AGENDA BOOK

April 23, 2015
8:00 am – 5:30 pm
Governor's Ballroom D-E, Fourth Floor

American Society of Addiction Medicine
4601 N. Park Avenue, Upper Arcade #101, Chevy Chase, MD 20815
Phone: 301-656-3920 | Fax: 301-656-3815 | Email: email@asam.org

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Short Definition of Addiction - ASAM

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Note: This is the working definition we will use through the day
Also, DSM 5 will be used for diagnostic categories unless noted otherwise.
Introduction for Participants

Welcome to the American Society of Addiction Medicine’s (ASAM) course, the Fundamentals of Addiction Medicine. This is a practical, case-based course designed to support primary care physicians and general psychiatrists in their clinical treatment of patients at risk for or with substance use disorders (SUD). The increased interest in expanding the physician’s role in treating addiction has arisen, in part, because of the co-morbidities of medical and other psychiatric illnesses among patients who use substances. However, another facet to expanding the physician’s role is the development of new medications and access to those medications and medical care due to Affordable Care Act. With the expansion of the physician’s role and increased patient access to medical care, it is fitting that the need for early interventions starts to take place in primary care and general psychiatry practice. The following are the course goal and objectives.

Course Goal
Primary care physicians and psychiatrists will effectively treat adult out-patients at risk for or with addictive disorders.

Learning Objectives
After attending the 1 day course, attendees will be able to:
1. Identify their feelings and attitudes that promote or prevent therapeutic responses to their patients with substance use disorders.
2. Summarize the three major neurocircuits underlying addictive disorders and their clinical implications.
3. Use and recommend, validated universal screening tools to identify substance use in patients and demonstrate the ability with confidence to score and interpret the results for hazardous and harmful use.
4. Respond to positive substance use screening results with brief counseling strategies, including motivational interviewing, appropriate to the patient’s readiness to change.
5. Evoke “change talk” in patients at risk for or with substance use disorders to empathically motivate behavior change.
6. Conduct a biopsychosocial and developmental ambulatory assessment of an adult with a SUD to match the patient to an appropriate level of care.
7. List the indications, contraindications and duration of treatment of evidence based pharmacotherapy for alcohol, tobacco, and opioid use disorders and refer to specialty care where appropriate.
8. Reflect on the role of formal intensive ambulatory and inpatient treatment and informal programs such as mutual aid groups (e.g. AA) in the recovery process for patients in their practice/ communities.

Course Structure
This course is very interactive—you will be participating in role-plays and other exercises at the table where you are seated. You will be led in this process by a facilitator who is assigned to your table.

Three cases are in printed handouts, one male and one female version for each case: Sam, Pat, and Jesse. Female participants should use the female versions and male participants, the male versions. The information is identical in both the male and female version of each case. Sam appears throughout the entire course; but Pat is replaced by Jesse in Sessions 6 and 7. Information about each case is presented in the handout, separated by session dividers corresponding to the sessions in which you will be using the cases. The cases “unfold,” so you will find as the course progresses that additional information is added to the case; repeated information is highlighted.

The Agenda Book also contains worksheets that will be used or completed by you in most of the sessions. These worksheets are clearly marked, and the time during the session when you will use them is also indicated on the worksheet.

Resources referenced throughout this course and additional resources will be available on the ASAM Fundamentals of Addiction Medicine Resources website (http://www.asam.org/education/asam-fundamentals-resources).
Welcome Remarks and Course Introduction
Peter Selby, MBBS, CCFP, FCFP, DipABAM, FASAM

Session 1: Meeting Our Patient: An Introduction to Addictive Disorders
Peter Selby, MBBS, CCFP, FCFP, DipABAM, FASAM

Session 2: A Brain on Drugs: The Clinical Manifestations of the Neurobiology of Addictions
Steve Wyatt, DO

Session 3: Identifying Unhealthy Substance Use: Case Finding Made Easy
Ken Saffier, MD,
Paul Seale, MD

Refreshment Break

Session 4: Should I Open Pandora’s Box?: Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Paul Seale, MD

Session 5: When Your Patient says Yes, But!: A “Taste” of Motivational Interviewing
Ken Saffier, MD,
Cathy Friedman, MD,
Steve Wyatt, DO

Lunch Break (On Your Own)

Session 6: Matching the Treatment to the Patient: Developing an Appropriate Treatment Plan
Alexander Walley, MD, MSc

Refreshment Break

Session 7: For Every ill, There May Be a Pill: Treating Substance Use Disorders With Medication and Counseling
Miriam Komaromy, MD, FACP

Course Wrap Up & Evaluation
Peter Selby, MBBS, CCFP, FCFP, DipABAM, FASAM
SESSION FACILITATORS

Peter L. Selby MBBS, CFCP, FCFP, dipABAM, FASAM - Chair
Chief, Addictions Division, Centre for Addiction & Mental Health
Professor, Dept. of Family & Community Medicine and Psychiatry, Dalla Lana School of Public Health, University of Toronto, Toronto, ON

Miriam Komaromy, MD, FACP - Vice Chair
Associate Director, Project ECHO
Associate Professor of Internal Medicine, University of New Mexico Health Sciences Center, Albuquerque, NM

Catherine R. Friedman, MD
Assistant Professor, Alpert Medical School of Brown University- Dept. of Psychiatry and Human Behavior
Attending Psychiatrist, Bradley Hospital, Providence, RI

Peter D. Friedmann, MD, MPH, FASAM, FACP
Professor of Medicine, and Health Services, Policy & Practice Alpert Medical School and School of Public Health, Brown University
Director, Research Section, Division of General Internal Medicine, Rhode Island Hospital
Director, Center of Innovation in Long-Term Services and Supports, Providence Veteran Affairs Medical Center, Providence, RI

Kenneth A. Saffier, MD
Residency Leadership Group
Contra Costa Regional FMR, Martinez, CA

J. Paul Seale, MD
Professor and Director of Research
Department of Family Medicine
Medical Center of Central Georgia & Mercer University School of Medicine, Macon, GA

Alexander Walley, MD, MSc - Vice Chair
Assistant Professor of Medicine
Boston University School of Medicine, Boston, MA

Stephen A. Wyatt, DO
Medical Director Addiction Medicine, Behavioral Health, Carolinas HealthCare System, Charlotte, NC

ASAM Fundamentals Staff

Arlene C. Deverman, CAE, VP, Professional Development

Alexandra (Alli) Unger, Manager, Professional Development

Marcia Jackson, PhD, ASAM Consultant
CME Information and Disclosure Listing

The American Society of Addiction Medicine (ASAM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The American Society of Addiction Medicine designates this material for a maximum of 8 AMA PRA Category 1 Credits™. The American Academy of Family Physicians designates this activity for a maximum of 8 Prescribed credits by the AAFP. Participants should claim credit commensurate with the extent of their participation in the activity.

In accordance with the disclosure policies of ASAM and the ACCME, the effort is made to ensure balance, independence, objectivity, and scientific rigor in all educational activities. These policies include resolving all conflicts of interest between the CME Committee, Planning Committee and faculty, and commercial interests that might otherwise compromise the goal and educational integrity of this activity. All CME Committee, Planning Committee and faculty participating in the activity have disclosed all relevant financial relationships with commercial interests. The CME Committee has reviewed these disclosures and determined that the planning committee and faculty relationships are not inappropriate in the content of their respective presentations and are not inconsistent with the educational goals and integrity of the activity.

The ASAM Fundamentals of Addiction Medicine Planning Committee

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<td>Peter L. Selby MBBS, CFCP, FCFP, dipABAM, FAASAM, Chair</td>
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<td>Miriam Komaromy, MD, FACP, Vice Chair</td>
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<td>Peter D. Friedmann, MD, MPH, FASAM, FACP, American College of Physicians (ACP) Representative</td>
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<td>Alexander Walley, MD, MSc</td>
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<td>Stephen A. Wyatt, DO</td>
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# The ASAM Fundamentals of Addiction Medicine Session Facilitators

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Session 1
Meeting Our Patient: An Introduction to Addictive Disorders
8:10 – 9:00 a.m.

Session Facilitator(s)
Peter Selby, MBBS, CCFP, FCFP, DipABAM, FASAM, The ASAM Fundamentals Curriculum Director

Learning Objective # 1
Identify their feelings and attitudes that promote or prevent therapeutic responses to their patients with substance use disorders.

Session Overview
The purpose of this session is for participants to (1) become acquainted with their colleagues at the small table, (2) be immediately engaged through a powerful, visual medium; (3) identify and reflect upon their individual affective response to the disease of substance use disorder and their patients who show evidence of this disease, (4) identify and discuss the many factors associated with SUD, e.g., enabling behaviors of others in the abuser’s life, physical features of SUD, etc., (5) be aware that the goal of the day is to prevent such outcomes through early identification and treatment, and (6) identify a referral pathway to an addiction medicine specialist for severely addicted patients. You will also “meet” our two continuing cases.

Reflection
You will find a reflection worksheet on the next page of this Agenda Book. Please record any reflections on that worksheet as you view a brief video clip from the film “Leaving Las Vegas.” Your table will be asked to record what you saw and felt about the clip.

Resources
- VIDEO: Addiction as a Brain Disease: What Every PCP Should Know. Nora D. Volkow, MD, Director of the National Institute on Drug Abuse, NIH (10 min, 29 sec); https://secure.quantiamd.com/player/yaqskivkk?cs=18pwpw11wvg7cp
- VIDEO: Drug and Alcohol Abuse: Detection and Intervention. Richard Saltz, MD (11 min, 33 sec); https://secure.quantiamd.com/player/yaqskivkk?cs=18pwpw11wvg7cp
- VIDEO: Medications for the Treatment of Addictive Disorders, Charles, P. O’Brien (9 min, 01 sec); https://secure.quantiamd.com/player/yaqskivkk?cs=18pwpw11wvg7cp
- VIDEO: Responsible Opioid Prescribing & Prescription Drug Abuse. Scott M. Fishman, MD (7 min, 20 sec); https://secure.quantiamd.com/player/yaqskivkk?cs=18pwpw11wvg7cp
“LEAVING LAS VEGAS” REFLECTIONS WORKSHEET
[To be completed during the film clip of “Leaving Las Vegas”]

**Directions:** Note below what you observe in the clip of “Leaving Las Vegas.”

1) Diagnostic features of alcohol use disorders- DSM-5 in Nicolas Cage (Ben)

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<tr>
<th>Item</th>
<th>When Seen</th>
<th>Comments</th>
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<tr>
<td>1. Taking the substance in larger amounts or for longer than meant to</td>
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<td>2. Wanting to cut down or stop using the substance but not managing to</td>
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<td>3. Spending a lot of time getting, using, or recovering from use of the substance</td>
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<td>4. Cravings and urges to use the substance</td>
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<td>5. Not managing to do what he should at work, home or school, because of substance use</td>
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<td>6. Continuing to use, even when it causes problems in relationships</td>
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<td>7. Giving up important social, occupational or recreational activities because of substance use</td>
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<td>8. Using substances again and again, even when it puts the self in danger</td>
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<td>9. Continuing to use, even when they know they have a physical or psychological problem that could have been caused or made worse by the substance</td>
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<tr>
<td>10. Needing more of the substance to get the effect they want (tolerance)</td>
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<tr>
<td>11. Development of withdrawal symptoms, which can be relieved by taking more of the substance</td>
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2) Behavior of others

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<thead>
<tr>
<th>Item</th>
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<td>Ignoring the issue</td>
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<td>Getting violent with the issue</td>
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<td>Holding him accountable</td>
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Session 2
A Brain on Drugs: The Clinical Manifestations of the Neurobiology of Addictions
9:00 – 9:35 a.m.

Session Facilitator(s)
Steve Wyatt, DO (Lead Facilitator)

Learning Objective # 2
Summarize the three major neurocircuits underlying addictive disorders and their clinical implications.

Session Overview
The purpose of this session is to introduce the neurobiology of SUD, highlighting that this is a chronic illness and noting that the point of first entry into the healthcare system is through the primary care physician. The following points will be emphasized:
1. Early factors in SUD development
2. Tolerance/withdrawal
3. Reward
4. Memory path
5. Treatment

Reflection
You will find a reflection worksheet as a final page of this Agenda Book. Please record any reflections from this session and others throughout this course on that worksheet, as you wish.

Resources
- The Happiness Hypothesis (http://www.happinessthypothesis.com/)
Session 3
Identifying Unhealthy Substance Use: Case Finding Made Easy
9:35 – 10:15 a.m.

Session Facilitator(s)
Ken Saffier, MD (Lead Facilitator)
Paul Seale, MD

Learning Objective # 3
Use and recommend, validated universal screening tools to identify substance use in patients and demonstrate the ability with confidence to score and interpret the results for hazardous and harmful use.

Session Overview
The purpose of this session is to introduce and practice using validated screening tools for detecting unhealthy alcohol and other substance use in healthcare settings. Factual information about available tools will be presented, and participants will discuss how these tools could be integrated into their own practice. The SBIRT (screening, brief intervention, and referral to treatment) approach, including national guidelines advocating universal alcohol screening, will be introduced as a bridge to a more expanded discussion in session 4.

Resources

Reflection
You will find a reflection worksheet on the final page of this Agenda Book. Please record any reflections from this session on that worksheet, as you wish.
Directions: The two of you (dyad) will engage in two brief clinical skills practice scenarios, each 5 minutes in length. The session facilitator will call “time” at the conclusion of the first scenario, at which time you will switch to the second role-play for 5 minutes. Use the information provided in your relevant case study handout to answer the questions posed by the “healthcare provider.” Note that at the conclusion of the Session 3 case study, Sam and Pat have some additional information that has been given to the healthcare provider.

In scenario 1, the member of your dyad assigned the role of Sam will be the “patient”; the other member will play the healthcare provider. In scenario 2, the “patient” in scenario one will play the role of the healthcare provider. The healthcare provider in scenario 1 will play this or her assigned role of Pat in scenario 2. Note that you will engage in several more clinical skills practices throughout this course. Each of you should always retain the patient role used in these two scenarios in subsequent activities.

Sam and Pat each have an appointment with their primary care provider for common primary care complaints. Sam is requesting a sleeping pill; Pat is requesting a URI. Sam and Pat should use the information provided in the respective case studies to answer the healthcare provider’s questions.

Sam and Pat have each completed brief assessment forms, the AUDIT and the DAST, which have been provided to the healthcare provider in advance of their respective appointments. The results for each are presented in the Case Study Booklet for each.

During the first 5 minutes, one dyad member will play the healthcare provider role, interviewing “Sam” with respect to alcohol and drug risks. The interview will begin with the provider asking the screening questions (NIAAA single question screen followed by determining frequency and quantity limits, then the single question drug screen) and providing feedback to the patient. The healthcare provider will then review the AUDIT and DAST scores and interpret them for the patient. After 5 minutes, dyad members will switch roles for the next 5 minutes and repeat this same exercise, where “Pat” is the patient.

IMPORTANT: The participant playing the healthcare provider role in each exercise is to share information with the patient about their drug or alcohol use as discovered by screening. They are only to use the screening instruments, not counsel their patient to cut back or abstain.
Instructions for Healthcare Provider in Both Role-Plays:

You are to review the results of the assessment data with the patient, modeling what you have seen on the demonstration video. Ask questions to validate the assessment data, listen carefully to the patient, and follow-up with additional questions to gather further information. Practice using single screening questions. The AUDIT and DAST scores for each patient are located in the Case Studies Booklet behind the tab labeled with the appropriate patient name (i.e. if this is for the female version of Sam turn to the “Sam-Female” tab and locate the table labeled “Session 3”).
Session 4
Should I Open Pandora’s Box? Screening, Brief Intervention, and Referral to Treatment (SBIRT)
10:30 – 11:30 a.m.

Session Facilitator(s)
Paul Seale, MD (Lead Facilitator)

Learning Objective # 4
Respond to positive substance use screening results with brief counseling strategies, including motivational interviewing, appropriate to the patient’s readiness to change.

Session Overview
The purpose of this session is to provide further training and skills practice in assessment and brief intervention for persons with risky substance use, and referral to treatment for persons with substance use disorder. These SBIRT steps will be demonstrated in two brief videos, each followed by an opportunity for participants to practice the SBIRT approach, e.g., the brief negotiated interview. The discussion of how best to integrate the SBIRT approach into the participants’ individual practices will be continued in the small groups. The continuing case studies will be used in this session; the process of motivational interviewing (MI) will be introduced as a bridge to the next expanded session.

Reflection
You will find a reflection worksheet on the final page of this Agenda Book. Please record any reflections from this session on that worksheet, as you wish.

Resources

- ONLINE SCREENING TOOL: NIDA Drug Use Screening Tool;
- VIDEO TRAINING MODULES: SECSAT (Southeastern Consortium for Substance Abuse Training) Training Modules--Screening, Brief Intervention, and Referral to Treatment for Alcohol; [http://sbirtonline.org/curriculum/](http://sbirtonline.org/curriculum/)
- ONLINE SCREENING TOOL: Alcohol Screening; [http://www.alcoholscreening.org/Screening/Page02.aspx](http://www.alcoholscreening.org/Screening/Page02.aspx)
• ONLINE SCREENING TOOL: Drug use disorder screening tool from Join Together, a project of the Boston University School of Public Health; [http://www.drugscreening.org](http://www.drugscreening.org)
• SBIRT Primary Care--A site with video demonstrations of SBIRT, practice management tools and clinic workflow; [www.sbirtoregon.org](http://www.sbirtoregon.org)
• ONLINE SCREENING TOOL: Level 2: Substance Use--Adult. A tool that is an adaptation from the NIDA-Modified ASSIST; [http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures](http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures)
• ARTICLE: DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale
ROLE PLAY WORKSHEET

[To be completed during role-plays that start at 10:40]

Directions: Your dyad will engage in two brief role-play scenarios, each 5 minutes in length. The role-plays will be separated by a brief discussion in the large group setting.

In scenario 1, one member of your dyad will continue to play the role of Sam, the other member will play the healthcare provider. You will have 10 minutes for this scenario, which will be followed by a large session debriefing. Scenario 2 begins at 11:10. Sam—the “patient” in role-play one—will play the role of the healthcare provider in this scenario and the healthcare provider from scenario 1 will play the role of Pat. Note that each of you should retain the patient role that you played in the preceding role-plays.

Instructions for Healthcare Provider in Both Role-Plays:

You are to lead an SBIRT or BI discussion with the patient, modeling what you have seen in the demonstration videos. Conduct the discussion (SBIRT and/or BI), following the four-step approach demonstrated in the video. If you suspect your patient has alcohol or substance use disorder, offer an appropriate menu of options for additional treatment services, e.g., referral to a substance abuse treatment program, engagement with a 12-step program, beginning a medication, etc., and negotiate a treatment plan with the patient.
Instructions for Sam, Patient 1:

You are Sam at age 20. You have come in due to inability to sleep, which began about 3 months ago after you had a DUI and decided you needed to cut back on your drinking. Before, you would have 2 glasses of wine at lunch, 3 - 4 at dinner and 1 or 2 of brandy or mixed drinks during the evening. You cut your intake about in half and stopped drinking larger amounts on weekends. Before going to court a week ago, you noted that you were irritable and shaky when you drank only 1 glass of wine and 1 drink before bed the night before. You ask, “Can you prescribe something to help me sleep? I find I’m nervous all of the sudden in the mornings and don’t want to go out.”

Additional history: Father left home when you were 10 and he had an alcohol and anger problem.
Family history: You think your mother is “hooked on pills and we don’t see her much.”

You have an AUDIT score of 17, with individual question scores as noted in the Case Study Booklet.

Readiness to change 7, because the DUI worried and embarrassed you. You are shocked you shake in the mornings if you cut back too much, and your boyfriend (or girlfriend) has been telling you he’s (she’s) concerned about your drinking.

If the clinician initiates a discussion about support or treatment options, state that you have thought about going to the Employee Assistance Program at work; you have heard good things about it, and you think you can get help there without endangering your work.
**Instructions for Pat, Patient 2:**

You are 25 years old, don’t really like to drink that much, are a low risk drinker.

Alcohol consumption:

a. Female patients: 1 glass of wine with friends on Saturday or Sunday once or twice a month when entertaining or when you are out with friends;

b. Male patients: 2 or 3 twelve ounce beers with friends on Saturday or Sunday once or twice a month while watching sports events on TV.

You are recovering from a shoulder sprain from a fall at work 3 months ago (your workman’s comp doctor is treating this with hydrocodone) and you come in with a chief complaint of symptoms of an upper respiratory infection (runny nose, non-productive cough, no chills or fever).

Medications: Hydrocodone 5 mg. three times daily. Recently your friends told you about getting a “buzz” from chewing your hydrocodone pain pills on an empty stomach with 2 or 3 drinks. You tried it two or three times and found out it felt “really good.”

Your single question alcohol score is 0 and your AUDIT score is 3 (low risk; see AUDIT included in Case Study Booklet). Your single question drug score is 3 (you chewed hydrocodone with 2 drinks on 3 different occasions) and your DAST score is 2 (at risk for problems related to drug use). Your shoulder pain is present every day (pain score of 4 to 5) and flares when you overdo things at work and you are aware that you are beginning to use your medication recreationally.

Readiness to change: 4. You enjoy drinking and an occasional hydrocodone; You don’t drink nearly as much as your friend, but your dad was a bad alcoholic and you don’t want to end up like him. You feel a little bit bad about the way you use your hydrocodone, but you really “need it” to control the pain so you can work. In addition, you only combine it with alcohol every once in a while and you’re certainly not addicted to it. You agree to stop using alcohol and hydrocodone together, if asked to do so, and to try to begin using hydrocodone only “as needed,” rather than routinely three times every day.
Session 5
When Your Patient says Yes, But!: A “Taste” of Motivational Interviewing
11:30 – 12:30 a.m.

Session Facilitator(s)
Ken Saffier, MD (Lead Facilitator)
Cathy Friedman, MD
Steve Wyatt, DO

Learning Objectives #4 & 5
Respond to positive substance use screening results with brief counseling strategies, including motivational interviewing, appropriate to the patient’s readiness to change.

Evoke “change talk” in patients at risk for or with substance use disorders to empathically motivate behavior change.

Session Overview
The purpose of this session is to introduce motivational interviewing and provide an opportunity for participants to practice using the MI approach in interacting with patients, especially those who are ambivalent to change.

Reflection
You will find a reflection worksheet on the final page of this Agenda Book. Please record any reflections from this session on that worksheet, as you wish.

Resources
Videos that illustrate motivational interviewing:
• “Motivational Interviewing for Addictions”; http://www.youtube.com/watch?v=EvLquWI8aqc
• “Motivational Interviewing for Busy Clinicians: Mr. Smith’s smoking evolution” by a primary care internist, Damara Gutnick, MD, that lasts 10 minutes. It’s creatively and entertainingly done and demonstrates how MI can be done with an economy of time in an office based setting. http://www.youtube.com/watch?v=0z65EppMfHk
• “Motivational Interviewing, An Introduction” by Bill Matulich, PhD, that lasts 17:23. It provides a nice overview/review and summarizes the main points of MI. http://www.youtube.com/watch?v=s3MCJZ7OGRk
• “Can listening save time?, a story of Dr. Ng Min Yin” that describes a physician applying what she has learned after a MI workshop to help a challenging patient. (7:57) https://vimeo.com/67088727
• When describing the "spirit" of MI, which is essential to its successful practice, empathy is integral. This powerful and moving video, "Empathy, the Human Connection to Patient Care" (4:25) from the Cleveland Clinic illustrates this poignantly and beautifully. http://www.youtube.com/watch?v=cDDWvj_q-o8&feature=youtu.be

For information on MI trainings and other resources, go to www.motivationalinterviewing.org.
Online alcohol and drug screening resources for patients:

- [www.alcoholscreening.org](http://www.alcoholscreening.org) This is a motivational interviewing consistent tool that can be done at home or in the office, providing both patients and providers with a printout if desired. There is also a very easy-to-use treatment locator as part of this site.
“TASTE OF MI” REAL PLAY WORKSHEET
[To be completed during real-play that begins at 12:00 noon]

Patient Role
Select a personal behavior that you might wish, need, should or know how to change, but have been unsuccessful or only moderately successful in accomplishing so far. Note that you will be sharing this behavior with others, so don’t select a personal behavior that might cause you some discomfort if shared. If you prefer, you could select a behavior from a patient with whom you have experience, similar to Sam or Pat, who has been unsuccessful in changing that behavior. Divulge information only if you feel comfortable with the interviewer. Examples of such behavior might include losing weight, exercising more, reading, working less, eating more fruit and vegetables, adopting a salt free diet, smiling more, etc. At the end of this real-play, the session facilitator will lead a de-briefing discussion for a few minutes, asking you to reflect on the experience from a responder’s perspective.

Interviewer Role
The interviewee in your dyad has selected a personal behavior that s/he wishes to change, but has been unsuccessful or only moderately successful in accomplishing so far. As the interviewer, you should not try to persuade the interviewee to do anything. Do not offer advice, nor try to “fix” anything. Instead, ask only the 5 questions below, one at a time, and listen carefully to what the interviewee says. Listen especially for change talk- or DARN statements- Desire, Ability, Reasons, Need to change the behavior.

Interviewer Questions:

1. Why would you want to make this change? (This evokes reasons and needs to change )
2. If you did decide to make this change, how might you go about it in order to succeed? (This explores abilities to change)
3. What are the three best reasons for you to do it? ( This evokes reasons to change)
4. How important would you say it is for you to make this change, on a scale from 0 to 10, where 0 is “not at all important” and 10 is “extremely important”? And why are you at ___ rather than a lower number of 0? ( elicits desire to change and reflection on ambivalence)

After you have listened carefully to the answers to the above questions, give back a short summary of what you heard, of the person’s motivations for change. (builds an empathic relationship)

5. Then ask one more question: So what do you think you’ll do? And listen with interest to the answer. ( elicit commitment to change- listen for CAT statements)
GUIDE FOR MOTIVATIONAL INTERVIEWING

1. **Start the conversation with open ended questions**
   - How can I stop myself from asking “why?” questions?
   - How can I get permission before giving advice?

   Examples:
   a. How can I help you today?
   b. Given we have 30 minutes, what would you like to talk about today?
   c. Since the last time we met, how have things changed for you?

2. **Listen for Desire, Ability, Reasons, Needs, Commitment, Action, Taking Steps**
   Construct two reflections for each statement you hear. Go as deep as feels comfortable but be tentative.

   Examples:
   a. what I hear you say is ............
   b. It seems to me you are feeling..........
   c. This means a lot to you....yet ....

3. **Construct at least one affirmation; more is better (most likely to generate change talk)**
   e.g. I know how hard it must be to keep coming back but I am glad you found the courage to do so. If you are stuck, ask “What else?” or “Tell me more?”

4. **Summarize to signal transition into focusing.**

5. **Scale readiness to change**
   a. Given everything going on in your life right now, on a scale of 0 to 10, where 10 is the most important thing to do and 0 is not at all important, how important is it for you to <insert behavior change here>? By when?
   b. On a similar scale how confident are you that you will <insert behavior change here>? By when?
   c. Optional question: On the same scale how ready are you to <insert behavior change here>? By when?

6. **Ask: Help me understand what is good about staying the same for you? What else?**
   Use OARS

7. **Ask: Help me understand what is not so good about staying the same? What else?**
   Use OARS
8. **Ask: So what do you think/feel you will do next?** Listen for Change talk or sustain talk.
   a. If Commitment language: Ask: What might come in the way of you achieving your goal?
   b. If sustain talk, listen and use OARS to evoke change talk.

9. **Begin planning: SMART goals:** Listen for specificity, measurable, achievable, realistic and time limited goals.

10. **End interview with a brief summary and ask:** When would you like to come back and see me again to discuss how things are going for you?

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**The Spirit of MI**

*Compassion, Acceptance, Partnership, Evocation Acceptance, Absolute worth, Accurate empathy*
Session 6
Matching the Treatment to the Patient: Developing an Appropriate Treatment Plan
1:30 – 3:30 p.m.

**Session Facilitator(s)**
Alexander Walley, MD, MSc (Lead Facilitator)

**Learning Objective # 6**
Conduct a biopsychosocial and developmental ambulatory assessment of an adult with a SUD to match the patient to an appropriate level of care.

**Session Overview**
In this session, learners will review the DSM-5 diagnostic criteria, then learn and practice using ASAM patient placement criteria. Based on the severity of the disorder and the patient’s readiness, learners will develop an appropriate treatment plan for patients that will account for medical and psychiatric co-morbidity. The table facilitators will lead small group discussions regarding patient assessment and treatment planning and a case role-play. Relevant web-based applications to assist the assessment process will be illustrated.

**Reflection**
You will find a reflection worksheet on the final page of this Agenda Book. Please record any reflections from this session on that worksheet, as you wish.

**Resources**
- APA Substance-Related and Addictive Disorders Fact Sheet
- NIAAA Clinician’s Guide to Helping People Who Drink Too Much
- SCOPE of Pain: Safe and Competent Opioid Prescribing Education [www.scopeofpain.com](http://www.scopeofpain.com)
**ASAM PATIENT PLACEMENT CRITERIA WORKSHEET**  
*[To be completed during Table Exercise 1 at 1:50]*

**Directions:** You are to complete this table based on what you learned about the woman in the video that you viewed as part of this session. Circle the box that best reflects this patient for each of the ASAM dimensions. You will have 5 minutes to complete this table, then your table facilitator will lead a 10 minute group discussion of the individual placements.

<table>
<thead>
<tr>
<th>ASAM Dimension</th>
<th>ASAM Patient Placement Criteria</th>
<th>Levels of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I. Outpatient</td>
<td>II. Intensive Outpatient</td>
</tr>
<tr>
<td>1: Acute Intoxication and/or Withdrawal Potential</td>
<td>no risk</td>
<td>minimal</td>
</tr>
<tr>
<td>2: Biomedical Conditions &amp; Complications</td>
<td>no risk</td>
<td>manageable</td>
</tr>
<tr>
<td>3: Psychological/Behavioral Conditions &amp; Complications</td>
<td>no risk</td>
<td>mild</td>
</tr>
<tr>
<td>4: Readiness to Change</td>
<td>Action</td>
<td>Preparation/Action</td>
</tr>
<tr>
<td>5: Relapse Potential</td>
<td>Maintains abstinence</td>
<td>More symptoms</td>
</tr>
<tr>
<td>6: Recovery Environment</td>
<td>supportive</td>
<td>can cope with structure</td>
</tr>
</tbody>
</table>
DSM-5 Criteria (Reference for Table Exercise 1)

In the past 12 months, has your patient’s substance use repeatedly caused or contributed to:

A. **Impaired control:**
   1. Taking more or for longer than intended
   2. Not being able to cut down or stop (repeated failed attempts)
   3. Spending a lot of time obtaining, using, or recovering from use
   4. Craving for substance

B. **Social impairment:**
   5. Role failure (interference with home, work, or school obligations)
   6. Kept using despite relationship problems caused or exacerbated by use
   7. Important activities given up or reduced because of substance use

C. **Risky use:**
   8. Recurrent use in hazardous situations
   9. Kept using despite physical or psychological problems

D. **Pharmacologic dependence:**
   10. Tolerance to effects of the substance*
   11. Withdrawal symptoms when not using or using less*

* Persons who are prescribed medications such as opioids may exhibit these two criteria, but would not necessarily be considered to have a substance use disorder

Mild = 2-3 criteria, Moderate = 4-5 criteria, Severe = 6 or more criteria
**ASAM PATIENT PLACEMENT CRITERIA WORKSHEET**

[To be completed during Table Exercise 2 at 2:30]

**Directions:** If you have played the continuing role of “Sam,” you are to complete this table as it relates to the information provided in the case study booklet, Session 6, for the new patient, “Jesse.” If you have played the continuing role of “Pat,” you are to complete this table as it relates to the information provided in the case study booklet for “Sam.” Using your placement criteria for this assigned case study, use that information to complete the Treatment Plan Template on the following page. You have 5 minutes to complete this table.

<table>
<thead>
<tr>
<th>ASAM Dimension</th>
<th>ASAM Patient Placement Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Levels of Care</td>
</tr>
<tr>
<td></td>
<td>I. Outpatient</td>
</tr>
<tr>
<td>1: Acute Intoxication and/or Withdrawal Potential</td>
<td>no risk</td>
</tr>
<tr>
<td>2: Biomedical Conditions &amp; Complications</td>
<td>no risk</td>
</tr>
<tr>
<td>3: Psychological/Behavioral Conditions &amp; Complications</td>
<td>no risk</td>
</tr>
<tr>
<td>4: Readiness to Change</td>
<td>Action</td>
</tr>
<tr>
<td>5: Relapse Potential</td>
<td>Maintains abstinence</td>
</tr>
<tr>
<td>6: Recovery Environment</td>
<td>supportive</td>
</tr>
</tbody>
</table>

April 23, 2015
CASE STUDY TREATMENT PLAN TEMPLATE
[To be completed during Table Exercise 2 at 2:35]

Directions: Using the information on the ASAM Patient Placement Criteria that you just completed with regard to your assigned case study, prepare a treatment plan for that patient. You will have 10 minutes to complete this plan, at which point you will discuss both the placement criteria and your plan with your small group table members.

Assessment

Plan

Treatment plan considerations:

- Co-morbid substance use, psychiatric, medical, and social problems impact the treatment plan
- The patient’s readiness frames the treatment plan
- Resources available in your practice setting
- UDT as an assessment tool
- Non-pharmacological treatment options
- Harm reduction – optimizing safety
- Medication
- Need for withdrawal management
- Family and social supports
ROLE PLAY WORKSHEET

[To be completed during Table Exercise 2 at 3:00]

Directions: You will again form your same dyads that you have used in previous sessions and engage in two brief role-play scenarios, each 5 minutes in length. Sam is a continuing patient, but Pat has left your practice and Jesse is a new patient. The dyad partner who has played the role of Sam will continue in this role; the partner who has played Pat will now assume the role of Jesse. This dyad member should use the handout reflecting the sex-appropriate case study for Jesse. As in previous role plays, one partner in the dyad will play the patient role and the other will play the healthcare provider role.

The “healthcare provider” will lead the “patient” through a discussion of the treatment plan that has been prepared for that patient. Conduct the first role-play for about 5 minutes, where Sam is the patient. At that time, reverse roles, and repeat the role play where Jesse is the patient and the “health care provider” leads the discussion of Jesse’s treatment plan for 5 minutes. Your table facilitator will serve as the time-keeper.

Instructions for Healthcare Provider in Both Role-Plays:
You are to discuss the patient’s treatment plan that you have prepared, modeling what you have seen and discussed in Session 6.

Instructions for Patient Role:
Use the information provided in the respective case studies to answer the healthcare provider’s questions.
Session 7
For Every Ill, There May Be a Pill: Treating Substance Use Disorders With Medication and Counseling
3:45 – 4:50 p.m.

Session Facilitator(s)
Miriam Komaromy, MD, FACP

Learning Objective # 7 and #8
List the indications, contraindications and duration of treatment of evidence based pharmacotherapy for alcohol, tobacco, and opioid use disorders and refer to specialty care where appropriate.

Reflect on the role of formal intensive ambulatory and inpatient treatment and informal programs such as mutual aid groups (e.g. AA) in the recovery process for patients in their practice/communities.

Session Overview
The purpose of this session is to engage participants in dialogue about medications and behavioral treatments including mutual aid groups that may be used to treat three types of SUDs: alcohol, tobacco, opioids. Participants will review and discuss the two continuing cases with respect to the use of the appropriate pharmacotherapies and other treatment modalities for these cases and their related SUDs. The session and table facilitators will provide evidence-based information about medications and behavioral treatments as appropriate within the context of the small and large group discussions.

Resources
http://www.pcssmat.org/
http://www.pcss-o.org

- VIDEO: Medications for the Treatment of Addictive Disorders, Charles, P. O’Brien MD, PhD (9 min, 01 sec); https://secure.quantiamd.com/player/ywthwryxq?cs=18kwpw11wvg7cp
- VIDEO: Responsible Opioid Prescribing & Prescription Drug Abuse. Scott M. Fishman, MD (7 min, 20 sec); https://secure.quantiamd.com/player/ydftdjcjm?cs=18kwpw11wvg7cp
TREATMENT PLAN FOR SAM

Directions: Your table facilitator will lead a discussion about the case of Sam, if that is the case that has been assigned to your small group, with the goal to determine Sam’s treatment plan. If you need further information about Sam’s case, use the information that you have been provided in the Case Study Booklet. Sam’s case information has been abbreviated in this session for purposes of discussion and treatment planning.

<table>
<thead>
<tr>
<th>ID</th>
<th>Sam is still 35 year old single female; diagnosed with a severe alcohol use disorder</th>
<th>Sam is still 35 year old single male; diagnosed with a severe alcohol use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for visit</td>
<td>Expresses motivation to stop using alcohol.</td>
<td>Expresses motivation to stop using alcohol.</td>
</tr>
<tr>
<td>Physical</td>
<td>No evidence of alcohol withdrawal at the moment; odor of alcohol on breath; no withdrawal</td>
<td>No evidence of alcohol withdrawal at the moment; odor of alcohol on breath; no withdrawal</td>
</tr>
<tr>
<td>Labs</td>
<td>AST &gt;ALT 2x; bili normal. Hb N; MCV elevated; Urine tox: positive alcohol, neg THC, Urine HCG neg</td>
<td>AST &gt;ALT 2x; bili normal. Hb N; MCV elevated. Urine tox: positive alcohol, neg THC</td>
</tr>
<tr>
<td>Tobacco</td>
<td>20 cpd (cigarettes per day) with first cigarette within 5 minutes of waking</td>
<td>20 cpd (cigarettes per day) with first cigarette within 5 minutes of waking</td>
</tr>
</tbody>
</table>

Discussion Questions for Sam’s Case

1. How would you assess Sam’s risk for withdrawal symptoms?
2. If you decide that Sam is at significant risk of alcohol withdrawal syndrome, where and how would you treat the alcohol withdrawal?
3. Once Sam has withdrawn from alcohol, what treatment settings would be appropriate for Sam?
4. What treatment modalities would you offer Sam for Alcohol Use Disorder?
5. How about for Tobacco Use Disorder?
6. What are your treatment targets, and what duration would you recommend for the treatment?
7. Would you advise Sam to engage in treatment for one SUD or the other (alcohol or tobacco) first, or to address both simultaneously?
TREATMENT PLAN FOR JESSE

Directions: Your table facilitator will lead a discussion about the case of Jesse, if that is the case that has been assigned to your small group, with the goal to determine Jesse’s treatment plan. If you need further information about Jesse’s case, use the information that you have been provided in the Case Study Booklet. Jesse’s case information has been abbreviated in this session for purposes of discussion and treatment planning.

<table>
<thead>
<tr>
<th>ID</th>
<th>Jesse, 35 year old divorced female, 2 kids -10 and 8 - no custody but can visit</th>
<th>Jesse, 35 year old divorced male, 2 kids- 10 and 8 - no custody but can visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for visit</td>
<td>Wants to explore pharmacotherapeutic options for opioid use disorder.</td>
<td>Wants to explore pharmacotherapeutic options for opioid use disorder</td>
</tr>
<tr>
<td>Physical</td>
<td>Evidence of mild opioid withdrawal; no track marks</td>
<td>Evidence of mild opioid withdrawal; no track marks</td>
</tr>
<tr>
<td>Labs</td>
<td>HCV pos; HIV neg; HBV negative; LFTs Normal. Rest Normal. HCG neg</td>
<td>HCV pos; HIV neg; HBV negative LFTs Normal. Rest Normal</td>
</tr>
<tr>
<td>Psychosocial treatment</td>
<td>Nil in the past. Doesn’t believe in NA or AA.</td>
<td>Nil in the past. Doesn’t believe in NA or AA.</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Smokes 25 cpd. First cig within 5 minute of waking</td>
<td>Smokes 25 cpd. First cig within 5 minute of waking</td>
</tr>
</tbody>
</table>

Discussion Questions for Jesse’s Case

1. Jesse is interested in pharmacotherapy for opioid use disorder (OUD). What options would you explore with him/her? Note that Information about each of these agents is in the last page of your guide for this session, as well as in the Agenda Book for this session.
2. Depending on Jesse’s choice of medication options s/he may need to undergo opioid withdrawal. What are your options for managing his/her withdrawal, and how do they relate to the choice of ongoing pharmacotherapy?
3. What treatment settings would be appropriate for Jesse, and how would you decide?
4. Jesse has stated that s/he is not interested in Narcotics Anonymous. How would you respond? What other types of Peer Support are available? What types of counseling/psychotherapy are effective?
5. What types of harm reduction and health care maintenance interventions would be appropriate?
6. How about treatment for Tobacco Use Disorder? Note that Information about each of these agents is in the last page of this session in your guide, as well as in the Agenda Book for this session.
7. What are your treatment targets, and what duration would you recommend for the treatment?
8. Would you advise Jesse to engage in treatment for one SUD or the other (opioids or tobacco) first, or to address both simultaneously?
OPIOID MEDICATIONS

**Methadone**: highly effective maintenance therapy for OUD. Reduces injection drug use, decreases mortality and costs of care, decreases crime, and reduces risk of HIV and hepatitis C infection. In the US, must be dispensed from an Opioid Treatment Program (OTP) operated by the federal government; it is illegal for office-based physicians to prescribe methadone for treatment of OUD. Starting dose is up to 30 mg per day, and dose is gradually increased to effective dose, which is typically 60-120 mg per day. Treatment is daily directly-observed therapy, but eventually patients may qualify for “take-homes.” Risk of overdose if dose is raised too quickly or if the medication is diverted and taken in large doses, especially when combined with other opioids or sedative-hypnotics. Side effects include sedation, constipation, and (rarely) prolongation of the QT interval leading to increased risk of torsades de pointe (ventricular arrhythmia)

**Buprenorphine**: Also highly effective maintenance therapy for OUD. Prescribed as buprenorphine/naloxone (brand names Suboxone, Zubsolve, Bunavail, plus generics) or buprenorphine alone (indicated almost exclusively in pregnancy). Also reduces injection drug use, decreases mortality and costs of care, decreases crime, and reduces risk of HIV and hepatitis C infection. Can be prescribed in the physician office, but only by physicians who have obtained the federal “waiver” to provide them with a special DEA # for prescribing this medicine. In order to obtain this waiver physicians have to complete 8 hours of training through an approved organization such as ASAM (http://www.asam.org/education/online-training-(cme) or AAAP. Generally very safe, unless combined with sedative/hypnotics in which case overdose can occur, or in infants/small children in which even minimal ingestion can be lethal.

**Naltrexone**: largely ineffective in oral form, but increasing evidence for use to decrease relapse to OUD when administered as a long-acting intramuscular injection (brand name Vivitrol). Each injection is effective for 4 weeks, and acts by blocking the effect of other opioids during that period. Long term studies are largely unavailable, and studies comparing this drug with opioid agonists are underway. **Overdose risk is elevated due to decreased tolerance if patients relapse shortly after discontinuing naltrexone.**
TOBACCO MEDICATIONS

**Combined Nicotine replacement therapies (NRT):** Nicotine replacement is available as a long-acting daily patch and several short-acting options for nicotine replacement. These are most effective when used in combination, with the patch providing baseline control of nicotine withdrawal symptoms and the short-acting agents addressing craving and breakthrough withdrawal symptoms. Patches, gum, and lozenges are available over the counter, while the nasal spray and oral inhaler require prescription. People who smoke > 10 cigarettes (1/2 pack) per day should start with the highest dose patch (21 mg), and taper the dose over 10 weeks. Those who smoke less should start with the 14 mg patch. Patients should also use a short acting form of NRT concurrently. Starting treatment with more than one daily patch may be appropriate for patients who smoke more than 1 pack per day.

**Varenicline (brand name Chantix):** A partial agonist of nicotinic acetylcholine receptor, varenicline is administered as a daily oral dose of 1 mg BID (titrated up from 0.5 mg qd). It should be started at least one week before the planned quit date, and continued for 12 weeks or longer. Taking it with food and water diminishes nausea. There is some mixed evidence that it is associated with neuropsychiatric symptoms, and its use is not recommended in patients who are psychotic or markedly mentally unstable. Follow up monitoring should be arranged for all patients within one week of starting treatment.

**Bupropion (brand names Zyban, Wellbutrin SR):** is an agent also used as an anti-depressant, which works by enhancing noradrenergic and dopaminergic release. Compared with other medications used for smoking cessation, bupropion is associated with less short-term weight gain; however, this appears to be a temporary effect. Initiate with 3 days of 150 mg po daily, and increase to 150 mg BID. Although usually treatment lasts for 4 weeks, treatment may be continued for up to a year. Bupropion decreases the seizure threshold and may also be associated with neuropsychiatric symptoms; however, it is first-line therapy in schizophrenic patients who have tobacco use disorder. Follow up monitoring should be arranged for all patients within one week of starting treatment.
ALCOHOL MEDICATIONS

**FDA-Approved Medications**

**Naltrexone** is effective in reducing heavy drinking when used in the oral form (brand name Revia, 50-100 mg/day, administered daily) or the long-acting injectable form (brand name Vivitrol, 380 mg injected monthly). It reduces craving for alcohol, and makes drinking alcohol less pleasurable. It is an opioid-blocker (antagonist at the mu-opioid receptor), and so cannot be used in patients who take opioids. It can occasionally cause hepatic impairment, and should be used cautiously in patients with liver disease.

**Acamprosate** (brand name Campral) is administered as an oral medication (666 mg TID), and acts at the glutamate receptor. It appears to be most effective for maintaining abstinence, rather than decreasing heavy drinking. It decreases post-withdrawal anxiety. It can be used in patients with significant liver disease, but is renally excreted and is contraindicated in renal failure.

**Disulfiram** (brand name Antabuse) acts by causing unpleasant symptoms when alcohol is consumed. The medication interrupts the normal metabolism of alcohol and causes a build-up of acetaldehyde, which produces symptoms of nausea, vomiting, flushing, dyspnea, among others. A typical dose is 250 mg po daily. Care must be taken to avoid all forms of alcohol (eg in mouthwash) in order to avoid symptoms. It is contraindicated in patients with severe coronary disease or psychosis. It works best when supervised daily administration of the medication is provided, in order to avoid non-adherence.

**Non FDA-Approved therapies**

**Topiramate** acts at both GABA and glutamate receptors and is associated with both decrease in heavy drinking days and increased abstinent days. The dose is slowly titrated up from 25 mg per day to a maximum of 150 mg po BID. It may be started while patients are still drinking, and can cause a gradual reduction in intake. Side effects include mental slowing, paresthesias, and headache.

**Gabapentin** interacts with GABA receptors and improves rates of abstinence and decreases heavy drinking. The preferred dose is 1800 mg/day, divided TID; sedation and dizziness may occur. Some evidence suggests that combining naltrexone and gabapentin is helpful in improving naltrexone adherence and decreasing insomnia, and may be more effective than either medication alone.

**Baclofen** (10 mg po TID) also acts at GABA receptors. It may be effective at this dose for decreasing drinking in patients with cirrhosis. In non-cirrhotic patients there is some evidence that considerably higher doses (> 60 mg per day) may be more effective.
REFLECTION WORKSHEET

Directions: Record any reflections that you wish to make throughout the course on this worksheet.