs.)

Recent public attention on homelessness has shifted beyond emergency services and supportive housing to primary prevention. This study compares a national sample of homeless and nonhomeless Veterans Affairs (VA) mental health services users to determine risk and protective factors for homelessness. Using VA administrative data, veterans were identified as homeless (ie, used VA homeless services or received a diagnostic code for "lack of housing") or nonhomeless and compared using logistic regression. Additional analyses were conducted for two low-risk subgroups: veterans who served in current Middle East wars (Operation Enduring Freedom [OEF]/Operation Iraqi Freedom [OIF]) and veterans with $\geq 50\%$ service-connected disability. Among all VA mental health users, OEF/OIF (odds ratio [OR] = 0.4) and $\geq 50\%$ service-connected (OR = .3) veterans were less likely to be homeless. In the overall and subgroup analyses, illicit drug use (OR = 3.3-4.7) was by far the strongest predictor of homelessness, followed by pathological gambling (PG) (OR = 2.0-2.4), alcohol use disorder (OR = 1.8-2.0), and having a personality disorder (OR = 1.6-2.2). In both low-risk groups, severe mental

illness (schizophrenia or bipolar disorder), along with substance use disorders, PG, and personality disorders, increased homelessness risk. Substance use, PG, and personality disorders confer the greatest modifiable risk of homelessness among veterans using VA services, while service-connected disability conferred reduced risk. Clinical prevention efforts could focus on these factors. Copyright 2011, Wiley-Blackwell.

Attitudes of Florida pharmacists toward implementing a state prescription drug monitoring program for controlled substances.

Fass JA; Hardigan PC. *Journal of Managed Care Pharmacy* 17(6): 430-438, 2011. (38 refs.)

BACKGROUND: As of May 23, 2011, 35 states had an operational prescription drug monitoring program (POMP), and 13 additional states, including Florida in 2009, had passed legislation to implement a POMP. PDMPs, electronic databases that collect and track designated data on controlled substances and other commonly abused medications, are intended to serve as a tool for health care practitioners when prescribing and dispensing controlled substances to reduce drug abuse and diversion. In an analysis of 1,268 drug-caused deaths from January through June 2010 in Florida, the top 3 prescription drugs included the controlled substances oxycodone (56%), alprazolam (35%), and methadone (26%), all of which would be subject to reporting in Florida's POMP when implemented. Because pharmacists are the health care professionals most affected by POMP reporting requirements, evaluating their attitudes about POMP implementation is important. **OBJECTIVES:** To assess Florida pharmacists' attitudes toward implementing a POMP in the state. **METHODS:** This was a cross-sectional study conducted in Florida between February 2010 and June 2010 prior to the implementation of the proposed POMP. A random sample of 5,000 of approximately 26,000 pharmacists licensed in Florida was invited to participate in a voluntary and anonymous 10-question self-administered mail survey of which 4 survey items assessed pharmacists' attitudes towards implementing a POMP in the state. **RESULTS:** Of the 5,000 pharmacists contacted by mail, 911 (18.2%) completed the survey, of whom 836 responded to the items assessing opinions about PDMPs and provided practice site information. A majority of pharmacists across all practice settings agreed or strongly agreed with the statements that a POMP "should be implemented in Florida" (chain 84.0%, hospital 74.2%, independent 77.9%, and other 71.1%) and that a POMP would decrease "the incidence of doctor shopping" if implemented (chain 80.8%, hospital 67.2%, independent 71.7%, and other

63.3%). A majority of pharmacists across all practice settings disagreed or strongly disagreed with the statements that they would be "discouraged to dispense controlled substances" by the POMP (chain 61.4%, hospital 50.0%, independent 60.2%, and other 63.8%) and that POMP implementation would be "an invasion of patients' privacy" (chain 80.3%, hospital 67.7%, independent 67.3%, and other 69.3%). **CONCLUSION:** In a small-sample survey, a majority of Florida pharmacists across all practice settings were in favor of implementing a POMP in Florida. This is the first study to examine Florida pharmacists' attitudes toward POMP implementation, and the results should prompt future analyses of relevant outcomes, such as drug abuse, drug-related mortality, and doctor shopping. Copyright 2011, Academy of Managed Care Pharmacy.

Availability of substance abuse treatment services in Spanish: A GIS analysis of Latino communities in Los Angeles County, California.

Guerrero EG; Pan KB; Curtis A; Lizano EL.

Substance Abuse Treatment, Prevention and Policy 6: e-article 21, 2011. (39 refs.)

Background: The percentage of Latino clients entering outpatient substance abuse treatment (OSAT) in the United States has increased significantly in the past 10 years. Evidence suggests that a lack of services in Spanish is a significant barrier to treatment access among Latinos. **Methods:** Using a geographic information system (GIS) approach, data from the U.S. Census Bureau and the National Survey of Substance Abuse Treatment Services (N-SSATS) were analyzed to determine the geographic distance between OSAT facilities with services in Spanish and Latino communities throughout Los Angeles County, CA. Data from N-SSATS were also analyzed using logistic regression models to examine organizational characteristics and their association with offering services in Spanish. Our GIS methods are tested in their ability to provide baseline measures to inform future analysis comparing changes in demography and service infrastructure. **Results:** GIS analysis revealed cold spots representing high-density Latino communities with extensive travel distance to facilities offering services in Spanish. The average linear distance between Latino communities and facilities offering Spanish-language services ranged from 2 to 6 miles, while the location of the cold spots pointed to a need for services in Spanish in a particular subregion of the county. Further, secondary data analysis revealed that, on average, being privately owned (OR = .23, 95% CI = 0.06-0.90) was associated with a lower likelihood of providing services in Spanish

compared to public facilities. Additionally, a facility with a state license (OR = 2.08, 95% CI = 1.12-3.88) or a higher number of Medicaid recipients (OR = 2.98, 95% CI = 1.76-5.05) was twice as likely to offer services in Spanish. Conclusion: Despite the significant presence of Latinos in L. A. County in 2000, low capacity was found in discrete Latino communities in terms of offering OSAT services in Spanish. Funding and regulation play a significant role in facilities' capacity to offer these services. Future studies should build from our multi-method approach to compare changes in population demography and system infrastructure and inform health care policy that seeks to improve providers' capacity to provide linguistically competent care. Copyright 2011, BioMed Central.

Social policy, and public health perspectives on new psychoactive substances. (review).

Sumnall HR; Evans-Brown M; McVeigh J. *Drug Testing and Analysis* 3(7-8, special issue): 515-523, 2011. (119 refs.)

New psychoactive substances pose a particular challenge to those formulating drugs policy and related public health responses. This paper outlines some of the main issues arising from their use, with a particular focus on user perspectives. Such substances are often (at least initially) produced and distributed for different reasons than controlled drugs. They emerge in users' repertoires undetected by most monitoring systems and general population drug surveys. While reasons for use by innovators and early adopters are often in the spirit of self-experimentation, such substances may rapidly diffuse to the recreational arena as a result of enthusiastic user propagation where they act as substitutes or complements to controlled drugs. The majority of substances are believed to be sourced, albeit not exclusively, from manufacturers based in China. They are retailed to consumers through the Internet and physical shops (such as 'head' and 'smart' shops), as well as traditional 'street dealers' (although data on the significance of this latter route of supply are limited). The data required for risk assessment of the harms such substances may pose, as well as information required for accurate user-derived harm reduction advice, are often limited. Moreover, some involved in the commercial supply have deliberately misbranded products, including substituting the active substance, in apparent attempts to circumvent regulatory frameworks. This leaves users susceptible to both health and criminal justice harms. Despite various attempts to restrict the supply, they often continue to be available through the illicit market, although it is

not yet possible to predict whether they will join other drugs such as MDMA and LSD as mainstays of the recreational pharmacopeia. Copyright 2011, Wiley-Blackwell.

The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine.

Clark RE; Samnaliev M; Baxter JD; Leung GY. *Health Affairs* 30(8): 1425-1433, 2011. (23 refs.)

Many state Medicaid programs restrict access to buprenorphine, a prescription medication that relieves withdrawal symptoms for people addicted to heroin or other opiates. The reason is that officials fear that the drug is costlier or less safe than other therapies such as methadone. To find out if this is true, we compared spending, the use of services related to drug-use relapses, and mortality for 33,923 Massachusetts Medicaid beneficiaries receiving either buprenorphine, methadone, drug-free treatment, or no treatment during the period 2003-07. Buprenorphine appears to have significantly expanded access to treatment because the drug can be prescribed by a physician and taken at home compared with methadone, which by law must be administered at an approved clinic. Buprenorphine was associated with more relapse-related services but \$1,330 lower mean annual spending than methadone when used for maintenance treatment. Mortality rates were similar for buprenorphine and methadone. By contrast, mortality rates were 75 percent higher among those receiving drug-free treatment, and more than twice as high among those receiving no treatment, compared to those receiving buprenorphine. The evidence does not support rationing buprenorphine to save money or ensure safety. Copyright 2011, Project Hope.

Lower Risk Cannabis Use Guidelines for Canada (LRCUG): A narrative review of evidence and recommendations. (review).

Fischer B; Jeffries V; Hall W; Room R; Goldner E; Rehm J. *Canadian Journal of Public Health* 102(5): 324-327, 2011. (49 refs.)

Objectives: More than one in ten adults - and about one in three young adults - report past year cannabis use in Canada. While cannabis use is associated with a variety of health risks, current policy prohibits all use, rather than adopting a public health approach focusing on interventions to address specific risks and harms as do policies for alcohol. The objective of this paper was to develop 'Lower Risk Cannabis Use Guidelines' (LRCUG) based on research evidence on the adverse health effects of cannabis and factors that appear to modify the risk of these harms. Methods: Relevant

English-language peer-reviewed publications on health harms of cannabis use were reviewed and LRCUG were drafted by the authors on the basis of a consensus process. Synthesis: The review suggested that health harms related to cannabis use increase with intensity of use although the risk curve is not well characterized. These harms are associated with a number of potentially modifiable factors related to: frequency of use; early onset of use; driving after using cannabis; methods and practices of use and substance potency; and characteristics of specific populations. LRCUG recommending ways to reduce risks related to cannabis use on an individual and population level - analogous to 'Low Risk Drinking Guidelines' for alcohol - are presented. Conclusions: Given the prevalence and age distribution of cannabis use in Canada, a public health approach to cannabis use is overdue. LRCUG constitute a potentially valuable tool in facilitating a reduction of health harms from cannabis use on a population level. Copyright 2011, Canadian Public Health Association.

Economic costs of excessive alcohol consumption in the U.S., 2006.

Bouchery EE; Harwood HJ; Sacks JJ; Simon CJ; Brewer RD. *American Journal of Preventive Medicine* 41(5): 516-524, 2011. (39 refs.)

Excessive alcohol consumption causes premature death (average of 79,000 deaths annually); increased disease and injury; property damage from fire and motor vehicle crashes; alcohol-related crime; and lost productivity. However, its economic cost has not been assessed for the U.S. since 1998. To update prior national estimates of the economic costs of excessive drinking. This study (conducted 2009-2010) followed U.S. Public Health Service Guidelines to assess the economic cost of excessive alcohol consumption in 2006. Costs for health care, productivity losses, and other effects (e.g., property damage) in 2006 were obtained from national databases. Alcohol-attributable fractions were obtained from multiple sources and used to assess the proportion of costs that could be attributed to excessive alcohol consumption. The estimated economic cost of excessive drinking was \$223.5 billion in 2006 (72.2% from lost productivity,

11.0% from healthcare costs, 9.4% from criminal justice costs, and 7.5% from other effects) or approximately \$1.90 per alcoholic drink. Binge drinking resulted in costs of \$170.7 billion (76.4% of the total); underage drinking \$27.0 billion; and drinking during pregnancy \$5.2 billion. The cost of alcohol-attributable crime was \$73.3 billion. The cost to government was \$94.2 billion (42.1% of the total cost), which corresponds to about \$0.80 per alcoholic drink consumed in 2006 (categories are not mutually exclusive and may overlap). On a per capita basis, the economic impact of excessive alcohol consumption in the U.S. is approximately \$746 per person, most of which is attributable to binge drinking. Evidence-based strategies for reducing excessive drinking should be widely implemented. Copyright 2011, American College of Preventive Medicine.

If substance use disorder treatment more than offsets its costs, why don't more medical centers want to provide it? A budget impact analysis in the Veterans Health Administration.

Humphreys K; Wagner TH; Gage M. *Journal of Substance Abuse Treatment* 41(3): 243-251, 2011. (41 refs.)

Given that many studies have reported that the costs of substance use disorder (SUD) treatment are more than offset by other savings (e.g., in health care, in criminal justice, in foster care), why haven't health care system managers rushed to expand treatment? This article attempts to explain this puzzling discrepancy by analyzing 1998-2006 data from the national Veterans Affairs (VA) health care system. The main outcome measures were annual cost and utilization for VA SUD-diagnosed patients. The key independent variable was the medical centers' annual spending for SUD treatment. There was no evidence that SUD spending was associated with lower medical center costs over time within the medical center that paid for the treatment. Health care system managers may not be influenced by research suggesting that the costs of SUD treatment are more than fully offset because they bear the cost of providing treatment while the savings largely accrue to other systems. Copyright 2011, Elsevier Science..