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# Non-medical prescription drug and illicit street drug use among young Swiss men and associated mental health issues

Stéphanie Baggio<sup>1</sup>, Joseph Studer<sup>1</sup>, Meichun Mohler-Kuo<sup>2</sup>, Jean-Bernard Daeppen<sup>1</sup>, Gerhard Gmel<sup>1,3,4,5</sup>

<sup>1</sup>Alcohol Treatment Center, Lausanne University Hospital CHUV, Av. Beaumont 21 bis, Pavillon 2, CH - 1011 Lausanne, Switzerland, Stephanie.Baggio@chuv.ch, Joseph.Studer@chuv.ch, Jean-Bernard.Daeppen@chuv.ch, Gerhard.Gmel@chuv.ch.

<sup>2</sup>Institute of Social- and Preventive Medicine, University of Zurich, Hirschengraben 84, 8001 Zurich, Switzerland, meichun.mohler-kuo@uzh.ch

<sup>3</sup>Addiction Switzerland, Case postale 870, CH - 1001 Lausanne, Switzerland.

<sup>4</sup>Center for Addiction and Mental Health, 250 College St, Toronto, Ontario, M5T 1R8, Canada

<sup>5</sup>University of the West of England, Frenchay Campus Coldharbour Lane, Bristol BS16 1QY, United Kingdom

**Corresponding author and guarantor:** S. Baggio; Alcohol Treatment Center, Lausanne University Hospital CHUV, Av. Beaumont 21 bis, Pavillon 2, CH-1011 Lausanne, Switzerland, Stephanie.Baggio@chuv.ch; Tel.:+41 21 3143951; Fax: +41 21 3140562

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## **Abstract**

Non-medical use of prescription drugs (NMUPD) is increasing among the general population, and particularly among teenagers and young adults. Although prescription drugs are considered as safer than illicit street drugs, NMUPD can lead to detrimental consequences. The aim of the present study was to investigate the relationship between drug use (NMUPD on the one side, illicit street drugs on the other side) with mental health issues, and to compare these associations. A representative sample of 5,719 young Swiss men aged around 20 filled in a questionnaire as part of the baseline ongoing Cohort Study on Substance Use Risk Factors (C-SURF). Drug use (16 illicit street drugs and 5 NMUPD: sleeping pills, sedatives, pain killers, antidepressants, stimulants) and mental health issues (depression, SF12) were assessed. Simple and multiple linear regressions were used. In simple regressions, all illicit and prescription drugs were associated with a poorer mental health. In multiple regressions, most of the NMUPD were significantly associated with a poorer mental health, excepted for stimulants and anxiolytics with depression. On the contrary, the only associations that remain significant between illicit street drugs and mental health involved cannabis. NMUPD is of growing concern not only because of its increasing occurrence, but also because of its association with depression and mental health problems, which is stronger than the association observed between these problems and illicit street drug use, excepted for cannabis. Therefore, NMUPD need to be considerate in screening for substance use preventive purposes.

**Key words:** Depression; Illicit street drug; Mental health; Non-medical use of prescription drug.

## **Introduction**

Prescription drugs are fundamental to the treatment of pain and psychiatric disorders such as depression or anxiety. Unfortunately, they can also cause abuse and dependency (1, 2) and this kind of use constitutes a critical public health concern (3). Non-medical use of prescription drugs (NMUPD) has been defined as the use of a prescription drug i) without a doctor's prescription; ii) for a longer period than prescribed; iii) for other reasons than those for which it was prescribed; or iv) in doses higher than those recommended (3-5). The purpose of use can be recreational (getting high, euphoric or intoxicated) or self-medication (5-7). Most studies took place in the United States, and no comparison with other drug use was investigated. This study compared NMUPD and illicit street drugs in Switzerland.

NMUPD is of growing concern for several reasons. First, NMUPD has been shown in the United States to be the the second most common type of drug use after marijuana among teenagers and young adults (8-10). Second, NMUPD is increasing, particularly among young populations (11). For example, NMUPD increased by 67% in the USA between 1991-1992 and 2001-2002 (12), and is growing faster than marijuana use (10, 13). So NMUPD did not seem to be used only among heavy substance users. Third, prescription drugs are easier to obtain than illicit street drugs (14, 15). People also tend to think that prescription drugs are safer than illicit street drugs (7, 14, 16)., but many studies which looked at the association between NMUPD and mood or personality disorders showed that NMUPD is associated with detrimental effects such as cognitive deficit, mood disorders such as depression, accidental overdoses, psychiatric disorders, but also physical problems such as organ damage, and other substance use disorders (2, 12, 15-22). These results seemed to be inconsistent with the belief that NMUPD are safer than illicit

street drugs and that prescription drugs are not “really drugs” (23). However, no study compared the the associations of NMUPD and mental health issues with the one of the associations of illicit street drugs and mental health issues.

Therefore, the aim of this study was to investigate the relationship between drug use (illicit street drugs and NMUPD) and mental health issues (depression and mental health problems, i.e. sadness, nervousness and depression). We aimed to find out which association was higher. A total of 16 illicit street drugs including cannabis and 5 type of NMUPD (sleeping pills, sedatives, pain killers, antidepressants, and stimulants) were analyzed. Moreover, this study aimed to provide further insights regarding NMUPD in an other country (Switzerland) than the U.S. and Canada, where most previous studies have been conducted (15).

## **Methods**

### *Sample and data collection*

The data used in this study form part of the Cohort Study on Substance Use Risk Factors (C-SURF). C-SURF is a longitudinal study which takes place in Switzerland and is designed to assess substance use patterns and related consequences in Swiss young men. Illicit drug use, NMUPD and mental health issues were collected at the same time during the baseline assessment of the C-SURF study. Enrolment took place between August 23, 2010 and November 15, 2011 at three (of six) army recruitment centers located in Lausanne (French-speaking) and Windisch and Mels (German-speaking). These centers cover 21 of 26 cantons in Switzerland, including all French-speaking cantons. In Switzerland, army recruitment is mandatory, so the study was

largely representative of all young Swiss men. The study got ethical approval by the Ethics Committee for Clinical Research of the Lausanne University Medical School and followed the Helsinki declaration.

Altogether, of the 13,245 conscripts informed about the study, 7,563 gave written consent to participate and 5,990 filled in the baseline questionnaire. Missing values were listwise deleted, so the study ultimately included 5,719 participants (95.5% of the sample). More information about sampling and non-response can be found in Studer et al. (24). Shortly non-respondents were more often substance users, but the differences between respondent's and non-respondents were small and may be significant only because of the large sample size.

### *Measures*

Participants who consented to participate were invited by mail or email to fill in a paper and pen or an online questionnaire, according to the favorite way they indicated in the written consent. The questionnaire lasted approximately 1 hour and included topics such as sociodemographic background, health, family background, substance use (alcohol, tobacco, cannabis, other illicit drugs, NMUPD), personality and leisure time activities and sexuality. Participants answered first health issues, and then substance use.

*NMUPD.* NMUPD was assessed with five questions about the use of prescription drugs without a doctor's prescription or for reasons other than those indicated during the past 12 months. The answers were collected on a 8-point scale (never, once, 2-3 times a year, 4-9 times a year, 1-2 times a month, 3-4 time a month, 2-3 times a week and 4 times a week or more) and coded dichotomously as "used" or "not used". The prescription drugs and associated examples were as

follows: i) sleeping pills (e.g., benzodiazepine (Dalmadorm®, Rohypnol®, Halcion®), barbiturate, chloralhydrate (Nervifène®), zopiclon, zolpidem (Imovane®, Stilnox®)); ii) tranquilizers (e.g., benzodiazepine (Valium®, Xanax®, Librax®, Temesta®, Normison®, Demetrin®, Dalmadorm®) and muscle relaxing drugs); iii) strong painkillers (e.g., buprenorphine (Tamgesic®), codeine (Benylin®), opium-based products (Fentanyl®, Hydrocodon®, Journista®, Palladon®, Targin®, Oxycontin®, Vicodin®, Dilaudid®) and DXM (Bexin®); but over-the-counter painkillers such as Aspirin® and Paracetamol® were excluded); iv) antidepressants (Remeron®, Fluoxetine®, Citalopram®, Trimin®); and v) stimulants (e.g. amphetaminsulphate (Aderall®), atomoxetine (Strattera®), methylphenidate (Ritalin®)).

*Illicit street drugs.* The prevalence rate of illicit street drugs during the past 12 months was measured for 16 drugs. The drugs were as follows: i) cannabis (hashish, marihuana, grass); ii) hallucinogens, magic mushrooms, psilocybin, peyote, mescaline; iii) other hallucinogens (LSD, PCP/Angeldust, 2-CB, 2-CI); iv) salvia divinorum; v) speed; vi) amphetamine, methamphetamine, amphetaminsulfate (e.g., Dexedrine, Benzedrin); vii) crystal meth (Ice); viii) poppers (Amylnitrit, Butylnitrit); ix) solvent sniffing (e.g., glue, solvent and gas such as benzin, ether, toulol, trichloräthylen, nitrous oxide); x) ecstasy, MDMA; xi) cocaine, crack, freebase; xii) heroin; xiii) ketamine (Special K), DXM; xiv) GHB / GBL / I-4 Butandiol (BDB); xv) research chemicals used in research (e.g., mephedrone, butylone and methedrone); and xvi) spices or similar substances (synthetic marijuana). The drugs were aggregated in 5 subclasses: 1) cannabis; 2) hallucinogens, including magic mushrooms, other hallucinogens, salvia divinorum and spice; 3) uppers, including speed, ecstasy, cocaine and amphetamine; 4) sniffed drugs, including poppers and solvents; 5) “hard” drugs, including crystal meth, heroin, ketamine and

chemicals used in research. Each subclass was collected on a 3-point scale (never, 1-3 times, 4 times or more) and coded dichotomously “used” or “non-used”.

Participants indicated first their illicit street drug use, and then their NMUPD.

*Mental health issues.* Mental health issues were assessed with depression and mental health problems. The Major (ICD-10) Depressive Inventory (WHO-MDI) was used to determine the level of depression (25, 26). It comprises 10 criteria, with two criteria being assessed by two questions (restless vs. subdued and increased vs. reduced appetite, where the higher score of the two alternatives for each criterion was used). A six-point scale from “never” (0) to “all the time” (5) was used, and a total score from 0 to 30 was computed (Cronbach’s  $\alpha = .91$ ). Mental health was assessed with six questions from the 12-items Short-Form Health Survey (SF-12) (SF-12; 27) dealing with sadness, nervousness and depression. The total score was computed according to the authors’ recommendations (with a standardized mean of 50, with lower values reflecting a bad mental health, Cronbach’s  $\alpha = .61$ ). Participants completed first SF12, and then WHO-MDI.

*Covariates.* Demographic covariates included language (French- or German-speaking), urbanicity (urban area: more than 10,000 inhabitants; rural area: less than 10,000 inhabitants), perceived family income (“below-average income”, “average income”, “above-average income”) and completed education (primary: 9 years of schooling; secondary: around 12 years; tertiary: 13 years or more, including university).



### *Statistical analyses*

First, descriptive statistics were computed to investigate the prevalence rate of NMUPD. Linear regressions were then performed to test the relationship between drug use and mental health issues, comparing illicit street drugs and NMUPD's associations with mental health issues.

Depression and mental health were considered successively as outcome variables and illicit street drug and non-medical prescription drug use as dichotomic exposure variables. Simple linear regressions were performed for each of the 5 subclasses of illicit street drugs and 5 NMUPD for the 2 outcome variables, and then multiple linear regressions including all the illicit and NMUPD were performed for the 2 outcome variables. Multicollinearity was checked to avoid reducing the predictive power of the model. Simple and multiple regressions were performed to test the individual and combined influence of each drug on mental health and to isolate the relationship between each drug used and mental health, accounting for the other drugs. Indeed, one can suppose that the drugs share common variance and this covariance should be taken into account to reflect properly the relationship between drug use and mental health. All the models were tested with adjustment for demographic variables (adjusted models). Standardized regression slopes ( $\beta$ ) were presented instead of raw slopes to permit comparability between different drugs (illicit street drugs and NMUPD) with a scale-free estimation (28). The standardized slope could be considered as an effect-size index (28). A Bonferroni-Holms correction was performed in post-hoc comparisons to keep the type I error rate at 5%. All the analyses were conducted with SPSS 20.

## Results

### *Preliminary results*

The participants' mean age was 20.0 years (SD: 1.23), 55.0% were French-speaking and 41.1% lived in urban areas. Most participants had completed primary education (48.4%, secondary: 26.0%; tertiary or higher: 25.5%) and only 14.3% had a family income below average (average: 41.5%; above average: 44.1%). The average level of depression was low (mean = 7.0, SD = 7.2) as the average level of mental health problems (mean = 47.4, SD = 9.1).

The prevalence rates of drug use are illustrated in Table 1. The most prevalent illicit street drugs were cannabis (30.3%), then uppers (5.6%) and hallucinogens (5.0%). The most prevalent non-medical prescription drugs were painkillers (6.8%), then sleeping pills (3.0%) and anxiolytics (2.6%). Stimulants and antidepressants were less prevalent (1.9% and 0.9%, respectively).

Please insert Table 1 about here

### *Associations of mental health issues with NMUPD and illicit street drugs*

The simple regressions showed that all the drugs were significantly associated with mental health issues (see Table 2). The use of the drug considered during the past 12 months was associated with a poorer mental health (increased depression, coefficients range between .080 and .163; decreased mental health, coefficients range between -.056 and -.131).

Please insert Table 2 about here

In multiple regressions, the comparisons showed that cannabis, sleeping pills, painkillers, antidepressants and anxiolytics were significantly associated with mental health issues (excepted for anxiolytics with SF12), whereas other illicit street drugs were never significantly associated with mental health issues (see Table 3). Participants who reported higher levels of depression or mental health problems were more likely to be cannabis and non-medical prescription drugs users, with the exception of stimulants, which were not associated with mental health. Mental health was not significantly associated with any other illicit street drug.

Please insert Table 3 about here

## **Discussion**

### *Main findings*

This study compared the associations of NMUPD and illicit street drug use with mental health issues (depression and mental health problems) within a sample of young Swiss men, and tried to find out if one of these two kinds of drugs was associated with increased mental health issues. It also provided further insights regarding NMUPD in countries other than the U.S. and Canada, where NMUPD has been most studied.

The prevalence rate for NMUPD and illicit street drug use during the previous 12 months indicated that cannabis was by far the most common drug used by the participants (30.3%). The second most used substance was painkillers (6.8%). This result is in accordance with previous studies that reported painkillers to be the most common NMUPD (15, 29-31), after cannabis use.

The new epidemic observed in North America may then also affect Switzerland. Calming prescription drugs were more prevalent than stimulants (sleeping pills: 3.0%, anxiolytics: 2.6%), as was found in the U.S. in the “Monitoring the Future” study (31). In contrast, the most prevalent illicit street drugs other than cannabis were stimulants (5.6%) and hallucinogens (5.0%). Downers seemed to be more popular among prescription drugs and uppers among illicit street drugs.

Mental health issues were found to be differently associated with drug use when simple or multiple regressions were performed. In simple regression, the use of each substance was associated with a poorer mental health. However, when multiple regressions were performed, the only significant associations were for cannabis and NMUPD (excepted stimulants for depression and SF12, and anxiolytics for SF12). Cannabis use and NMUPD were associated with higher level of mental health problems and depression than non-cannabis use or non-NMUPD. That is to say, the illicit street drugs other than cannabis and prescription stimulants showed no longer detrimental associations with mental health when their common variance with cannabis and NMUPD was eliminated. Even if illicit drugs other than cannabis were individually associated with a poorer mental health, when all the substances were combined, cannabis and NMUPD were sufficient to explain the relationship between drug use and mental health, as the remaining and proper variance of illicit drugs other than cannabis was not significantly associated with mental health issues. The result was true even for the “hardest” illicit street drugs, including heroin, ketamine or crystal meth. Previous studies reported that users think that prescription drugs are safer than illicit street drugs (7, 14, 16), and the results highlighted in this study showed it was not the case. Interestingly, prescription stimulants showed a similar pattern as

illicit street drugs. It suggested that prescription stimulants should be used similarly as illicit street drugs, whereas downers NMUPD were not. Maybe prescription stimulants and illicit street drugs were used to get high and in recreational purpose, whereas downers NMUPD were used in a coping way. However, more studies are needed, as motives of use were not investigated in the current study. Cannabis was the only illicit street drug that showed significant associations with mental health issue. Previous findings showed that cannabis is harmful to health (32), and the result of this study, even it did not access a causal relationship between cannabis use and mental health, is especially worrying as cannabis is the most used illicit drug worldwide (33, 34).

### *Limitations*

This study presents several limitations. The most critical is that this cross-sectional study did not allow determination of causality: is NMUPD a cause or a consequence of mental health issues? This is a common limitation in studies on drug use (5, 16, 35). For example, antidepressants may be overused by people who are already depressed, so NMUPD may be a consequence of depression and not a cause. However, irregular use of antidepressants is also associated with worsening depression (36, 37). Another limitation is the similarity between mental health issues and intoxication symptoms. Indeed, many symptoms of intoxication resemble the symptoms of mood disorders (8). It can be difficult to distinguish between “real” mental health issues and the effects of heavy use of non-medical prescription drugs. Nevertheless, the participants in our study were not heavy users.

Regarding stimulants, both illicit street drugs and prescription stimulants included similar components (for example, Dexedrine). Therefore, confusion may have occurred for these two subclasses of substances.

We do not know whether prescription drugs were used by our participants to get high or as self-medication. Further research is needed to highlight the prevalence rate and effect of NMUPD in relation to reasons for this use, and to investigate the difference between downer prescription drugs and prescription stimulants. Finally, the study focused exclusively on young Swiss men and is not representative of the general population. However, sex effects on NMUPD are well documented (3, 12, 15, 16, 18, 21) and the enrolment procedure in army centers enables a representative sample that was not exclusively composed of college or high school students.

### *Conclusion*

This study indicated that NMUPD could be just as worrying as illicit street drug use. Indeed, NMUPD not only show a high and increasing occurrence in Western countries; it is also strongly associated with mental health issues and these associations outstripped those of mental health issues with illicit street drugs. The findings supported the idea that NMUPD are not “safe drugs”, and preventive information and interventions may focus on this class of drugs, especially for NMUPD that are highly addictive (opiates and sleeping pills).

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	% of users
Illicit street drugs	
Cannabis	30.5
Hallucinogens	5.0
“Hard” drugs	1.2
Sniffed drugs	4.2
Uppers	5.6
Non-medical use of prescription drugs	
Antidepressants	0.9
Anxiolytics	2.6
Painkillers	6.8
Sleeping pills	3.0
Stimulants	1.9

Table 1. Prevalence rates of illicit street drug and NMUPD use during the past 12 months

Variables	Depression		SF12	
	$\beta$	p	$\beta$	p
Illicit street drugs				
Cannabis	.114	.000	-.116	.000
Hallucinogens	.111	.000	-.078	.000
“Hard” drugs	.125	.000	-.067	.000
Sniffed drugs	.080	.000	-.056	.000
Uppers	.107	.000	-.092	.000
Non-medical use of prescription drugs				
Antidepressants	.159	.000	-.108	.000
Anxiolytics	.162	.000	-.101	.000
Painkillers	.126	.000	-.086	.000
Sleeping pills	.163	.000	-.131	.000
Stimulants	.123	.000	-.076	.000

Table 2. Simple linear regressions of mental health (depression and SF12) on illicit drugs (illicit street drugs and NMUPD)

Remarks: Adjusted standardized slopes ( $\beta$ ),  $\beta$  standard errors (SE) and p-value (p) are given. A Bonferroni-Holm correction was applied.

Variables	Depression		SF12	
	$\beta$	p	$\beta$	p
Illicit street drugs				
Cannabis	.080	.000	-.093	.000
Hallucinogens	.026	.082	-.005	.759
“Hard” drugs	.036	.060	.004	.772
Sniffed drugs	.022	.098	-.015	.276
Uppers	.000	.994	-.027	.080
Non-medical use of prescription drugs				
Antidepressants	.073	.000	-.052	.000
Anxiolytics	.073	.000	-.035	.084
Painkillers	.056	.001	-.040	.021
Sleeping pills	.078	.000	-.080	.000
Stimulants	.028	.176	-.006	.684

Table 3. Multiple linear regressions of mental health (depression and SF12) on illicit drugs (illicit street drugs and NMUPD)

Remarks: Adjusted standardized slopes ( $\beta$ ) and p-value (p) are given. A Bonferroni-Holm correction was applied.