Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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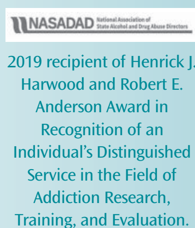

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CDC reports stimulant-involved OD deaths up; Researchers look at why

Bottom Line...

In a study published last week, researchers look at why opioid users like stimulants; last month the CDC noted dramatic rise in stimulant-involved OD deaths.

Last month in the *Morbidity and Mortality Weekly Report*, the federal Centers for Disease Control and Prevention (CDC) reported a dramatic increase in the presence of cocaine and methamphetamine in opioid overdose (OD) deaths. The increase is largely driven by illicitly manufactured fentanyl, according to the CDC. Users are getting tired of illicit fentanyl, they try to boost it with methamphetamine (mainly, because methamphetamine is less expensive than cocaine), or find themselves exposed to stimulants when they weren't expecting to be due to sloppy lab techniques, according to a study, "The motives and methods of methamphetamine and 'heroin' co-use in West Virginia," published July 12 in *Harm Reduction Journal* (see https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-023-00816-8 for the full study).

However, the increasing presence of stimulants heralds what epidemiologist and study senior author Daniel Ciccarone, M.D., MPH, professor of family and community medicine at the University of California, San Francisco, calls the "fourth wave" of the opioid epidemic. This, like the crack

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Substitute behaviors in recovery pose consistent threat to well-being

Results of a new study based on in-depth interviews with 23 Narcotics Anonymous (NA) attendees in South Africa suggest that treatment and recovery programs should pay closer attention to potentially problematic substitute behaviors in recovery. Nineteen of the 23 participants reported engaging in a substitute behavior, with nicotine the most common replacement substance and binge eating/overeating the most common non-substance behavior.

Bottom Line...

Interviews with participants in Narcotics Anonymous suggested that people in recovery want more guidance on how to keep substitute behaviors from becoming addictions.

The study's authors suggested that the findings point to several strategies that could prove productive for individuals in recovery from a substance use disorder (SUD), including smoking cessation efforts in early recovery and development of alternative behaviors that would constitute more adaptive coping. Study results were published online July 5 in the journal *Substance Abuse Treatment, Prevention, and Policy*.

"While the use of substitutes for time-spending, harm reduction, relapse prevention and coping, broadly construed, is commonly

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epidemic of the 1980s, is likely to end the opioid epidemic and replace it with a stimulant epidemic — or something worse — according to Ciccarone's colleague and study lead author, Jeff Ondocsin, MPH, who is with the Department of Family and Community Medicine at the University of California, San Francisco.

"It all fits together," said Ciccarone of the increase in stimulants in opioid OD deaths in an interview with *ADAW* last week. "This is the fourth wave. We had a lot of eras of opioid use, and at the tail end, we see the stimulants," he said. "The speedball is common at the late stage, and this time people have become highly dependent on a strong opioid such as fentanyl, they're not having so much CNS [central nervous system] response anymore, so they add to it with stimulants."

Aren't opioids supposed to create a "down" effect, and stimulants a "high" or "upper" effect? "If you use them correctly, you can have both," said Ciccarone. "You just potentiate the opioid with the stimulant. People who don't like the speedball say they don't like the up and down. But people who learn to finesse it, they get more high, they have a better sensation, and that's what we're writing about now."

Study authors Ondocsin, Ciccarone, and colleagues of participants in a syringe services program in West Virginia highlighted the reasons and rationale by users for combining opioids with stimulants. Their study comes as the CDC continues to note dramatically rising stimulant presence in opioid overdose deaths.

"Speedballs are the Reese's pieces" of drugs today, said Ciccarone.

CDC OD data

During January 2021–June 2022, about one-third of IMF [illegally made fentanyls]-involved OD deaths co-involved cocaine (35.2% of those with xylazine detected and 30.4% of those without), and approximately one in five co-involved methamphetamine (18.0% of those with xylazine detected and 22.3% of those without). Although cocaine was involved in a slightly higher percentage, and methamphetamine in a slightly lower percentage of IMF-involved deaths with xylazine detected compared to those without xylazine, the co-involvement of cocaine and methamphetamine is similar to previous reports, the CDC told *ADAW* last week.

(For the CDC study, see Illicitly Manufactured Fentanyl–Involved Overdose Deaths with Detected Xylazine — United States, January 2019–June 2022, *MMWR*, lead author Mbabazi Kariisa, Ph.D.)

Xylazine was present in 99.5% of all opioid OD deaths involving IMFs from January 2021–June 2022 (see chart, page 3).

Among 21 jurisdictions, the monthly percentage of IMF-involved deaths that had xylazine detected increased 276% from January 2019 (2.9%) to June 2022 (10.9%), the report noted. "During January 2021–June 2022 in 32 jurisdictions, xylazine was detected in a higher percentage of IMF-involved deaths in the Northeast U.S. Census Bureau region; listing xylazine as [the] cause of death varied across jurisdictions."

For the data, jurisdictions entered information on drug OD deaths that were unintentional or of

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News for policy and program decision-makers

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Co-involved drugs in IMF [illicitly manufactured fentanyl] overdose deaths

Drug	Total (%)	With xylazine detected	Without xylazine detected
Heroin	6,675 (12.4)	709 (14.6)	5,966 (12.1)
Prescription opioids	6,371 (11.8)	695 (14.3)	5,676 (11.6)
Alcohol	9,636 (17.9)	724 (14.9)	8,912 (18.1)
Benzodiazepines	6,213 (11.5)	656 (13.5)	5,557 (11.3)
Cocaine	16,653 (30.9)	1,708 (35.2	14,945 (30.4)
Methamphetamine	11,815 (21.9)	874 (18.0)	10,941 (22.3)

Source: CDC

undetermined intent into the CDC's State Unintentional Drug Overdose Reporting System (SUDORS) using death certificates, medical examiner and coroner reports (including information about circumstances of the OD from scene evidence and witness reports), and toxicology reports.

It's possible that the magnitude of increase in xylazine might reflect "increased frequency of testing and true increased presence in the drug supply in recent years," the CDC report noted. However, since the Office of National Drug Control Policy designated fentanyl adulterated with xylazine an emerging threat last April (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33742), some jurisdictions have scheduled, or are trying to schedule, xylazine as a controlled substance. It is a veterinary anesthetic not suitable for human consumption. Because of inconsistent testing, it's likely that xylazine is still underestimated, the CDC said.

If jurisdictions do schedule xylazine, it's important to monitor trends and other sedatives such as medetomidine, the CDC said.

Repeated injections of xylazine are associated with skin lesions, ulcerations, abscesses and amputations. Harm reduction measures using xylazine test strips are recommended to prevent morbidity or mortality.

Speedballs in West Virginia

Based on "rapid ethnography," the study by Ondocsin and colleagues used a non-random convenience sample. Rapid ethnography is an adaptation of a technique used early on in HIV research that is "a way to get some answers in a short amount of time," Ondocsin told *ADAW* last week. "We went to a syringe services program in West Virginia and interviewed anyone who showed up who met the criteria," he said. The criteria: The participants had to be injecting heroin or fentanyl ("it was mostly fentanyl at that point, but they still used the word 'heroin,'" said Ondocsin).

The word "speedball" was used to describe the combination of heroin (fentanyl) and methamphetamine, said Ondocsin. The timing, methods, and rationale for this combination varied widely, with the study full of quotations from participants. This speedball is different from the one of the 1980s, which involved heroin (actual) and cocaine (crack).

"We've been to West Virginia a few times," said Ondocsin. "In the prior trip, we weren't finding people who were using methamphetamine and fentanyl."

Is there a way to pull all of the experiences together, to sum up a basic reason for the combination? "This is hard to answer," said Ondocsin. "Is it supply led? Is it demand led? What are the forces?"

Protective effect?

Whether stimulants, such as methamphetamine, would actually prevent or reduce the likelihood of an OD from opioids (referred to as "heroin" by the participants, although they were likely using fentanyl) is "unclear," said Ondocsin, "but the people we spoke to said they believe it. The bottom line: Whatever is true, "it is possible to for people to believe it [that methamphetamine prevents OD] is true."

From one participant in the study:

I like doing them both too, especially if it's the fentanyl because it keeps my heart rate up as well as you know not ODing. […] fentanyl just slows your heart rate down and stuff like that — it just shuts you down. And the meth will keep you going. I know it's bad on your heart and it's gotta be, but I do believe that it does has some type of protection of overdose, the meth does.

And another:

If I do a shot of heroin, I can instantly do a shot of meth. […] But if I do a shot of meth, you're gonna wanna wait a little while before you do heroin. I don't know why, but that's just the way it is. […] But, you know, if you're on the ice already and you do heroin and you do too much, then it's not gonna work the same.

And from another:

[…] I've seen it with my two eyes. They, I mean, they weren't in a full-fledged — they weren't dead, dead, but they were well on their way to going into a full-fledged overdose. […] I've been around plenty of people that overdosed, and you know when they're about to overdose. And somebody can — usually somebody else has to shoot 'em, but it gives 'em a large shot of meth, it's like shooting with adrenaline will bring 'em back a little bit, enough to keep 'em alive, you know, so.

Ciccarone agreed, saying that drug users "feel as if it [the methamphetamine] is protecting them" from ODs, especially in a time of fentanyl.

ADAW asked the National Institute on Drug Abuse (NIDA) for an answer to these two questions: Can stimulants reduce the likelihood of an opioid overdose;? Can stimulants resuscitate someone from the opioid

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overdose? Apparently, the users in the West Virginia study believe and feel wrongly, according to officials. For For a response, NIDA sent us these facts:

- "Mixing stimulants and depressants doesn't balance or cancel them out. In fact, the results of combining drugs are unpredictable, often modifying or even masking the effects of one or both drugs. This may trick you into thinking that the drugs are not affecting you, making it easier to overdose." (from CDC's Polysubstance Use Facts page).
- "**Myth:** One way to reverse an opioid poisoning is to administer a stimulant like cocaine or methamphetamine. **Fact:** Stimulants do not address the slowed/stopped breathing that opioids cause and which leads to death. The opioid blocker, naloxone, can temporarily counteract opioids. In fact, opioid poisoning deaths in which stimulants have been present have risen dramatically in recent years, pointing to stimulant use as a potential risk factor in these deaths." (from this 2021 publication by the University of Washington).
- "DON'T inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is naloxone." (from **Guidance from SAMHSA's "Dos and Don'ts When Responding To An Opioid Overdose" list in the SAMHSA Opioid Overdose Prevention TOOLKIT**

For additional information, NIDA recommended:

- Editorial: A Changing Epidemic and the Rise of Opioid-Stimulant Co-Use
- Concurrent use of opioids and stimulants and risk of fatal overdose: A cohort study

Researcher views

Why do people going to the SSP [syringe services programs] continue to use opioids, or stimulants for that matter?

"A lot of them are trapped," said Ondocsin. "They can't stop using for a whole assortment of reasons. It's not just addiction, it's their life circumstances, what they have going on."

Ondocsin got involved in the field in 2013 when he started working with a University of Pennsylvania anthropologist on a project involving an ethnography about drug dealing in Kensington (at the time, a heavily drug dealing/using area in Philadelphia). "He relocated to UCLA [University of California at Los Angeles] and recommended me to Dan [Ciccarone]."

Most people use methamphetamine because it is so much less expensive than cocaine; in the West Virginia study, they called it "ice" most of the time.

As for why the team went to West Virginia: It's the state with the highest rate of opioid overdose deaths.

Reasons, methods, motives

Here are some of the details about participants' use of speedballs in the Ondocsin study:

Q: So do you normally do speedballs like actual meth and heroin together, or do you do them separately at different times of the day?

A: Oh no, I put that shit together. […]

Q: And if you only had a certain amount of money in a day, would you choose one over the other?

A: Oh it would definitely be heroin. I mean because the only time I like the ice at all is to add […] to the speedball.

Q: But when you do a speedball, how it is different than if you're just using them both back and forth?

A: You go up and down, I don't know […] it makes it both the same. … if the heroin is good and the ice is good, you're doing the damn thing, you'll be up and down, up and down. The duration of this effect or 'legs,' depended on the quality of the heroin in particular.

Q: And how long does it last, that feeling?

A: It depends if it has legs or not. If it has good legs, it should last for a couple hours.

Q: And what do you think gives something good legs?

A: How good the dope [heroin] is…

Q: Now, do you use the heroin and meth separately or in combination?

A: Uh both, both from time to time. I feel like mixing them, one may draw from the other so like when you mix them you lose one of them. […] The only time I do them together is if I'm in like a hurry or only got a little bit of each.

Q: So what's your typical day like drug-wise?

A: I wake up, I do a shot of dope.

Q: So you do just heroin in the morning?

A: Yeah, well it depends, sometimes I do both, but I make sure I have enough heroin that I won't be sick if I do the meth. […]

Q: How long will the meth keep you high before you have to do that again?

A: Well I've been up six days high off of it.

Q: Okay. Tell me about a day where you chose to use heroin, why heroin that day?

A: Because my back's hurting or I've got a really bad toothache, or my legs are hurting and it takes the pain away.

Q: […] Or do you ever have a day like that where you use heroin at one point in the day and meth at another point in the day?

A: Yeah, but as long as I use it, don't use it in the same, if there's at least two and a half hours within me using it that's fine.

As for motives for combining heroin and methamphetamine, for some users, it was very clear:

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You're on top of the world. You know what I mean? You're just, you feel good, you know you've got that warm, fuzzy feeling from the heroin and then you've got the euphoria feeling you get off the ice you know, just a mixture or a combination of both it's kind of unexplainable.

…Really how I know when I've done a good shit [sic] of ice is because I'll yawn, get the munchies and ready to take a nap and that's off the speed. But I'm also ADD, ADHD, ODC [sic], bipolar, split personality, explosive anger and very rambunctious. […] So I'm hyper as can be. I do a shot of speed and it slows me down.

There were also beliefs that in the old "drug holiday" to reduce tolerance, and one person said he used methamphetamine for "detox:"

A: Sometimes I detox myself.

Q: Why do you do that? A: So I can lower down my tolerance so I ain't gotta do so much to get high.

Q: And how do you do that?

A: I detox myself off of heroin by using ice.

And there were SSP participants who plainly did not like methamphetamine. For example:

Q: Is there anything that you — tell me what you don't like about ice?

A: What I don't like about it? I don't like that it burns, I don't like the buzz, I don't like anything about it really, I just like the first five minutes.

"Everyone had their preferred order; the amounts they would use varied. It was a very social phenomenon, particularly for those reluctant about methamphetamine use," said Ondocsin.

'Now is the time'

Of course, the big difference between opioid dependence and stimulant dependence is treatment: For opioids, there are medications (methadone and buprenorphine) which substitute, but there are no such medications for stimulants.

With synthetics like fentanyl and methamphetamine, which are so inexpensive to make, similar or even worse replacements coud be coming, he said.

Ciccarone is concerned too. "The fact that we're in a stimulant rise now, means that new people coming in may not be using fentanyl," he said. "Too many people are dying, fentanyl is harsh on the body; they're not suicidal, fentanyl has challenged us throughout the last nine years." But as for the addition of stimulants, it's most likely "accidental," and not a ploy by the drug dealers, he said.

"It used to be that the drug organizations were very disciplined, highly vertical, and if you disobeyed, you were either out or treated harshly," he said. "Now the discipline has gone away, with the arrest of "El Chapo," head of the Sinaloa drug cartel. The consequences of this "horizontalization" are mainly smaller dealers fighting over every little bit of turf. "The drugs are so cheap," said Ciccarone. If someone leaves a little bit of methamphetamine on the same scale used to weigh fentanyl, or, heartbreakingly, vice versa, the users die.

"All of this goes along with the desire for the speedball, of people trying to get more out of the latter days of fentanyl," said Ciccarone.

But Ciccarone is optimistic, providing that the right steps are taken. "Now is the time to up our ante," he told *ADAW*. "We probably have a population that is getting tired of the fentanyl, or even of the speedball, so open up the gates, get more treatment options," he said. Ciccarone said he is appalled at the "very narrow gateway that people have to navigate" to get treatment. "How have we evolved to this?" •

ONDCP calls for all-government response to xylazine-fentanyl

Last week the Office of National Drug Control Policy (ONDCP) issued a plan for a "whole-of-government" response to the combination of xylazine and fentanyl. The plan outlines specific responsibilities for what appears to be every single federal agency, in an action to be coordinated by the ONDCP.

"Since we announced the emerging drug threat earlier this year, we've been working tirelessly to create the best plan of attack to address this dangerous and deadly substance head-on," said Rahul Gupta, M.D., ONDCP director, when he announced the plan on July 10. "Now, with this National Response Plan, we are launching coordinated efforts across all of government to ensure we are using every lever we have to protect public health and public safety and save lives. As a doctor, I have seen the devastating consequences of xylazine combined with fentanyl firsthand. And as President Biden's drug policy advisor, I am laser-focused on finding every tool we have and following the best evidence-based practices to take on this new challenge. This will be an all-hands-on-deck effort, but I am confident we can take action together and eradicate this emerging threat."

Xylazine has been detected in nearly every state. The ONDCP plan outlines six action steps:

- Testing;
- Data collection;
- Evidence-based prevention, harm reduction and treatment;
- Supply reduction;
- Scheduling; and
- Research.

As required by statute in the SUPPORT Act and the criteria for designating evolving and emerging drug threats, the goal of the National Response Plan is the termination of fentanyl combined with xylazine as an emerging threat. This will require a 15% reduction (compared to 2022 as the baseline year)

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of xylazine-positive drug poisoning deaths in at least three of four U.S. census regions by 2025.

In addition, the ONDCP wrote that a "whole-of-society effort to save lives" is needed.

- Health care providers are encouraged to be on the alert for signs and symptoms of patients' exposure to fentanyl adulterated with xylazine…
- State, county and city health authorities are encouraged to proactively seek out those believed to be consuming fentanyl adulterated with xylazine to offer mobile, low-threshold care before their conditions worsen.
- Addiction treatment and emergency responders should consult with experts on xylazine detoxification methods to understand emerging practices.
- Law enforcement and elected officials must coordinate with their public health colleagues…

Community-based programs

Illicit fentanyl on its own is deadly, and often mixed with other drugs, including heroin and stimulants, and the ONDCP is still focused on fentanyl. But there are more problems. "To make matters worse, the country now faces a severe challenge from xylazine, especially when combined with fentanyl," the ONDCP plan noted. "There is an urgent need to determine the source of xylazine and how to reduce the illicit supply; to develop evidence-based testing and overdose response protocols; and to determine how to treat those who have become dependent on the dangerous fentanyl and xylazine combination."

There is a long way for funds to trickle down from the ONDCP and from the $50 billion in opioid settlement money to the community-based programs that will be the first to see individuals who are dealing with fentanyl-xylazine. And the ONDCP recognizes that those community-based programs need help, but they are not specifically part of the federal plan that will culminate in another report with recommendations.

Here are steps that the ONDCP said it is required to follow under the SUPPORT Act:

- First, ONDCP, in collaboration with relevant federal agencies, must draft and publicly issue a fentanyl-adulterated or associated with xylazine response plan within 90 days of designation (which happened on April 12; thus last week's plan).
- Second, ONDCP must issue imp-lementation guidance to agencies (120 days after designation).
- Third, agencies must provide a specific agency implementation report to ONDCP (180 days after designation).
- Fourth, ONDCP must publish a national implementation report on the National Response Plan (in February 2024, along with other ONDCP annual reports).

"The SUPPORT Act also requires that the ONDCP director decide whether a stand-alone national media campaign would be effective in addressing the emerging threat," the ONDCP plan stated. "In the case of xylazine-adulterated fentanyl, Director Gupta has determined that it will be productive to include such public messaging on fentanyl adulterants in existing campaigns and other federal messaging on fentanyl in lieu of establishing a new stand-alone campaign focused solely on xylazine."

So the ONDCP declared an emergency, called on all agencies plus all society to help fix it, and announced plans to publish a report by next February. And there will be more public messaging including fentanyl, instead of a special campaign aimed at xylazine. Stay tuned. •

For the plan, go to here.

Kent on OTPs and new regulations: Promise for the future

"The new rules will help opioid treatment programs," said Rob Kent, former counsel for the Office of National Drug Control Policy (ONDCP) and the New York state Office of Addiction Services and Supports (OASAS), now a consultant, in an interview with ADAW last month. He was referring to the SAMHSA [Substance Abuse and Mental Health Services Administration] proposed regulations to modernize methadone treatment (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33643), which have nothing to do with the proposed bills to allow office-based physicians to prescribe methadone to people with opioid use disorder (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33720). In fact, Kent said he supports making methadone treatment easier to access, but has concerns about the proposals, supported by the American Society of Addiction Medicine and almost all other medical societies, to allow patients to be treated outside of the OTP [opioid treatment program].

The American Association for the Treatment of Opioid Dependence (AATOD) supports patients being able to get OTP-prescribed methadone from pharmacies but does not support taking the control of who gets the medication away from the OTP. AATOD has been criticized as merely protecting its own turf by taking this stance. AATOD President Mark Parrino has long had the same answer to this charge – basically, that AATOD is supporting quality patient care -- which he reiterated to us last week:

"There are several problems in what has been proposed legislatively," Parrino told ADAW. "First, medication alone is not treatment – it is a component of treatment. Second,

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OTPs are staffed by clinical treatment teams and they make determinations about the safety of providing take-home medications to patients. An individual practitioner does not have the benefit of such team discussions. Third, providing a prescription of methadone products to clinically unstable patients using fentanyl is dangerous. If a practitioner writes a methadone prescription for 2 weeks or 4 weeks, and gives that prescription to a newly admitted and unstable patient, a disaster is certain to follow. This is not protecting a treatment monopoly as much as it is protecting the integrity of patient care."

Kent pointed out a key factor, however: Many of the "rules" that OTPs complain about are not rules at all — at least not in New York which has long allowed 28 days of take-homes. They are self-imposed burdens. "Almost from day one at OASAS, OTP providers would come up to me and talk about how the regulations were overwhelming and burdensome," said Kent. "So I tested this. More than once I went to a provider and asked them to run me through their intake process. I found out that a good bit of what these programs do is of their own creation."

This happens across all of health care, of course. How many patients are asked to fill out forms every year, which include information that has not changed, and take at least half an hour to complete? Nobody requires these forms to be filled out, but providers insist on it.

So at OASAS, model forms were created for OTPs — "what information you need to get in order to follow the rules," explained Kent. No more than that.

The other problem is that everyone is using electronic records, he said. "When we rewrote the outpatient rules at OASAS, to change the chart reviews regularly instead of just when you see the patient, they had to put checks in," he said. Kent, a lawyer, said he believes that many providers have been advised that collecting all of this unnecessary information "will help us if we ever get sued."

Hospitals are the worst when it comes to creating their own problems, said Kent. "They overthink everything, they're so risk-averse."

OTPs are also risk-averse, which is one reason that they won't give unlimited take-homes to patients. If something goes wrong — there is diversion resulting in a death, for example — the OTP gets sued. And malpractice carriers aren't happy to know this. And, not to put too fine a point on it, but nobody who is ordering OTPs to give more take-homes has offered to indemnify them. •

Substitutes from page 1

known, participants also identified self-soothing, distraction, escapism and avoidance as motives," wrote the study's authors, led by Deborah Louise Sinclair of Ghent University in Belgium. Acknowledging this variety of motivations could help in suggesting alternative behaviors/activities that would be less risky, the authors stated.

There is a need for considerably more data on substitute behaviors and how they develop, according to John F. Kelly, Ph.D., the Elizabeth R. Spallin Professor of Psychiatry in Addiction Medicine at Harvard Medical School and director of the Research Recovery Institute at the Massachusetts General Hospital. "There are two problematic aspects to any potential addictive/substitute behaviors: The potential direct health harms from those behaviors and the indirect harms transmitted through shame/guilt and secrecy, which can lead to direct harms," Kelly told *ADAW*.

Powerful comments

The new study was designed to explore NA attendees' perceptions of and experiences with substitution in the Western Cape region of South Africa. Unlike some research that has looked only at substitute substances for one's primary addiction, this study also encompassed potentially addictive behaviors around food, sex, gambling, shopping, exercise, religious activity and use of the internet.

Twenty-three in-person interviews with adults aged 22 to 55 (mean age 39.3) were conducted in late 2018. Fourteen of the 23 interviewees were men. Ten participants each were in sustained recovery (one to five years) and stable recovery (more than five years), with the other three individuals in recovery for less than a year.

"Nineteen participants believed they had substituted for their SUD with substances or behaviors of varying severity since beginning their recovery journey," the study's authors wrote. The most common substance-to-substance replacement was cigarettes and e-cigarettes, cited by 11 interviewees.

Many reflected on the relative acceptance of smoking in recovery, with one suggesting that treatment professionals actually drove the decision to start smoking. "So, I didn't smoke even in active addiction, but in recovery, when I was in treatment they said like 'I think you probably need to smoke.' I started smoking a bit more," the participant said.

Another interviewee expressed the desire to quit smoking but said "I also don't see smoking as a bad thing considering all the stuff I've dropped."

The three most commonly cited substance-to-behavior substitutions were binge eating/overeating (10 participants), exercise (5 participants) and pornography/sex/relationships (5 participants). One interviewee who reported engaging in long binge and purge cycles attributed this type of behavior to "our inability to connect with our true feelings...something to pull over ourselves when we're afraid ... nervous ... uncomfortable ... don't want to deal with feelings." Another said, "This chocolate ... it's almost like a drug to me now."

Some participants touted the mental and physical benefits of exercise but realized they needed to make sure the behavior didn't escalate to

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the level of an addiction. One said, "And then I started exercising and then ... overexercising and then I messed up my back. So yes, I always go overboard, with everything."

One participant who was engaging in multiple extramarital affairs and pornography consumption remarked that these behaviors were beginning to dominate his life to the extent that "my substitute addiction became my primary addiction." He went on to say that "it's a matter of time before it takes me back to my first addiction."

Kelly said he thinks a strong recovery support network might hold the key to preventing a substitute behavior from becoming a new addiction. "If someone is attending NA or AA and is in remission from their primary psychoactive SUD and talking openly about these other 'substitute' behaviors, with a sponsor or other trusted persons in their support network, then they are less likely to have a negative impact and be addressed sooner, or within a reasonable timeframe, as the person is open about their health harms and risks."

The study's interviewees emphasized the importance of recognizing patterns in substitute behaviors and determining whether these activities were making life unmanageable. The study's authors wrote that "participants advised service providers to focus on and process the underlying emotional states that may underpin addictive behaviors and add to, or develop a repertoire of, adaptive coping skills."

One participant suggested patient education should take a practical approach, with specific guidance on what constitutes healthy meal planning, exercise and sexual behavior.

But another said the guidance would mean more coming from others in the NA group as opposed to professionals. "Sometimes if someone like my psychologist ... would say: 'Try that.' What do you know? … You don't know how my mind works."

Who is susceptible?

A systematic review of 96 studies of addiction substitution in recovery, published in 2021 in *Clinical Psychology Review*, found that the most common substance-to-substance substitutes were opioids and cannabis, both outpacing tobacco in the review.

The review found that male gender, younger age, greater substance use severity and the presence of a mental health disorder all increased the likelihood of addiction substitution. The researchers suggested that more study of changes in addiction during recovery could lead to better treatments overall and preventing substitutions.

Kelly said he agrees that research to this point has only scratched the surface. He described a phenomenon he has seen in studying recovery as "a process of progress where people gradually let go of the most harmful/risky addiction first then gradually the others over time. Some people may institute new ones (e.g., start gambling/porn, etc.) that can have a life of their own, which is a risk, but we need more data on the natural history of these things — still got a lot to learn here." •

Coming up...

The **Research Society on Marijuana (RSMj) Annual Scientific Meeting** will be held **July 21-23** in Long Beach, California. For more information, go to **https://www.researchmj.org/**

The **NIA-NIAAA workshop on "Role of Alcohol Misuse in the Onset and Progression of Alzheimer's Disease and Its Related Dementias"** will be a hybrid event held **July 26-27** in the Natcher Conference Center on the NIH Campus, in Bethesda, Maryland. For more information, go to **https://www.nia.nih.gov/research**

The **National Prevention Network conference** will be held **August 15-17** in Birmingham, Alabama. For more information, go to **http://npnconference.org/**

The **California Society for Addiction Medicine (CSAM) State of the Art Addiction Medicine Conference** will be held **August 30 - September 2** in San Diego, California. For more information, go to https://csam-asam.org/

The **Contemporary Drug Problems Conference** will be held **September 6-8** in Paris, France. For more information, go to **https://www.latrobe.edu.au/arcshs/events/contemporary-drug-problems-conference**

The **Cape Cod Symposium on Addictive Disorders** will be held **September 7-10** in Hyannis, Massacchusetts. For more information, go to **https://www.capecodsymposium.com/**

The **NAADAC annual conference** will be held **October 6-12** in Denver, Colorado. For more information, go to **https://www.naadac.org/annualconference**

In case you haven't heard...

"Your liver doesn't care if you're an alcoholic or a heavy drinker." In this fascinating conversation between two drinkers — one who espoused moderation; one who went to abstinence — the discussion focused on a love of alcohol and ways to get away from it. Neither man was an "expert," except in lived experience, but both spoke with honesty and kindness. A great read. https://www.theguardian.com/society/2023/jul/12/moderation-or-total-abstinence-adrian-chiles-and-john-robins-talk-honestly-about-their-drinking.

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