ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

Volume 36 Number 27
July 15, 2024
Online ISSN 1556-7591

In This Issue...

SAMHSA requests public comment on ICCPUD alcohol intake and health study

Public comment on the proposed Alcohol Intake and Health (AIH) study methodology is due by Aug. 2, 2024. The federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) announced its proposed methodology for the study, which includes literature reviews, interviews with experts and interviews with a population sample, in the Federal Register on June 28. ICCPUD and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly announced the methodology, which, despite ICCPUD's name, is not related to underage drinking only. Comments go to SAMHSA, which is particularly interested in the following:

- Are the topic areas defined in the methodology sufficient for understanding the relationship between alcohol intake and health?
- Is the methodology clear and transparent?

Bottom Line...
In preparation for the next round of dietary guidelines, the federal government is developing a report on the connection between alcohol and health, focusing on how much is safe to drink.

See **ICCPUD** page 2

Report calls for decisive action to guide growth in psychedelics

With interest in psychedelic drugs clearly back on the public's radar, policymakers should act now to take measures that would avoid a repeat of mistakes made during the mass commercialization of cannabis, a new report suggests.

Produced by RAND, "Considering Alternatives to Psychedelic Drug Prohibition" makes the case that states have numerous options outside of the extremes of outright prohibition and the emerging cannabis model. While its authors acknowledge that the market for psilocybin and other psychedelics is considerably smaller than other illegal drug markets, they wrote that the "product proliferation in the cannabis market over the past few decades has been tremendous, and it would be naïve to think this will not occur once the industry has the freedom to innovate in the psychedelics space."

The report focuses on the policy discussions around expanding access to psychedelics for nonclinical use. It does not go into great detail on the growing clinical research initiatives examining psychedelics' potential in the treatment of several health conditions, including substance use disorders. But the

Bottom Line...
A new report from RAND urges the federal government to set clear policy direction around the potential commercialization of psychedelics, as more states consider establishing a legal market for psilocybin and possibly other drugs.

See **Psychedelics** page 7

ICCPUD from page 1

- Are the methods proposed scientifically valid?
- Are the risks of bias identified?
- Are strategies to minimize bias included?
- Are there other methodological approaches that should be considered to estimate the risk of alcohol consumption on specific health outcomes?
- Are the methods proposed subject to major limitations? If so, what strategies could be employed to minimize these limitations?
- Are there additional data sources that should be considered and/or included for a comprehensive understanding of the burden of alcohol-related diseases?
- Are there specific scientific papers or research that should be included in the assessment of risk, or concerns regarding the overall methodology outlined in the document?

The timeline for the project, which includes the involvement of the National Academies of Sciences, Engineering and Medicine (NASEM), started two years ago and is projected to be completed in 2028. Many agencies, including the National Institute on Alcohol Abuse and Alcoholism, are involved.

In 2025, NASEM will provide a synthesis of its study findings related to the health effects of alcohol intake by adults, and ICCPUD will summarize the science for its 2025 Report to Congress.

All of this is in preparation for the 2025–2030 Dietary Guidelines for Americans. The current (2020–2025) guidelines still note two drinks or fewer a day for men, and one drink or fewer a day for women. There are some who contend that no alcohol is safe, others who say that Americans view the 2/1 as an endorsement of drinking that much, and others who, well, just want to drink. America is a drinking nation, and alcohol-related deaths have gone up along with alcohol consumption.

Below are some of the methodologies proposed:

Injuries

Collecting and generating evidence on weekly thresholds to minimize health risks: Two methods can be used to generate evidence on weekly thresholds to minimize health risks associated with different levels of average alcohol consumption: (i) the examination of all-cause absolute risk curves from cohort studies (which include deaths from all causes, including conditions from which a causal relationship with alcohol use has not been determined); and (ii) the modelling of lifetime all-cause, absolute alcohol-attributable mortality and morbidity risk curves by combining data on cause-specific relative risks with corresponding data on absolute mortality risks for lifetime abstainers.

The second step in the estimation of the relative risks for people in the United States who drink (i.e., people who consumed alcohol in the past year; RRD) is based on the average amount of alcohol consumed per day (operationalized as x). The process used to estimate the RRD is based on data regarding the population attributable fractions of road injuries (using toxicology reports on blood alcohol content [BAC] as a proxy) and data on alcohol use. While a proportion of injuries that occur among people who have a BAC below 0.10 g/dL may also be causally associated with alcohol (in particular among people with a BAC between 0.05 to 0.10 g/dL), these injuries are not modelled due to a lack of certainty as to whether they are attributable to alcohol use. The derivation of the relative risk for an alcohol-attributable injury among drinkers (RRD) is based on the estimate of the population relative risk (compared to a counterfactual scenario of everyone in the population abstaining from alcohol for their lifetimes).

Health conditions

To ensure the selection of the most precise relative risks for each

ALCOHOLISM & DRUG ABUSE WEEKLY
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Alcoholism & Drug Abuse Weekly (Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Monday in April, the second Monday in July, the first Monday in September, and the first and last Mondays in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Online only: $672 (personal, U.S./Can./Mex.), £348 (personal, U.K.), €438 (personal, Europe), $672 (personal, rest of world), $8717 (institutional, U.S./Can./Mex.), £4451 (institutional, U.K.), €5627 (institutional, Europe), $8717 (institutional, rest of world). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at +1 877 762 2974; email: cs-journals@wiley.com.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO MasterFILE Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), ProQuest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

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condition causally linked to alcohol use, nominal group members will receive data extracted from systematic reviews and meta-analyses, along with the A Measurement Tool to Assess Systematic Reviews (AMSTAR 2) checklist and the Risk of Bias in Systematic Reviews (ROBIS) tool for each review. With this information at hand, experts within each group will rank the meta-analyses and provide free-form comments on the ranking. For the second round of reviews, all participants in the expert group will receive summary statistics of the article rankings, along with any comments from other experts. Group members will then be asked to re-rank the top seven reviews (or all reviews if fewer than seven systematic reviews exist).

The results of this ranking exercise will be processed using a Borda count algorithm to select the most accurate systematic review (Emerson, 2013). In the event of a tie in the top-ranked systematic review, each expert group will vote to determine the most accurate systematic review among the tied systematic reviews.

To understand how our assessment of the health impacts of alcohol use align with the alcohol consumption of the general public, the study will examine alcohol use in the general population using data from the National Alcohol Survey, National Survey on Drug Use and Health, National Health Interview Survey, The National Epidemiologic Survey on Alcohol and Related Conditions - III (NESARC-III), and Behavioral Risk Factor Surveillance System (BRFSS) in order to obtain data on alcohol exposure in the United States. These population surveys, which have differing sampling frames, response rates and validation of self-reporting of alcohol use, provide comprehensive data on alcohol consumption patterns and allow estimations of the prevalences of different levels of alcohol use in the population.

"To understand how our assessment of the health impacts of alcohol use align with the alcohol consumption of the general public, the study will examine alcohol use in the general population..."

ICCPUD

To gain an understanding of the public's understanding and reaction to the risks of alcohol use on health produced by this project, we will engage in public consultations. This will involve a mixed methods design focusing on Americans' alcohol use and whether they are trying to follow the alcohol consumption guidance in the Dietary Guidelines for Americans, 2020–2025 and their reasons for following or not following the guidelines; (vii) their requirements for and expectations of the Dietary Guidelines for Americans, 2026–2030; (viii) what information they found useful about the project's assessment on alcohol and health; and (ix) what challenges they had in interpreting the project's assessment on alcohol and health.

About ICCPUD

The Interagency Coordinating Committee on the Prevention of Underage Drinking provides national leadership in federal policy and programming to support state and community activities that prevent and reduce underage drinking. The ICCPUD's role is especially important in light of these key facts:

- Alcohol remains the number one substance used by people under the age of 21;
- Binge drinking (consuming four or more drinks at a time by females and five or more drinks by males) is a common consumption pattern among underage drinkers; and
- Underage drinking, especially binge drinking, results in many public health harms and societal costs, including deaths from traffic crashes, sexual assaults and other violence, and changes in normal brain development.

The ICCPUD was created in 2004 when Congress directed the Secretary of the U.S. Department of Health and Human Services to establish an interagency committee to coordinate all federal agency activities related to the problem of underage drinking. The ICCPUD's role was formalized in the 2006 Sober Truth on Preventing Underage Drinking (STOP) Act, which was reauthorized in 2016 as part of the 21st Century Cures Act. SAMHSA was directed to supervise and convene ICCPUD. •

For the announcement and request for comment, as well as how to comment, go to https://www.federalregister.gov/documents/2024/07/03/2024-14650/the-interagency-coordination-committee-on-the-prevention-of-underage-drinking-requests-for-public?utm_source=SAMHSA&utm_campaign=6a753d590d-EMAIL_CAMPAIGN_2024_06_26_03_38&utm_medium=email&utm_term=0_-6a753d590d-%5BLIST_EMAIL_ID%5D.

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NIAAA: Craving reduction and alcohol—a measure of recovery?

In the last issue, we wrote about research using craving reduction as a measure of recovery from drug addiction (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.34167), based on coverage at the College on Problems of Drug Dependence (CPDD) from National Institute on Drug Abuse (NIDA) researchers. We wanted to find out whether craving reduction can also be used as a measure of recovery from alcohol use disorder (AUD). So we asked George F. Koob, Ph.D., director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), who, with Laura E. Kwako, Ph.D., chief of NIAAA's treatment, health services and recovery branch, responded to our questions.

Here are their responses.

ADAW: Can reduction of craving for alcohol be used as a measure of recovery?

NIAAA: While the literature on the associations between craving and recovery is somewhat mixed, studies have found that higher levels of craving during and after treatment are associated with higher rates of relapse (e.g., https://onlinelibrary.wiley.com/doi/full/10.1111/j.1521-0391.2012.00297.x, https://www.sciencedirect.com/science/article/pii/S0376871621007481). Thus, reduction of craving may be considered a desirable outcome in recovery, as it is associated with lower rates of relapse among some individuals with AUD.

It is likely that the duration of recovery is relevant for the importance of craving, as well. Many people in early recovery, particularly from moderate to severe AUD, continue to experience craving for alcohol. That experience does not mean that recovery isn't beneficial or is "failing," rather, that reduction of craving likely takes longer to abate for those individuals.

Indeed, think of tobacco smoking. It is well known that a form of craving persists for years, even a lifetime for tobacco craving. For this reason, the NIAAA operational definition of recovery criteria of remission of *DSM-5* criteria excludes the criteria of craving.

If an individual in treatment is experiencing significant craving for alcohol in early recovery, it's an indicator that additional forms of treatment, e.g., medications for AUD, may be beneficial. Naltrexone, FDA-approved to treat AUD, reduces the rewarding effects of alcohol consumption. Many people who take naltrexone to treat AUD report that it reduces or eliminates their craving for alcohol. Note that another contribution to craving is the presence of negative emotional states, which exacerbate the craving associated with cues. Here, both acamprosate and gabapentin can help with craving.

ADAW: Is abstinence necessary to reduce craving? Researchers who presented at CPDD reported that they found that reduction in use also led to reduction in craving. (The question applies to alcohol.)

"It is likely that the duration of recovery is relevant for the importance of craving, as well. Many people in early recovery, particularly from moderate to severe AUD, continue to experience craving for alcohol. That experience does not mean that recovery isn't beneficial or is "failing"...."

NIAAA

NIAAA: There is no definitive answer to this question. One study (https://onlinelibrary.wiley.com/doi/full/10.1111/adb.12934) found that among individuals dependent on alcohol, alcohol craving in the presence of alcohol cues increased with [the] number of days abstinent. However, this study only went up to 26 days of abstinence. Moreover, the impact of abstinence on craving likely also depends on the amount of alcohol initially being consumed, such that the higher the level of consumption, the more likely it is that (protracted) abstinence will be required to reduce craving. That process may be facilitated by medications for AUD, as described above. For individuals with lower levels of alcohol consumption, who may or may not have mild AUD, reduction in alcohol consumption may be sufficient to reduce craving for alcohol.

ADAW: Are there any studies of how to measure craving/reduction of craving for alcohol?

NIAAA: Measurement of craving for alcohol has been widely studied. The Penn Alcohol Craving Scale (PACS) is a commonly used self-report measure of craving for alcohol. It has excellent psychometric properties and has been used in many studies on craving for alcohol. Reference: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1530-0277.1999.tb04349.x.

Other self-report measures of craving include the Alcohol Urge Questionnaire, Obsessive-Compulsive Drinking Scale (Obsessive Subscale), and visual analog scales of craving. Studies have also used measures of physiologic response to alcohol stimuli as a proxy for alcohol craving. The latter methodology falls under the measure of alcohol cue reactivity, i.e., the level of an individual's reactivity to alcohol cues.

ADAW: The time-worn recommendations by non-clinicians for

alcohol, i.e., "ride the wave," "don't get hungry, angry, lonely or tired," "stay away from people, places and things," that trigger craving such as bars and parties where there's drinking, "avoid having alcohol in your house," were not even remotely referred to in the CPDD drug craving session.

NIAAA: Many of these recommendations are made by clinicians as well as non-clinicians and are applicable to alcohol craving and methods for "riding out" the urge to drink. In particular, given studies on cue reactivity (i.e., craving resulting from exposure to people, places and things), implementing these kinds of concrete behavioral approaches is an important part of reducing craving and facilitating recovery. "Urge surfing" and stress reduction techniques (which also address the negative emotion side of craving), are regularly taught by health care professionals to people with AUD as a means of sustaining recovery, and for good reason. They can typically be done anytime, anywhere, and are often free (e.g., breathing techniques) or low-cost.

ADAW: For opioids, the point of using methadone or buprenorphine is to therapeutically remove craving by replacing the other opioid with a therapeutic one. There was no reference at the CPDD craving talk for naltrexone (which blocks opioids).

NIAAA: As described above, studies on naltrexone indicate that it can reduce craving for alcohol among individuals with AUD, while not eliminating craving entirely. Many individuals with AUD find that this reduction in craving helps them "get over the hump" of early recovery and is a useful tool in the toolbox of treatment approaches. For opioids, naltrexone is effective in treatment for opioid addiction, but compliance is a real problem. One has to be very careful of the timing of taking naltrexone because in early abstinence from opioids, naltrexone can precipitate an intense withdrawal syndrome. •

What Chevron doctrine's rejection by Supreme Court means

In the substance use disorder (SUD) field, one regulation in particular stands out in reference to last month's ruling by the Supreme Court to cut back on federal agencies' power to interpret laws. It's Charitable Choice, a law developed by the administration of former President George W. Bush that said a person could get a voucher supported by federal dollars to go to, for example, a church, to have, for example, prayer solve their addiction. It's a perfect example of what could happen when the full weight of the Supreme Court's ruling on the Chevron doctrine is brought to bear.

What happened: The 1984 decision in *Chevron U.S. A. Inc. v. Natural Resources Defense Council* said that if Congress did not specifically address a question in a dispute, a court was required to uphold whatever the federal agency said — in this case, the Environmental Protection Agency. On June 28, 2024, Chief Justice John Roberts, writing for the 6-3 majority, called the doctrine "fundamentally misguided."

Now, a judge can overrule a federal agency's interpretation of a law.

Federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) are better able than a judge to figure out what kind of SUD treatment works best and should be funded. How will the ruling change things?

The main change will be in regulations that are unclear, experts told *ADAW*. "There will still be regulations, but they will be easier to challenge in court," said Andrew Kessler, principal with Slingshot Solutions consulting firm. Kessler represents various SUD and behavioral health clients on issues before Congress and the federal government. "You cannot lobby a judge," he said.

The June 28 case was brought by Loper Bright Enterprises against the Department of Commerce (*Loper Bright Enterprises v. Raimondo*).

"The Loper decision holds that courts do not need to defer to federal agency determinations and rule makings, they can decide what should or should not be rules, even when a federal agency was granted specific rulemaking authority," Rob Kent told *ADAW*. "It guts *Chevron* and the 40 years of federal remaking process and opens the door wide open for lawyers to challenge not just the process that was used to make the rule, but the content of the rule itself," added Kent, who was former general counsel for the White House Office of National Drug Control Policy. "This does not undo current rules, but it will make creating or amending rules much more difficult." Kent added that he is concerned about the impact of this ruling may have on the soon to be announced DEA rulemaking concerning the continued us of telemedicine to provide access to buprenorphine."

In addition, *Loper* "opens the door to significantly stalling rulemaking."

So last month's decision means that the rulemaking process can drag on in the courts. It's a win for whoever doesn't like regulations — typically, big corporations, polluters and so on. We are focusing on a tiny part of it. In the case of treatment dollars, who loses? "The people getting services," as one insider told *ADAW*. There are plenty of regulations that big companies like private health insurers aren't fond of, including requirements for education and quality of the treatment workforce. Left up to a judge, where there is no room for public comment, chaos — again, the word used by the dissenters — could reign. •

More than Narcan: Other OD rescue medications may be better

The problem with naloxone — trade name Narcan — is that it isn't strong enough in an era of fentanyl to rescue opioid overdose (OD) victims. This isn't new news, it's been publicized in peer-reviewed journals (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.34062), but it's particularly important now. States have used up all their money for overdose reversal medications on Narcan. And according to experts, not only is it not strong enough, but this policy is going to cause deaths. Last week, as reported in the *Buffalo News*, a coalition of addiction recovery organizations from across New York state has asked Gov. Kathy Hochul and state Comptroller Thomas DiNapoli to get rid of the "purchasing monopoly" on the state's availability of the anti-opioid overdose Narcan.

The *Buffalo News* report noted that Emergent Devices has a $21 million contract with the state Department of Health's contract for the OD-reversal drug naloxone.

"We need you to intervene now, using your executive powers, to open this contract to competitive bid and thus ensure that tax dollars are more efficiently used to procure and distribute more doses of this lifesaving medication," the groups asked the governor in a letter.

"Today, unconscionably, a significant percentage of the public resources dedicated to this program are driving corporate revenues, when, with one swift action by you, these wasted resources can be redirected to procure and distribute more naloxone — and save more lives," the coalition said. "Please act today before we are, yet again, locked into an indefensible sole-source contract that needlessly costs us lives and dollars."

"New York State should end its almost decade long exclusive contract with one maker of naloxone," Rob Kent told *ADAW*. "There are many FDA-approved versions now available. The state is absolutely not getting the best price for the product under the current exclusive arrangement. A competitive procurement, where naloxone makers are asked to offer their best prices per milligram, will save the state money that will allow more of this lifesaving product to be purchased. There is no FDA-preferred version of naloxone. Opioid overdoses have expanded beyond just those who know they are using opioids. New York State must make all tools in the toolbox available." (Kent was, for many years, general counsel for New York's Office of Addiction Services and Supports.)

Kent was formerly general counsel for the White House Office of National Drug Control Policy and the New York Office of Addiction Services and Supports. •

Also see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.34030.

WHO says there's a critical gap worldwide for SUD treatment

In its Global Status Report on alcohol, health, and treatment of substance use disorders (SUDs) released last month, the World Health Organization (WHO) presented a dim picture of how alcohol policies and SUD treatment are failing. The report is based on data collected by WHO from Member States and organized in accordance with the Sustainable Development Goals (SDG) health target 3.5, which calls on countries to strengthen "the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol." The report proposes a new service capacity index for these disorders as an additional contextual indicator for monitoring progress in this domain and concludes with broad directions for international action to accelerate progress towards achievement of SDG health target 3.5.

In a foreword to the report, Tedros Adhanom Ghebreyesus, Ph.D., WHO Director-General, puts it simply: "Despite some reduction in alcohol consumption and related harm worldwide since 2010, the health and social burden due to alcohol use remains unacceptably high." And he noted that "access to quality and ethical treatment for substance use disorders is still largely limited or unaffordable for those most in need."

Worldwide, almost half a billion people who live with alcohol or drug use disorders are not able access treatment, according to Ghebreyesus. "Stigma, discrimination and misconceptions about the efficacy of treatment contribute to gaps in health services and low prioritization of substance use disorders by health and development agencies," he wrote. "We are not on track to achieve significant progress for SDG target 3.5 unless we accelerate action now. WHO remains committed to working with governments, international partners, civil society organizations and, as appropriate, other stakeholders to make real and measurable progress towards these targets. Given the heavy health and social burden that psychoactive substance use continues to have on people, their families and communities across the world, efforts to reduce psychoactive substance use must be a public health priority."

There is a widespread myth that there is no effective treatment for SUDs, added Ghebreyesus. There

is. But the implementation of these effective treatments is haphazard. "More than half of countries do not report the availability of outreach services for people who use drugs, and about two-thirds of countries do not report availability of needle and syringe programs for people who inject drugs. Less than half of countries report the availability of national action plans and policies on the development of treatment of substance use disorders, and less than a quarter of countries report the involvement of representatives of affected and targeted populations in the development and formulation of treatment policies and plans. Most countries do not have a specific budget line or data on governmental expenditures for [the] treatment of substance use disorders, and in the majority of countries, people with substance use disorders are not eligible to receive governmental non-monetary or monetary support such as disability pensions, housing, educational assistance or subsidies for food," Ghebreyesus noted.

"More than half of countries do not report the availability of outreach services for people who use drugs, and about two-thirds of countries do not report availability of needle and syringe programs for people who inject drugs."

Tedros Adhanom Ghebreyesus, Ph.D.

Although effective treatment options for SUDs exist, treatment coverage — as estimated by different metrics — is very low, and the proportion of people with SUDs in contact with treatment services varies from less than 1% to no more than 35% in all countries where such data are available. About one-third of countries do not collect data on the epidemiology of SUDs, and more than 40% of responding countries do not collect data on service provision and service utilization for the treatment of SUDs.

The WHO proposes the Service Capacity Index for Substance Use Disorders (SCI-SUD) as a complementary contextual metric for the assessment and monitoring of treatment capacity of health and social care systems for alcohol and drug use disorders in the context of global monitoring of treatment coverage for SUDs. •

For the report, go to https://www.who.int/publications/i/item/9789240096745.

Psychedelics from page 1

report's lead author said he believes policy actions in the nonclinical area clearly could have an impact in the clinical arena as well.

"I haven't seen a rigorous cost-benefit analysis examining the health consequences of legalizing psychedelics for nonclinical purposes, but I do know this: There is a real concern that if efforts to expand nonclinical supply of psychedelics do not go well, it could generate a backlash that may have a chilling effect on research and potential clinical uses," Beau Kilmer, Ph.D., co-director of the RAND Drug Policy Research Center, told *ADAW*.

"There is a real concern that if efforts to expand nonclinical supply of psychedelics do not go well, it could generate a backlash that may have a chilling effect on research and potential clinical uses."

Beau Kilmer, Ph.D.

States' approaches

The RAND report focuses mainly on classic psychedelics such as psilocybin, LSD and MDMA. It does not take a formal position on traditional supply prohibition or any alternative policies but highlights various options in order to inform the ongoing debate.

Few states to this point have taken formal policy action outside of the realm of clinical research in psychedelics. However, Oregon and Colorado both have adopted measures, authorized via state ballot initiatives, that have legalized some forms of supply.

The Oregon Psilocybin Services Act, enacted in early 2021, established a regulatory program under which adults aged 21 and older can engage in supervised consumption of psilocybin. As of last March, a division of the Oregon Health Authority had issued licenses to 23 service centers and 276 facilitators who support but do not direct psilocybin-assisted therapy sessions. These facilitators do not treat a physical or mental health condition during the session.

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"The program has faced criticism for inaccessibly high cost of services and a taxation structure that has been unable to cover the cost of program administration," the report states, adding that "the longer-term trends in client-facing prices, demand and overall sustainability remain to be seen."

Colorado is at an even earlier stage of the process than Oregon, with the Natural Medicine Health Act having passed in November 2022. The regulatory framework is still being established, with an advisory board recommending the creation of separate license types for both clinical and nonclinical facilitators. The healing centers that will house the services can administer psilocybin and psilocin at the outset but could add other psychedelics by 2026.

Both of these state initiatives are taking a decidedly more restrictive approach than the typical state measures that have sought to regulate the cannabis market.

"So far, the Biden administration has not indicated that it will block or challenge the ongoing efforts in Oregon and Colorado," the report states. "It remains to be seen whether this continues, and there is also a possibility that the federal approach could change with a new administration. Moreover, it seems likely that more states and localities will consider and possibly implement alternatives to prohibiting the supply of some psychedelics."

Given this reality, the authors recommend that the federal government take a clearer stand now on what the regulatory landscape should look like.

"Now is the time for federal policymakers to decide what they want these supply models to look like and to start taking action," the report states. "Or, if they prefer a patchwork of state policies — possibly including those that allow for commercial supply and promotion — they can do nothing and just the watch the industry grow. If that happens, it can be difficult to make major changes to supply or regulations, but that will depend on the size and political power of the industry that has taken root."

Much smaller market thus far

The report outlines broad distinctions between the cannabis and psychedelics markets. Based on 2022 data from the National Survey on Drug Use and Health (NSDUH), past-month use days for cannabis ran along the lines of 650 million in total, compared to around 7 million for all hallucinogens.

Also, unlike the cannabis market, the psychedelics market is dominated by infrequent users. Around 60% of users of psychedelics report five or fewer days of past-month use, which is the case for only about 5% of cannabis users.

The report's authors wrote that overall, the data infrastructure for the understanding of psychedelics remains extremely limited. They recommended that the Substance Abuse and Mental Health Services Administration add more depth to the NSDUH survey questions around psychedelics, possibly adding a rotating module to ask about factors such as quantities consumed, intentions for use, details of the psychedelic experience and long-term effects.

Kilmer said he does not believe the eventual outcome of the Food and Drug Administration's (FDA's) decision on approval of MDMA-assisted therapy for post-traumatic stress disorder will have a major impact on policymakers' actions regarding psychedelics (an FDA advisory panel has recommended against approval; see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.34151).

"Regardless of the decision, I expect that more states will contemplate the legalization of some psychedelics for nonclinical purposes, and in some places, it will eventually pass," Kilmer said. "Of course, when it comes to legalizing the supply of these substances, there are a lot of choices in between prohibition and the commercial cannabis model we see in many parts of the U.S." •

Coming up...

The **National Prevention Network** annual conference will be held **August 13-15** in Phoenix, Arizona. For more information, go to **https://npnconference.org/**

The **Cape Cod Symposium on Addictive Disorders** annual conference will be held **September 5-8**. For more information, go to **https://www.hmpglobalevents.com/cape-cod-symposium**

The **Addiction Health Services Research Conference** will be held **October 16-18** in San Francisco. For more information, go to **https://www.ahsrconference.org/2024/**

The **NAADAC Annual Conference and Hill Day** will be held **October 18-23** in Washington, DC. For more information, go to **https://www.naadac.org/annualconference**

In case you haven't heard...

Of course, most of these movies are well known, like *The Lost Weekend*. But there are others. *Flight. Days of Wine and Roses. Notorious*. And guess what? These are great movies! Not just about substance use disorders. Thanks to Parade for bringing them to us under one roof last week. They always say: if you can't talk about it, you can at least watch and relate. https://parade.com/707506/samuelmurrian/best-movies-about-addiction-alcoholism-recovery/.