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Editor's Message

Is it just me, or do the "weather gods" know that after Labour Day, the weather has to change, no matter what? All the same, it would seem that the whole country had very decent summer weather!

Our Section continues to settle down into the groove of taking its place among the other various Sections in the CPA fold. The Executive is certainly getting better at the administrative side of "things", too. You may have also noticed that the membership fees have not been increased for the next membership year, as there really was no need to!

Moving onto the clinical front, many members are quite aware that those patients being treated for cocaine/crack cocaine dependence have not benefitted greatly from the various medications that have been used as a form of pharmacotherapy in this way. In addition to this, to date, there are no FDA-approved pharmacotherapies for cocaine dependence, as there are for both alcohol and opioid dependence. The literature over recent years has amassed many studies using various promising medications, including Disulfiram, Modafinil, Tiagabine, Baclofen, and Ondansetron, with variable outcomes.

The most current thinking is to develop a vaccine for cocaine addiction. At the present time, the National Institute on Drug Abuse (NIDA) is conducting clinical trials in several universities and treatment programs across the United States in this regard. The rationale is to curb cocaine use by engaging the body's immune reaction and stopping cocaine molecules from reaching the brain, thus decreasing cocaine's reinforcing and pleasurable effects.

I fully intend to continue to follow these NIDA clinical trials with great interest. Not only might this be a huge step in pharmacotherapy as it relates to cocaine addiction, but that it reinforces the interplay of several bio-psycho-social factors. It may also further help to put to rest one of the most common myths that "cocaine addiction is all psychological". Conversely, it would be just as absurd to exclude the role of psychosocial treatments in combination with pharmacotherapy and/or immunotherapy.

Respectfully,

Dr. David Teplin, C.Psych.
Section Chair

What's Up!

*All my life, I
always
wanted to
be
somebody.
Now I see
that I
should have
been more
specific.*

~Lily Tomlin

How do prescription opioid users differ from users of heroin or other drugs in psychopathology: Results from the NES on alcohol & related conditions.

This study examined substance use and psychiatric disorders among prescription opioid users, heroin users, and non-opioid drug users in a national sample of adults (N = 43,093). Four groups were identified among 9140 illicit or non-prescribed drug users: heroin-other opioid users (1.0%; used heroin and other opioids), other opioid-only users (19.8%; used other opioids but never heroin), heroin-only users (0.5%; used heroin but never other opioids), and non-opioid drug users (78.7%; used drugs but never heroin or other opioids). After adjusting for variations in socioeconomic characteristics, history of substance abuse treatment, and familial substance abuse, heroin-other opioid users had greater odds of several substance use disorders (SUDs; cocaine, hallucinogen, sedative, amphetamine, and tranquilizer) when compared with the other groups; heroin-only users had reduced odds of sedative and tranquilizer use disorders when compared with other opioid-only users. Non-opioid drug users had reduced odds of all SUDs and other mental disorders (mood, anxiety, pathologic gambling, and personality) when compared with other opioid-only users. Past-year other opioid-only users also reported slightly lower scores on quality of life than past-year non-opioid drug users. All opioid users had higher rates of SUDs than non-opioid drug users, and these rates were particularly increased among heroin-other opioid users. The findings suggest the need to distinguish between these four groups in research and treatment as they may have different natural histories and treatment needs.

Wu, LT., Woody, GE., Yang, C., Blazer, D. (2010). *Journal of Addiction Medicine*, (In Press).

Attention-Deficit/Hyperactivity Disorder Confounds Nicotine Withdrawal Self-Report in Adolescent Smokers

This study sought to investigate nicotine withdrawal in adolescent smokers with history of ADHD. Among a sample of 134 nicotine-dependent adolescents entering a smoking cessation research study, participants completed the Minnesota Nicotine Withdrawal Scale (MNWS) and lifetime diagnostic assessment for ADHD during the baseline visit. Responses on individual items and MNWS total score were compared between participants with and without a history of ADHD. Forty-eight participants (36%) met lifetime ADHD criteria. Adolescent smokers with a history of ADHD scored significantly higher on the MNWS than those adolescent smokers without history of ADHD. Treatment-seeking adolescent smokers with history of ADHD were more likely to endorse nicotine withdrawal symptoms than those without history of ADHD. Smoking research, particularly among adolescents in whom ADHD is so common, should carefully consider the complex issue of co-morbid ADHD and nicotine dependence.

Gray, KM., Nathaniel L. Baker, NL., Matthew J. Carpenter, MJ., A. Lee Lewis, AL., Upadhyaya, HP. (2010). *American Journal on Addictions*, 19 (4): 325-331.



Prevalence and Correlates of Withdrawal-Related Insomnia among Adults with Alcohol Dependence: Results from a National Survey.

The purpose of this study was to describe the prevalence of insomnia as a symptom of acute AWD and its correlates in a general population of alcohol-dependent individuals. Data were analyzed from the 2001 to 2002 National Epidemiologic Survey on Alcohol and Related Conditions. The prevalence of AWD-related insomnia among individuals with a lifetime diagnosis of alcohol dependence was 31.7%, which ranked fourth among the eight listed DSM-IV withdrawal symptoms. Among individuals who met lifetime criteria for both alcohol dependence and AWD, the prevalence of insomnia was approximately 50%. Lifetime diagnoses of major depression and drug use disorders were significant correlates of AWD-related insomnia in multivariate analyses. A less than 1-year duration of the heaviest drinking period as well as the onset of alcohol dependence between ages 18 and 27 were negatively associated with AWD-related insomnia. Because of its relatively frequent prevalence and association with relapse, assessment and treatment of AWD-related insomnia should be routinely considered in clinical settings.

Brower, KJ., & Perron, BE. (2010). *American Journal on Addictions*, 19 (3): 325-331.

Generalisability of clinical trials for cannabis dependence to community samples.

This study sought to assess the proportion of community dwelling adults with cannabis dependence who would have been eligible for a typical cannabis dependence treatment study. The authors applied a standard set of eligibility criteria commonly used in cannabis outcome studies to a large representative US adult sample interviewed face-to-face, the National Epidemiologic Survey on Alcohol and Related Conditions. Approximately 80% of the community sample of adults with a diagnosis of cannabis dependence would have been excluded from participating in clinical trials by one or more of the common eligibility criteria. Legal problems, other illicit drug use disorders, and current use of fewer than 5 joints per week would have excluded the largest percentage of individuals. Typical clinical trials likely exclude most community dwelling adults with cannabis dependence. This also supports the notion that clinical trials tended to recruit highly selective samples, rather than adults who were representative of typical patients. Thus, clinical trials should carefully evaluate the effects of eligibility criteria on the generalisability of their results.

Okuda, M., Hasin, DS., Olfson, M., Khan, SS., Nunes, EV., Montoya, I., Liu, SM., Grant, BF., Blanco, C. (2010). *Drug and Alcohol Dependence*, 111 (2): 177-181



"I don't care what your urine analysis and polygraph tests show. I say you're lying."

DON'T WORRY
ABOUT THE WORLD
COMING TO AN END
TODAY. IT IS
ALREADY
TOMORROW IN
AUSTRALIA.
~CHARLES SCHULZ



Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system.

This study sought to assess the risk factors for opioid drug dependence among 701 out-patients on long-term opioid therapy in a large health-care system. Using electronic health records, the authors identified out-patients receiving 4+ physician orders for opioid therapy in the past 12 months for non-cancer pain within a large US health-care system. Preliminary analyses indicated that current dependence was associated with variables often in the medical record, including age <65 [odds ratio (OR) = 2.33, $P = 0.001$], opioid abuse history (OR = 3.81, $P < 0.001$), high dependence severity (OR = 1.85, $P = 0.001$), major depression (OR = 1.29, $P = 0.022$) and psychotropic medication use (OR = 1.73, $P = 0.006$). The combination of age, depression, psychotropic medications and pain impairment predicted increased risk for current dependence, compared to those without these factors (OR = 8.01, $P < 0.001$). Knowing that the patient also had a history of severe dependence and opioid abuse increased this risk substantially (OR = 56.36, $P < 0.001$). Thus, opioid misuse and dependence among prescription opioid patients in the US may be higher than expected.

Boscarino, JA., Rukstalis, M., Hoffman, SN., Han, JJ., Erlich, PM., Gerhard, GS., Stewart, WF. (2010). *Addiction*, 105 (10): 1776-1782.

Benzodiazepine use among rural prescription opioid users in a community-based study.

The purpose of this study was to examine both medical and non-medical use of benzodiazepines among a community-based cohort of prescription opioid users. A total of 221 prescription opioid users from 2 rural Appalachian counties were recruited to participate in an interviewer-administered survey assessing socio-demographic characteristics, medical (source was valid prescription) and non-medical (source other than prescription, such as dealer, friend, or family member) prescription drug use, illicit substance use, psychiatric disorders, and pain. Almost all of the participants (92.8%) reported lifetime benzodiazepine use and two thirds were current users. Only 29.3% of the current users had a legitimate prescription for a benzodiazepine. Current users were significantly more likely than nonusers to report non-medical use of a variety of prescription opioids and other illicit drugs. The major source of benzodiazepines was a dealer. A high rate of non-medical benzodiazepine use was observed in this sample of prescription opioid users. Physicians should, therefore, be aware of the potential for non-medical use of benzodiazepines.

Havens, Jennifer, HR., Walker, R., Leukefeld, CG. (2010). *Journal of Addiction Medicine*, 4 (3): 137-139.

Upcoming Conferences...

October 2010

International Society of Addiction Medicine (ISAM) Annual Meeting

October 4-7, 2010

Milan, Italy

Contact: <http://www.isamweb.org/>

Canadian Society of Addiction Medicine (CSAM) Annual Meeting and Scientific Conference

October 19-23, 2010

Charlottetown, Prince Edward Island Canada

Contact: www.csam.org

American Association for the Treatment of Opioid Dependence, Inc. (AATOD) National Conference

October 23-27, 2010

Chicago, Illinois

Contact: www.AATOD.org

Addictions 2010: The New Frontier in Addiction Treatment: Evidence-Based Policy and Practice

October 28-31, 2010

Arlington, Virginia

Contact: <http://www.addictions-conference.elsevier.com/>

November 2010

Association for Medical Education and Research in Substance Abuse (AMERSA) 34th Annual Conference

November 4-6, 2010

Bethesda, Maryland

Contact: www.amersa.org

December 2010

American Academy of Addiction Psychiatry 21st Annual Meeting and Symposium

December 2-5, 2010

Boca Raton, Florida

Contact: <http://www2.aaap.org/meetings-and-events/annual-meeting/2010-general-information>

January 2011

International Academy of Behavioral Medicine, Counseling and Psychotherapy 37th Advanced International Winter Symposium on Addictive Disorders & Mental Health

January 27-29, 2011

Colorado Springs, Colorado

Contact: <http://www.iabmcp.net>

Pharmacotherapy for Opioid Dependence-An Alternative to Methadone-By Carolyn Plater, MSW

What is Suboxone?

Suboxone is a sublingual tablet that is available via a physician prescription and is now clinically indicated in many countries including Canada as a viable pharmacotherapy option to treat opiate dependency. Suboxone is a semi-synthetic opioid that has a high binding affinity at the mu receptor. In essence, suboxone helps prevent the user from experiencing opioid withdrawal symptoms and also helps to blunt or dull the effects of other opioids.

Suboxone is actually made up of 2 medications “buprenorphine” and “naloxone”. While the buprenorphine is the primary active ingredient, the naloxone plays a crucial role. Naloxone is a mu receptor antagonist and actually produces rapid onset of withdrawal symptoms and is typically used to counter opioid overdoses. The benefit of incorporating naloxone with buprenorphine is that it acts as a deterrent for those who may wish to inject the tablet intravenously. The naloxone has no active effect when ingested sublingually as suboxone is prescribed.

Initiation and Cessation of Suboxone

Suboxone is available in 2 mg and 4mg tablets. An individual is typically started on 4mg of suboxone and the dosage is gradually titrated upwards until the individual no longer experiences any withdrawal symptoms. An average daily dose of suboxone is between 8mg and 16mg. Suboxone also has a long duration which can allow for dosing every 2-3 days. It can be used for detoxification, or short term or long term maintenance depending on the individuals needs.

The one caveat to starting suboxone however is that the individual must present in opioid withdrawal. If an individual does not present in opioid withdrawal than “precipitated withdrawal” may occur. Precipitated withdrawal includes a cluster of symptoms similar to typical opioid withdrawal symptoms. These symptoms vary in severity and are not relieved by the administration of more opioids. Care needs to be taken to ensure that individuals are aware of the risks and are honest about their opioid use prior to suboxone induction. When an individual is ready to stop suboxone, it is recommended that the dose be tapered slowly in order to ensure withdrawal symptoms are minimal. Withdrawal symptoms from suboxone can typically start 1-3 days after the last dose, peak in 3-7 days, and last for 2-4 weeks.

Who should use Suboxone?

Suboxone is a viable treatment option for most individuals seeking assistance with overcoming their opioid dependency. Suboxone is also a particularly good option for individuals who have not done well on methadone maintenance therapy, have had adverse events to methadone, or who are looking to taper off of methadone.

Suboxone Efficacy

Overall, suboxone has been effective at increasing treatment retention, decreasing use of opioids and other substances as well as improving one’s overall functioning. Furthermore, research literature has consistently demonstrated the effectiveness of suboxone when compared to placebos. When compared to methadone, suboxone also produces favourable results. Doses of 8-16mg of suboxone have been found to be more effective than 20-40mg of methadone and similar in effectiveness to doses of 50-100mg of methadone.

Student Buzz.....

Hello Fellow Students!

I'd like to introduce myself as your Student Representative for the Substance Abuse/Dependence Section of CPA. My name is Breanne Faulkner. I am currently a Master of Arts student in Counselling Psychology at the Ontario Institute for Studies in Education (OISE) at the University of Toronto, where I am conducting research in the area of addictive disorders under the supervision of Dr. Abby L. Goldstein. My research involves examining the trauma-related pathways to substance abuse and other addictive behaviours, as well as the multidimensional relationship between addiction and aggression, and in particular, intimate partner violence.

Membership in the Substance Abuse/Dependence section of the CPA is a valuable resource for young professionals in the field. As busy students, we don't always have the time or energy to seek out recent research in our field. Our section serves us well in this regard; the Section newsletter, *The Chemical Independent*, will keep you updated on advances in understanding of the aetiology, assessment, treatment, and consequences of substance-related disorders. This will also be a source for information on current issues relevant to research and professional work with the substance dependence population, such as the proposed changes to addiction-related diagnostic categories in the DSM-V.

Of particular relevance to students, *The Chemical Independent* keeps you apprised of several upcoming conferences in the field. As your student representative, I will update you on a more frequent basis, sending monthly emails via our student listserv, noting student-relevant news, research, workshop information, and deadline reminders. This is also a venue through which you may disseminate your own research.

As the Substance Abuse/Dependence Section is relatively new to CPA, we, as students, have a great opportunity to take on an active role in our membership, and to have our voices heard. Please feel encouraged to contact me with information or research that you'd like me to distribute, or with questions or comments about the section.

Wishing you all a fantastic Fall,

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Mindfulness-Action Based Cognitive Behavioural Therapy for Concurrent Binge Eating Disorder and Substance Use Disorders

By Dr. Christine Courbasson, C.Psych.

There is hope for individuals with concurrent substance use disorders and binge eating disorders. In 2011, “Mindfulness-Action Based Cognitive Behavioural Therapy for Concurrent Binge Eating Disorder and Substance Use Disorders” authored by Courbasson, Nishikawa, & Shapira, will be published in a special issue on mindfulness and eating disorders in *Eating Disorders: The Journal of Treatment and Prevention*. Binge Eating Disorder (BED) and Substance Use Disorder (SUD) often co-occur together, resulting in poor outcome and a host of negative medical and psychological consequences, yet are not typically addressed concurrently in treatment. Consequently, this pilot study investigated a 16-week novel group therapy treatment for concurrent BED and SUD, Mindfulness-Action Based Cognitive Behavioural Therapy (MACBT). This therapy involves the practice of mindfulness techniques, especially mindful eating exercises, and provides psycho-education on the etiology of both BED and SUD. Adaptive coping skills for emotional dysregulation are taught in efforts to help participants tolerate difficult emotions without giving in to urges to use substances or engage in binge eating. Participants are encouraged to focus on their strengths, rather than solely on pathology, and set weekly goals to implement and maintain balanced physical activity. After completion of the MACBT group, outpatients receiving treatment for concurrent BED and SUD in a community mental health hospital evidenced improvements in objective binge eating episodes, attitudes perpetuating disordered eating, severity of addiction to drugs and alcohol, as well as a reduction in depressive symptoms. Effect sizes were large across outcome measures, and a medium effect size evidenced for drug addiction severity. This study highlights the promise of treatments that integrate mindfulness and cognitive behavioural components for individuals with BED/SUD. Treating co-morbid disorders concurrently, rather than sequentially, may have implications for the public health care system in terms of time and cost-effectiveness. Further, another study currently in preparation found that over time participants in the MACBT group also evidenced reductions in emotional eating as well as an increased capacity to regulate negative emotions.