WELCOME TO THE AMERICAN SOCIETY OF ADDICTION MEDICINE

Thursday, April 10, 2014 - 8:00 am – 5:30 pm
Hilton Orlando, Orlando, FL

MODERATOR FOR THE DAY & EXPECTATIONS

Peter Selby, MBBS, CFCP, FCFP, FASAM, Chair, Fundamentals of Addiction Medicine Curriculum

WELCOME FROM AMERICAN SOCIETY OF ADDICTION MEDICINE

Stuart Gitlow, MD, MPH, MBA, President, ASAM
The ASAM Fundamentals of Addiction Medicine Planning Committee

- Peter Selby, MBBS, CFCP, FCFP, FASAM (Chair, Curriculum Director)
- Jeanette M. Tetrault, MD, FACP (Vice Chair)
- Alexander Wally, MD, MSc (Vice Chair)
- Cathy Friedman, MD
- Peter D. Friedmann, MD, MPH, FASAM, FACP (ACP Rep)
- Ken Saffier, MD
- Mario San Bartolomé, MD, MBA
- Paul Seale, MD
- Steve Wyatt, DO

Table Facilitators

- Robbie Bahl, MD
- Melinda Campopiano, MD
- Kenneth Freedman, MD, MS, MBA, FASAM, FACP, AGAF
- William (Bill) Haning, MD, FASAM, DFAPA
- Todd Jaffe, MD
- Mark Kraus, MD, FASAM
- Judith Martin, MD, FASAM
- Yngvild Olsen, MD, MPH
- A. Ken Roy, MD, FASAM
- Edwin (Ed) Salsitz, MD, FASAM
- Mark P. Schwartz, MD, FASAM, FAAFP

- Samuel (Sam) Silverman, MD, FAPA
- Jacqueline Starrer, MD, FACOG, FASAM, DipABAM
- John Tanner, DO, FASAM
- Sarah Wakerman, MD
- Norman Wetterau, MD, FAAP, FASAM
- Amanda Wilson, MD
- Tricia Wright, MD, MS, FACOG
- Martha Wunsch MD, FAAP, FASAM
- Penelope Ziegler, MD, FASAM

ASAM Disclosure of Relevant Financial Relationships
Content of Activity: The ASAM Fundamentals of Addiction Medicine

<table>
<thead>
<tr>
<th>Name</th>
<th>Commercial Interests</th>
<th>Relevant Financial Relationships: What Was Received</th>
<th>Relevant Financial Relationships: For What Role</th>
<th>No Relevant Financial Interests with Any Commercial Interests</th>
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<tbody>
<tr>
<td>Peter L. Selby, MBBS, CFCP, FCFP, FASAM, Course Chair, Curriculum Director</td>
<td>Abbvie Canada Honorarium</td>
<td>Medico-Legalхо зеркало expert training for 12 nurses and physicians. Accredited CME course.</td>
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<td>Jeanette M. Tetrault, MD, FACP, Vice-Chair</td>
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<td>Alexander Wally, MD, MSc, Vice-Chair</td>
<td>Social Sciences Research, Inc. Honorarium Consultant</td>
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<tr>
<td>Peter D. Friedmann, MD</td>
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### ASAM Disclosure of Relevant Financial Relationships

**Content of Activity:**

The ASAM Fundamentals of Addiction Medicine, Continued

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<tr>
<td>Peter D. Friedmann, MD, MPH, FASAM, FACP, American College of Physicians (ACP) Representative</td>
<td>Medicines</td>
<td>Donated Medications</td>
<td>Research Studies</td>
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<td>Kenneth A. Saffier, MD</td>
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<td>Mario San Bartolomé, MD, MBA</td>
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<td>J. Paul Seale, MD</td>
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<tr>
<td>Stephen A. Wyatt, DO</td>
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</tbody>
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**Session 1 - Meeting Our Patient: An Introduction to Addictive Disorders**

**Facilitator:**

Peter Selby, MBBS, CCFP, DipSAM, FASAM

**Learning Objective:**

- Identify feelings and attitudes which promote or prevent therapeutic responses to patients with substance use disorders.

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**THE FUNDAMENTALS OF ADDICTION MEDICINE | A LIVE COURSE**
Session Overview

• Become acquainted with colleagues at the small table
• Be immediately engaged through a powerful, visual medium
• Identify and reflect upon individual affective response to the disease of substance use disorder and patients who show evidence of this disease

Session Overview, continued

• Identify and discuss the many factors associated with SUP, e.g., enabling behaviors of others in the abusers’ life, physical features of SUD, etc.
• Be aware that the goal of the day is to prevent such outcomes through early identification and treatment
• Identify a referral pathway to an addiction medicine specialist for severely addicted patients

Outcomes Consensus Worksheet
8:10 am – 8:25 am

• What do you hope to get out of this course today?
Leaving Las Vegas
8:25 am – 8:40 am

1. What did you see?
2. What did you feel?
3. What did you think?

Meet Our Patients

- On the next two slides are profiles of two patients, Sam and Pat.
- These cases will unfold throughout several sessions, and comprise the foundation for role-plays.
- The names can apply to either male or female participants, but once a role is initially assigned, the participant will continue in the same role throughout each session.

SAM

<table>
<thead>
<tr>
<th>ID</th>
<th>Life is a 20 year old single female; boyfriend- 2 years</th>
<th>Life is a 20 year old single male; girlfriend- 2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Lives with partner 1 year</td>
<td>Lives with partner 1 year</td>
</tr>
<tr>
<td>Education</td>
<td>Community college</td>
<td>Community college</td>
</tr>
<tr>
<td>Occupation</td>
<td>Service agent- car rental company</td>
<td>Service agent- car rental company</td>
</tr>
<tr>
<td>Reason for visit</td>
<td>Wants a sleeping pill</td>
<td>Wants a sleeping pill</td>
</tr>
<tr>
<td>Other</td>
<td>Patient relatively new to your practice</td>
<td>Patient relatively new to your practice</td>
</tr>
<tr>
<td>Med/Sx Hx</td>
<td>Nil significant</td>
<td>Nil significant</td>
</tr>
<tr>
<td>Fam Hx</td>
<td>Father: alcohol problem, Mother: uses pills for her nerves sometimes to excess 1 younger brother: age 15. Healthy</td>
<td>Father: alcohol problem, Mother: uses pills for her nerves sometimes to excess 1 younger brother: age 15. Healthy</td>
</tr>
</tbody>
</table>
PAT

<table>
<thead>
<tr>
<th>ID</th>
<th>Pat, 25 year old single female; boyfriend - casual relationship 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Lives with boyfriend</td>
</tr>
<tr>
<td>Education</td>
<td>Masters in biochemistry</td>
</tr>
<tr>
<td>Occupation</td>
<td>RA in a molecular lab</td>
</tr>
<tr>
<td>Reason for</td>
<td>Hurt R shoulder playing hockey</td>
</tr>
<tr>
<td>visit</td>
<td>Patient relatively new to your practice</td>
</tr>
<tr>
<td>Med/Sx Hx</td>
<td>Otherwise healthy</td>
</tr>
<tr>
<td>Fam Hx</td>
<td>Father: well, Mother: depression on meds 2 younger sisters: age 19, 15, Healthy No substance use problems</td>
</tr>
</tbody>
</table>

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Session 2
A Brain on Drugs: The Clinical Manifestations of the Neurobiology of Addictions

Facilitators:
- Steve Wyatt, DO
- Marion San Bartolomé, MD, MBA

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

- Early development
- Neurobiology of the Disease
- Treatment
- Summary

### Early Factors in the Development of a Substance Use Disorder

- Genetic Variation
- Exposure to Parental SUDs
- Averse Childhood Events (ACE)
- Age of Onset

### Genetic Variation

- 40-50% of the risk of having a substance problem is genetic.
  - Alcohol liking or disliking is linked alcohol and aldehyde dehydrogenases
- GWAS are able to identify SNPs
  - Nicotine receptor subunit doubles the risk for addiction, the area is influential in risk of disease. (Thorgerson et al. 2008)
  - Phenotype of impaired inhibitory control (Erlich et al 2012)
- Epigenetic – opening the genetic window.
  - COMT gene variants predict prevalence of psychosis in adolescents exposed to cannabis.
- Pharmacogenetics
  - Effect of naltrexone treatment for alcohol in individuals with a specific gene variant, Asp40. (Oslin et al 2003)
Exposure to Parental SUDs

- Familial environment is a significant risk factor in the development of adolescent risk for SUDs
  - Worse in high risk children, e.g. ADHD, Mood d/o (Biederman, et al., 2000)
- Parental psychoactive substance use disorder puts adolescents at significant risk of becoming embedded in a cycle of drug use, associations with drug using peers, and poor family relations. (Hoffman/Su, 2002)
- History of SUDs in both fathers and mothers increases abuse potential.
  - Contributors to abuse potential differed in fathers and mothers (Ammerman, et al., 1999)

Early Environmental Effects ACEs

- Severe childhood adversity place individuals at life-long risk for
  - Problems related to mental health,
  - physical health,
  - employment,
  - and legal difficulties (Putnam 2006).
- Five or more adverse childhood events (ACEs; i.e., emotional, physical, or sexual abuse; domestic violence; and household dysfunction) are 7–10 times more likely to report illicit drug use and addiction. (Anda et al. 2006).
- Studies of individuals seeking treatment for alcohol use disorders show a high prevalence of childhood adversity and PTSD.
  - 62 percent having been victims of childhood physical or sexual abuse (Grice et al. 1995).

Age of Onset

- Risk of drug dependence problems significantly greater for adolescent recent-onset users compared to adult recent-onset users. (Chen, et al., 2009)
- The rates of lifetime dependence declined from more than 40% age of onset 14 or younger to approx. 10% age of onset 20 and older.
- Odds of dependence decreased by 14% with each increasing year of age at onset of use, and the odds of abuse decreased by 8% (Grant/Dawson, 1997)
Cycle of Addiction

Intoxication

Relapse

Liking to Wanting

Craving

Habituation

Physical Dependence

Tolerance

Unconditioned Response:

Neuroreceptor Activation

- Dopamine effects on the nucleus accumbens is an active component of the unconditioned response by all drugs of abuse.
  - imitation
  - increased availability
  - GABA inhibition disinhibition of activation of the dopamine receptors in VTA.
- Neurotransmitter/receptors modulate the reinforcing effect of drugs of abuse.
  - Dopamine
  - Opioid Peptides
  - Y aminobutyric acid (GABA)
  - Endocannabinoids
Intoxication:
The Unconditioned Response

- Dependent on:
  1. the type and dose of drug
  2. individual's level of tolerance,
  3. the environment,
  4. genetics
- The effect of the intoxicant results in a specific affect/reward.

Intoxication:
The Unconditioned Response

- Response may not always reflect primary actions of the substance:
  - depressant drugs may lead to symptoms of agitation or hyperactivity
  - stimulant drugs may lead to socially withdrawn and introverted behavior.
  - cannabis and hallucinogens may be particularly unpredictable.
- Many psychoactive substances produce different types of effect at different levels.
  - alcohol may result in stimulant behavior at lower doses → lead to agitation and aggression at higher levels → clear sedation at very high levels
Moving from Liking to Wanting

Habituation

- Dorsal striatum - recruited during the development of compulsive drug seeking identifying its role in the transition to compulsive use. (Everitt/Balin, 1969)
- Neuroadaptations contribute to negative motivation.

Reinforcing effects of alcohol are partly located in the central nucleus of the amygdala associated with strong emotional memory.
Development of Tolerance

- Metabolic adaptation to the drug of abuse
  - alcohol and acetaldehyde dehydrogenase
- Receptor down regulation and eventually a reduction in the number of receptors.
  - Opiate tolerance
    - A reduction in G-protein coupling
    - This results in more opiate to provide the same response.
Craving: The Conditioned Response

- Mesocorticolimbic dopamine system is involved in the development of incentive salience to stimuli in the environment driving performance of goal-directed behavior or general activation. (Salamone, et al., 2007)

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Craving: The Conditioned Response

<table>
<thead>
<tr>
<th>Unconditioned stimulus</th>
<th>Associated stimuli</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol in brain</td>
<td>Enteroceptive — mood states that precipitate drinking</td>
</tr>
<tr>
<td>Response</td>
<td>Exteroceptive — environment, sight of alcoholic drinks, smell and taste of alcohol (or e.g. smoking) etc</td>
</tr>
</tbody>
</table>

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Physical Dependence:
Counteradaptation-Opponent-Process

- A cellular response to neutralize the drug effect.
- This neuro-adaptation once the drug is discontinued contributes to the withdrawal effects
Relapse

• Positive affect:
  – Activation of the conditioned response
dopamine activation of the mesolimbic system

• Negative affect:
  – glutaminergic / GABA adaptations resulting in
agitation/depression

• Long-term:
  – Decrease in dopamine release in the NAc reward
system persists protracted abstinence
vulnerability

Treatment

– Treatment Principles - Psychotherapeutic
– Treatment Principles - Pharmacologic

Treatment Principles - Pharmacologic

• Agonists (opiate/nicotine substitution,
varclenidine)

• Antagonists (naltrexone)

• Regulators of adverse response (clonidine,
SSRIs, gabapentin, toperimate)

• Aversion (Antabuse)

• Reduction in dopamine response to craving
(naltrexone)
Treatment Principles - Psychotherapeutic

The Rider and the Elephant

- Development of awareness
- Development of self-efficacy
- Development of motivation
- Behavioral Change.

Summary

- Understanding the patient’s childhood predisposition both genetic and environmental can help formulate the clinician’s treatment plan and empathic stance.
- Understanding the neurobiology of addiction can help in the development of a treatment plan both psychotherapeutically and pharmacologically.
- Understanding the complex relationship between the various components of the patient’s disease helps one understand the reason for establishing a stage of change.

ARS - The brain region most likely to mediate the pleasurable or binge/intoxicating effects of addictive drugs is:

1. Ventral Tegmental Area
2. Substantia Nigra
3. Hippocampus
4. Cerebellum
5. Gustatory cortex
ARS- Which brain regions is most involved in the irritable mood and negative affect associated with addictions?

1. Nucleus Accumbens
2. Extended Amygdala
3. Ventral Tegmental Area
4. Prefrontal Cortex
5. Lateral Dorsal Tegmentum

ARS- The brain regions that account for disrupted inhibitory control that makes it hard for patients with addictions to refuse drug use (i.e. loss of control) are:

1. Cingulate gyrus, dorsolateral prefrontal and inferior prefrontal cortex
2. Ventral tegmental area
3. Nucleus Accumbens
4. Substantia Nigra
5. Hippocampus

ARS- The brain regions most significantly associated with cravings even months after stopping drug use is:

1. Orbitofrontal Cortex, dorsal striatum, Hippocampus, insula
2. Ventral Tegmental Area
3. Pituitary Gland
4. Nucleus Accumbens
5. Locus Ceruleus
Session 3
Identifying Unhealthy Substance Use: Case Finding Made Easy

Facilitators:
Ken Saffier, MD
J. Paul Seale, MD

Learning Objective:
• 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.

Meet Sam:
• 20 years old
• She has a boyfriend of 1 year
• Sales agent in a local rental car company.
• Requesting sleeping pills.

As part of your history, you will gather important information about alcohol and drug use using validated screening tools.
Why is this important?

- Primary Care: 10 – 20% have alcohol use disorders, 5 – 10% have drug use disorders
- Inadequate medical school and post graduate training.
- 94% of PCPs failed to consider alcohol or drugs in a study about common patient presentations.
- 11% of those with SUDs get tx (vs 77% w/ HTN).
- Brief advice by PCPs is effective to change harmful drinking and using behavior resulting in less negative consequences.


Rankings of Preventive Services
National Commission on Prevention Priorities

25 USPSTF-recommended services ranked by:

*Clinically preventable burden (CPB)*
How much disease, injury, and death would be prevented if services were delivered to all targeted individuals?

*Cost-effectiveness (CE)* - return on investment - How many dollars would be saved for each dollar spent?


<table>
<thead>
<tr>
<th>#</th>
<th>Service</th>
<th>CPB</th>
<th>CE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aspirin - Men - 40+, Women - 50+</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Childhood immunizations</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Smoking cessation</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol screening &amp; intervention</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Colorectal cancer screening</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Hypertension screening &amp; treatment</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Influenza immunization</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Vision screening - 65+</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

*1 = lowest; 5 = highest*
Begin with:

► Do you sometimes drink beer, wine, or other alcoholic beverages?

► No  (“Why not?”)

► Yes

Screening for harmful alcohol use:

► Single question screen
  (www.niaaa.nih.gov/guide)

► AUDIT (Alcohol Use Disorders Identification Test)
  (www.who.org)

Single Question Screen for Harmful Alcohol Use

► During the last year, how many times have you had __ or more drinks*:
  ► 5 for men
  ► 4 for women  * "Standard" drinks
  ► 4 if > 65

Positive screen is 1 or more times.
82% Sensitivity
79% Specificity (unhealthy use)

Smith, PC, et. al., J Gen Int Med, 2010
(www.niaaa.nih.gov/public)
What’s a “standard drink”?

<table>
<thead>
<tr>
<th>Drink</th>
<th>Per Week</th>
<th>Per Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>&gt;14</td>
<td>&gt;4</td>
</tr>
<tr>
<td>Women</td>
<td>&gt;7</td>
<td>&gt;3</td>
</tr>
<tr>
<td>≥65yo</td>
<td>&gt;7</td>
<td>&gt;3</td>
</tr>
</tbody>
</table>

Exceptions: decrease or abstain

► Meds that interact with alcohol

► Health conditions made worse by alcohol

► Pregnancy (advise abstinence)
**U.S. Adult Drinking Patterns and Their Significance**

- Never exceed daily or weekly limits: 72%
- 2/3 of this group either abstain or drink < 12 drinks/yr
- Prevalence of alcohol use disorder: <1 in 100
- Exceed only daily limit: 16%
- >8/10 less than once/week
- Prevalence of alcohol use disorder: 1 in 5
- Exceed both daily and weekly limits: 10%
- >8/10 exceed the daily limit at least once/wk
- Prevalence of alcohol use disorder: 1 in 2

NIAAA, 2005

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**AUDIT – Alcohol Use Disorders Identification Test**

- Developed by the WHO
- 10 Questions
- Valid across cultures, Sens/spec varies w/population.
- Takes 5 minutes
- Positive score: >7 for men up to 60 yo
  - >4 for women, adolescents, men > 60.

www.niaaa.nih.gov/guide
What you’ve learned from Sam:

► See your agenda booklet:
  ► Answers to the NIAAA single question screen and quantify frequency of drinking.
  ► AUDIT scores (17).
  ► “No, I don’t use drugs.” (DAST = 0)

Meet Pat:

► 25 years old, here for a URI.
► Doesn’t like to drink (“my father was an alcoholic”).
► Had a dislocated shoulder 6 months ago.
► Takes his pain meds (hydrocodone/acetaminophen) by requesting refills (“because it makes me relax”).

1 Question Screen for Drug Abuse in Primary Care

► How many times in the past year have you used an illegal drug or used a prescription medication for a non-medical reason?
► A response of $\geq 1$ is considered positive.
► 100% sensitive, 74% specific for a drug use disorder
► Similar sensitivity and specificity to DAST-10

Smith, PC, et.al., Arch Int Med, 170:1155-1160, 2010
First Steps in Screening – Demo.

- Use a validated screening tool.
- Normalize its use. “This is what I ask all my patients…” Raise the subject.
- Provide feedback (and brief advice – in session 4).
- Provide a prevention message if negative.
- If positive, address the results nonjudgmentally.

(to be continued…session 4)

Clinical Skills Practice - #1

- First: Divide into pairs, one is Sam, the other Sam’s doctor.
- Take 5 minutes to do the following: Ask screening questions (1 question screens, if pos. followed by quantity-frequency questions.
- Provide feedback about what this means.

- Second: This time you have the results of Sam’s AUDIT that you review with her.
- (Her DAST was done and was 0.)
- Review the results; provide feedback.
- When finished, switch: Sam becomes the provider who interviews Pat.

What are your “take-home lessons” for screening?

- How does it work best for you?
- What would make it more effective in your practice?
“Red Flags” to Suspect Substance Abuse

What are your differential diagnoses?

Think Alcohol and/or Drugs
(effects and/or withdrawal)
(see handout)

Summary: Screening for Harmful Alcohol and Drug Use

• 1. Screen everyone at risk.
• 2. Use validated screening tools.
• 3. Provide nonjudgmental feedback with their results.
• 4. For positive screens: Proceed to the next steps of BNI.

Selected References


► For patients: Rethinking Drinking.niaaa.nih.gov

► www.alcoholscreening.org

► www.drugscreening.org
ARS - CASE QUESTION
A 60 year-old CEO of a bank reports difficulty sleeping for 4 weeks

Alcohol Consumption
3 standard drinks of beer on weekdays
=>5 on weekends.
No depressive symptoms/cravings/social or physical harms

Physical Exam
Normal.

Labs
GGT mildly elevated; AST and ALT are normal.

ARS - What advice will you give him to reduce his health risks from alcohol consumption?

1. No more than 8 drinks a week and 1 per day
2. No more than 10 drinks a week and 2 per day
3. No more than 12 drinks a week and 3 per day
4. No more than 14 drinks a week and 4 per day
5. No more than 16 drinks a week and 5 per day

ARS- CASE QUESTION
A 75 year-old single, retired female with well-controlled hypertension, is very active and plays golf twice per week.

Alcohol Consumption
4 glasses of wine per day - two with lunch and two with dinner since retirement.
No history of an alcohol use disorder.

Current Medications
1) Hydrochlorothiazide 25mg PO QD
2) ECASA 81mg PO QD
ARS- What advice will you give her to reduce her health risks from drinking alcohol?

1. No more than 3 drinks a week and 1 per day
2. No more than 5 drinks a week and 2 per day
3. No more than 7 drinks a week and 3 per day
4. No more than 9 drinks a week and 4 per day
5. No more than 11 drinks a week and 5 per day

ARS- CASE QUESTION
A 25 year-old school bus driver drinks less than 2 standard drinks most days but consumes 6 standard drinks at least once per month. He has never met criteria for an alcohol use disorder and never drinks and drives.

ARS- The next best step is to:

1. Provide a brief intervention
2. Refer him to an alcohol treatment agency
3. Prescribe naltrexone 25mg PO QD for 3 days and then increase to 50mg PO QD
4. Prescribe acamprosate 666mg PO TID
5. Declare him unfit to drive
REFRESHMENT BREAK
10:15 am – 10:30 am

Session 3
Identifying Unhealthy Substance Use:
Case Finding Made Easy
(Additional slides for Participants)

Facilitators:
Ken Saffier, MD
J. Paul Seale, MD

Learning Objective:
• 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.
(Another) One Question Screen for EtOH

- When was the last time that you had more than X drinks in one day?
  (Never, > 12 months, 3-12 months, < 3 mo)
- X = 5 drinks for men, 4 drinks for women
- Sensitivity = 88% for men, 83% women, overall 86%
- Specificity = 81% for men, 91% for women, overall 86%

Williams and Vinson, 2001 (ER patients with injuries)

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Two Question Screen

- Have you ever had a drinking problem?
- Did you have a drink within the last 24 hours?

Cyr and Wartman, JAMA, 259: 51-54, 1988

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Two Question Screen

<table>
<thead>
<tr>
<th>Item</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a drinking problem?</td>
<td>70</td>
<td>99</td>
</tr>
<tr>
<td>Did you take a drink in the last 24 hours?</td>
<td>36</td>
<td>91</td>
</tr>
<tr>
<td>Hx of problem and last drink &lt;24 hours</td>
<td>92</td>
<td>90</td>
</tr>
</tbody>
</table>
Screen for Adolescents
- CRAFT-

• C - ridden in a Car driven by person using alcohol or drugs (including self)
• R - Drink or use drugs to Relax
• A - Drink or use drugs Alone
• F - Forget things when drinking/using
• F - Family or Friends say to cut down
• T - Get into Trouble from drinking/using

>2 = positive screen

Knight Jr, Arch Ped Adol Med, 2002

NIAA Two Question Screen for Adolescents (14-18)

• “In the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?”
• For younger children, ask about friends first. (See Youth Guide)

• “If your friends drink, how many drinks do they usually drink on an occasion?”
• Binge drinking by friends heightens concern.

www.niaaa.nih.gov/YouthGuide


Adult Screen: 3 Questions

1. In the past year, have you ever drunk alcohol or used drugs more than you meant to?*
2. In the past year, have you ever thought you should cut down on your alcohol or drug use?*
Men
3. When is the last time you had more than 5 drinks?†
Women
3. When is the last time you had more than 4 drinks?†

* Positive response = anything but a definite no
† Positive response = within the last 3 months
CAGE for alcohol
(and drugs – CAGE-AID):

☐ Have you felt a need to **C**ut down on your drinking? (or using ____?)
☐ Have you been **A**ngry (or annoyed) by others’ comments about your drinking (or using____)?
☐ Have you felt **G**uilty (or badly) about your drinking (or using ____)?
☐ Have you had a drink or used drugs the first thing in the morning (E**yeopener**) to steady your nerves or get the day started?

Ewing, J. JAMA, 1984, 252: 1905-7

<table>
<thead>
<tr>
<th>Questions</th>
<th>No. of positive answers</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C</strong></td>
<td>All 4 items</td>
<td>37</td>
<td>100</td>
</tr>
<tr>
<td><strong>A</strong></td>
<td>3 items</td>
<td>67</td>
<td>98</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>2 items (positive screen)</td>
<td>81</td>
<td>89</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>1 item</td>
<td>90</td>
<td>21</td>
</tr>
</tbody>
</table>

NIAA T-ACE = **CAGE** – **G** + **T**
For Pregnancy

- Tolerance – How many drinks does it take to make you high or tipsy? 2 points (more than 2 drinks)
- A
- C
- E
- >2 is positive for risk drinking in pregnancy

What about lab screening?

- GGTP and MCV - 20-60% sensitivity

Others: CDT (carbohydrate deficient transferrin) not effective in primary care populations (and is expensive).

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

Facilitators:
- J. Paul Seale, MD
- Ken Saffier, MD

Learning Objective:
- Respond to positive substance use screening results with brief counseling strategies, including motivational interviewing, appropriate to the patients readiness to change.
Performing Brief Interventions

Brief Interventions

- 3 minutes or more
- Aimed to motivate behavior change
- Designed to:
  - Provide personal feedback; enhance motivation; promote self-efficacy; promote behavior change

Brief Intervention Pathways

- No substance use disorder: conduct brief intervention, provide follow-up and ongoing care

- Patients with possible substance use disorder: conduct brief intervention, offer menu of additional support options, & negotiate a plan that may include referral
Steps of the Brief Interventions:

- Raise the subject
- Provide feedback
- Enhance motivation
- Negotiate plan

D’Onofrio, et al., 2005

Steps of the brief intervention

Brief Intervention: “Steve”

[Video link]

Steps of the Brief Intervention

- Simple step, but important
- Screening forms as conversation starters
- Asking permission
Steps of the Brief Intervention

- State level of risk
- Address or ask about possible connection to health issues
- State low risk limits
- Give recommendation

Provide feedback

Steps of the brief Intervention

- Use the 0 – 10 readiness scale
- “Why not a lower number?”
- Explore pros and cons

Enhance motivation

Steps of the Brief Intervention

- If pt. is ready: “What would that look like for you?”
- Encourage a specific plan/goal to reduce use, abstain and/or seek referral
- Re-state recommendation
- Schedule follow-up

Negotiate plan
Practice: Sam

Dyads:
- Clinician
- Patient

Part 2: Brief interventions for patients at higher risk levels

- Use the same intervention outline
- Encourage abstinence
- With patient's permission, offer a menu of options
- Consider using a "prescription for change"
Brief Intervention: “Tom”

http://www.youtube.com/watch?v=1xk9ZC9eLx0&feature=related

Use the same brief intervention steps:

- Raise the subject
- Provide feedback
- Enhance motivation
- Negotiate plan

D’Onofrio, et al., 2005

Encouraging abstinence (alcohol):
“My best medical advice would be for you to quit.”

- Abstain
- Reduce use / Abstain
- Reduce use
- Low risk or abstention

III

II

I
Encouraging abstinence (drug use)

- No known low risk zone for drug use
- Casual marijuana use still carries consequences
- Medical marijuana possible exception

Other factors behind recommending abstention

- Prior history of alcohol or substance dependence
- Pregnancy
- Medications
- Serious mental illness, medical condition

Offer a Menu of Options: Ask Permission

• “Many patients at your risk level find they do better with more support. Could I share with you some of the things that have helped some of my other patients?”
Menu of Options

- Medication: (naltrexone, acamprosate, or disulfiram for alcohol; buprenorphine or methadone for opioids)
- Self-help/support group (e.g., AA/NA, Celebrate Recovery, Smart Recovery, etc.)
- Individual counseling (brief treatment)
- Formal substance use treatment programs

MI Principles for Making Treatment Referral

- Respect patient’s autonomy—“Any decision you make is entirely up to you”
- Make every effort to help patients make contact with treatment providers while they are still in your office ("warm handoff")

Prescription for change

“Those are great ideas! Is it okay for me to write down your plan, your own prescription for change?”

“Please help me summarize the steps you will take to change your [X] use.”

“I’ve written down your plan, a prescription for change, for you to keep with you as a reminder.”
Practice: Pat

Dyad:
- Physician
- Patient

Workflow resembles a pipeline

Billing the Brief Intervention

<table>
<thead>
<tr>
<th>Service</th>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full screen + Brief intervention</td>
<td>Medicaid* &amp; Commercial</td>
<td>99408</td>
<td>15-30 minutes spent administering and interpreting a full screen, plus performing a brief intervention.</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>G0396</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid* &amp; Commercial</td>
<td>99409</td>
<td>Same as above, only ≥ 30 minutes.</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>G0397</td>
<td></td>
</tr>
</tbody>
</table>

- *Not all states have approved Medicaid SBIRT codes
- Use a 25 modifier
- Reimbursement: $26 - $30 and $52 - $65
Installing the Pipeline

- Buy-in
- Clinic champions
- Training
- Tools
- EMR

ARS- CASE QUESTION

Thomas is a 27 year old employed carpenter who has screened positive for drinking above NIAAA guidelines.

ARS- What is the best way to initiate a discussion about his alcohol use?

1. “Thomas, you drink too much.”
2. “It is very important that you tell me the truth about your drinking.”
3. “I am sorry to say but you tested positive for alcoholism.”
4. “Is it okay with you if we talk about your alcohol consumption?”
5. “If you don’t stop drinking you are going to get sick.”
ARS- CASE QUESTION

• A 28 year old male is drinking above NIAAA guidelines
  – He is employed and has mild elevation of his GGT.
  – He has never met criteria for Alcohol use disorder- moderate or severe.

ARS- The most appropriate next step is:

1. Prescribe naltrexone to support abstinence
2. Refer to Alcoholics Anonymous (AA) or Celebrate Recovery
3. Referral to a specialty addiction treatment center
4. Provide Six sessions of Cognitive Behavioural Therapy
5. Invite his friends and family to conduct an intervention

ARS- CASE QUESTION

• A 45 year-old male reports consuming 60 standard drinks per week for the past 2 years.
  – He suffers monthly blackouts after a binge
  – Lost his job and missed his daughters dance recital because he was hung over.
  – There has been a pattern of missing work due to his drinking.
  – He drinks within 1 hour of waking to manage his shakes.
  – His wife is ready to divorce him if he doesn’t stop drinking.
  – Physical examination reveals a fine tremor and no flaps.
  – AST is twice the ALT level and bilirubin is normal.
ARS- The next best step is to:

1. Refer him to an addiction medicine specialist
2. Prescribe disulfiram
3. Recommend 14 sessions of weekly cognitive behavioral therapy (CBT)
4. Send him to the emergency department for immediate detoxification
5. Provide information on support groups such as Alcoholics Anonymous (AA)

ARS- CASE QUESTION

• Jeremy is a 40 year-old male who is drinking alcohol above NIAAA guidelines. You have already raised the subject of his alcohol use and advised him that he is at high risk for related health issues. You want to motivate Jeremy to cut down his drinking.

ARS- Which statement can elicit change talk (eliciting an argument for change from the patient):

1. “Think about what your drinking is doing to your family and friends.”
2. “On a scale of zero to ten how ready are you to change your drinking habits?”
3. “Why do you drink so much.”
4. “I am going to have to order a liver biopsy if you don’t stop.”
5. “Here is a referral to addiction medicine specialist, let them deal with you”
Session 5
When Your Patient Says, Yes But!: A “Taste” of Motivational Interviewing

Facilitators:
Ken Saffier, MD
Steve Wyatt, DO
Cathy Friedman, MD

Learning Objectives:
• Respond to positive substance use screening results with brief counseling strategies, including motivational interviewing, appropriate to the patient’s readiness to change.
• Respond succinctly to change and sustain talk in patients at risk for or with substance use disorders to motivate behavior change.

What is MI?
Motivational interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change.

It is person-centered, goal oriented, and compassionately addresses the common problem of ambivalence about change.

Adapted from Miller and Rollnick, 2013
Spirit of MI

- Collaboration
- Compassion
- Acceptance
- Evocation

Four Processes in MI

Engaging

- Do I understand this person’s perspectives and concerns?
- How comfortable does this person feel talking with me?
- Does this feel like a collaborative relationship?

Miller and Rollnick, 2013
Focusing

• What goals for change does this person really have?
• Are we working together with a common purpose?
• Do I have a clear sense of where we are going?

Miller and Rollnick, 2013

Evoking

• What are this person's own reasons for change?
• What change talk am I hearing?
• Is the righting reflex pulling me to be the one arguing for change?

Miller and Rollnick, 2013

Planning

• Am I remembering to evoke rather than prescribe a plan?
• What would help this person to move forward?
• Am I offering needed information or advice with permission?

Miller and Rollnick, 2013
A Brief Glimpse of MI

- [http://www.youtube.com/watch?v=EvlquWl8aqc](http://www.youtube.com/watch?v=EvlquWl8aqc)

Building Motivation: OARS
(the microskills)

- Open ended questioning
- Affirming
- Reflective listening
- Summarizing

Open ended questioning

- Change: “Did you stop smoking cocaine yet?”
  - To an open-ended question: at your tables, suggest some possibilities.

- Change: “Have you made it to your AA meeting?”
  - Open-ended question:
Reflective Statements

• Offers a hypothesis about what the speaker means.

• A good reflective listening response is a statement. Its inflection turns down at the end. (question may sound judgmental)

  • "You're still using cocaine, even after having a heart attack?" (up) vs "You're still using cocaine, even after having a heart attack." (down)

Reflective Statements Levels

• Repeating. The simplest reflection simply repeats an element of what the speaker has said.

• Rephrasing. Here the listener stays close to what the speaker said, but substitutes synonyms or slightly rephrases what was offered.

• Paraphrasing. This is a more major restatement, in which the listener infers the meaning. Continues the paragraph.

• Reflection of feeling. Deepest form of reflection, a paraphrase that emphasizes the emotional dimension through feeling statements

Which Style Do You Prefer?

Dancing  Wrestling
Motivation is particularly sensitive to Interpersonal Communications Styles

Counsel in a directive, confrontational manner—
- Resistance increases
- Change talk decreases

Counsel in a reflective, empathic manner—
- Resistance decreases
- Change talk increases

Miller & Rollnick, Motivational Interviewing, 2002

Recognizing Change Talk

and Elicit - ChangeTalk

D A R N - CAT

Desire to change:
D A R N – C A T

Ability to change:

“ I could ...”

D A R N – C A T

Reasons to change:

D A R N – C A T

Need to change:
Summarize: D A R N – CAT
Commitment language predicts change

C: commitment—Will, intend to, going to
A: activation—Ready to, willing to (w/o specific commitment)
T: taking steps—Report recent specific action toward change

Amrhein et al., 2003

Drumming for Change

- Sam wants to cut down on her drinking.
  When you hear change talk:
  
  D – A – R – N
  Drum on your table.
  
  C – A – T
  Clap!
  
  (When you hear sustain talk or neither: silence.)

- Pat wants to stop taking pain pills with alcohol.
Persuading Sam

• Samantha wants to cut back on her drinking.
• Her doctor will persuade her to change:
  – Explain why she should make this change.
  – Give at least three specific benefits that would result from making the change.
  – Tell her how she could make the change.
  – Emphasize how important it is for her to make the change.
  – Tell/persuade her to do it.

“A Taste of MI”

• All 1’s: pick something that you are thinking about changing and tell 2.

• All 2’s: 2 follows the handout exactly: NO advice. NO solutions offered.

• Then switch roles, and pick a target behavior you want to change.

A Taste of MI

• When finished:
  • At your tables, describe what your experiences were like being the patient and the interviewer.
  • Compare and contrast what is like for a patient to be persuaded (told) and the feelings of what it was like with “a taste of MI”.

Valuable MI Tools

- Elicit – provide – elicit (Ask – Tell – Ask)
  - E What is your understanding about ______? (May I share some information about _____?)
  - P Information shared…
  - E What do you think about this?
- Pros and Cons (What’s good and not so good about ______?)
- Importance and confidence rulers to elicit change talk.

Assess Readiness to Change

- On a scale of 1 to 10, how important is it for you to make a change, to ______?
  - “Why did you pick ___ and not 1 or 2 (or a lower number)?”
- On a scale of 1 to 10, how confident are you that you can ______?
  - “What would it take to go from ___ (lower #) to ___ (higher)?”

Clinical Skills Practice – in pairs

- Use the same target behavior in the “Taste of MI” role play and your provider uses the importance ruler followed by the confidence ruler. Then switch.
- Listen for change talk.
- If confident (>7), listen for commitment (C - A - T) when asking what would it take to go to a higher number.
MI is Effective Across Cultures

- Based on broad generalizable principles of human behavior.
- Cultural competence = cultural humility, respectful listening, learning, appreciating and understanding differences = “Spirit” of MI.
- Evidence: increased effect sizes in studies with predominantly minority populations. (Hettema, Steele and Miller, 2005)

Goals for MI Proficiency

Life-long Learning Skills

- Spirit of MI must be present
- Percent Open Questions: 70%
- Reflections to Questions Ratio: >2 to 1
- Percent Complex Reflections: 50%

Learning MI – consider:

- Attend a training workshop (CME)
- Read: Miller, Rollnick, others.
- Tape record your real plays or a clinic visit (after consent obtained) and then:
  - Rate yourself.
  - Have a colleague or mentor provide feedback, return the favor.
- Develop a learning plan and a timetable
- www.motivationalinterviewing.org
ARS- CASE QUESTION

- Sarah is a 27 year-old female who presents to your smoking cessation clinic. During the assessment Sarah says: “I just hate when people can smell the smoke on me, it's like they think I'm a scumbag.”

ARS- Which of the following options is the best reflection response?

1. “I can assure you that people don’t think you are a scumbag.”
2. “It is often best to ignore how other people view your smoking when you are trying to quit.”
3. “Do you feel like you are like a scumbag because of your smoking?”
4. “It really bothers you when people judge you negatively for being a smoker?”
5. “I feel you made the right decision in coming here today, and I am happy to help you quit smoking.”

ARS- Case Question

- Steve, is a 48 year-old man with a severe alcohol use disorder. He has a strong desire to change his behavior due to the many negative consequences of alcohol in his life.
ARS- Which of the following statements made by Steve would best indicate to you his ability to change?

1. “I really want to stop drinking.”
2. “My wife told me she would leave me if I continue drinking like this.”
3. “I know that if I had an anti-craving medication I could cut down my drinking.”
4. “I lost my job this past month because I was showing up to work intoxicated.”
5. “I really want to be around more for my daughter and cutting down drinking will help me to do that.”

ARS- Motivational interviewing is most effective for:

1. Guiding your patient to stop their unhealthy drinking by evoking their own reasons to change
2. Helping to force your patient to stop their unhealthy drinking
3. Persuading your patient to stop their unhealthy drinking
4. Using your patients’ guilt to make a change in their unhealthy drinking
5. Using your patients’ fear to make a change in their unhealthy drinking

ARS- Motivational interviewing’s effectiveness in facilitating behavior change in people from racially and ethnically diverse communities is:

1. Unknown because this research has never been done
2. Unknown because the research that has been done was inconclusive
3. Less effective than in Caucasian communities
4. About the same effectiveness as in Caucasian communities
5. More effective than in Caucasian communities
LUNCH BREAK 12:30 - 1:30 pm
(On Your Own)
Return Early for Apps/Tools at 1:15 pm

- **Inside Hotel:**
  - Marketplace - On-the-go Dining 24hrs
  - The Bistro – Casual Lunch Restaurant
  - Lobby Bar – Small Plate Options
  - Tropics Pool Grill – Simple Poolside Fare
  - In-Room Dining

- **Outside Hotel & Close:**
  - McDonald’s
  - Denny’s

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Session 6
Matching the Treatment to the Patient: Diagnosing Substance Use Disorders and Developing an appropriate Treatment Plan

**Facilitators:**
Alexander Walley, MD, MSc
Peter D. Friedmann, MD, MPH, FASAM, FACP
Mario San Bartolome, MD, MBA

**Learning Objectives:**
- Conduct a biopsychosocial and developmental ambulatory assessment of an adult with a SUD to match the patient to an appropriate level of care
  - Note this session focuses on the diagnosis of substance use disorders and does not address the diagnosis of substance intoxication or withdrawal.
VIDEO:

- https://www.scopeofpain.com/tools-resources/
- Case Study VII: PDMP Questionable Activity in a New Patient

Lecturette agenda

1. Overview of DSM – 5 Criteria for Substance-Use Disorders
   - Use ARS to apply it to the patient in the video
2. Factors to be accounted for in a comprehensive assessment
   - The patient’s readiness frames the treatment plan
   - Co-morbid substance use, psychiatric, medical, and social problems impact the treatment plan
   - UDT as an assessment tool
   - Illustrative “sample” of an assessment instrument(s)
3. Overview of non-pharmacological treatment options that can be incorporated into the treatment plan
4. Harm reduction that can be incorporated into the treatment plan

Addiction is a chronic disease, so
This can and should be done in the course of a longitudinal relationship with the patient
- over multiple visits

Does this patient have a substance use disorder?
   If so, how severe is it?
   What is our plan to address it?
The DSM-5 defines a substance use disorder as the presence of at least 2 of 11 criteria, which can be clustered in four groups:

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. Import 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

ARS Question: Does the patient in the video have a substance use disorder?

1. Yes
2. No
3. I don’t know

Which DSM-5 criteria does the patient meet?

- 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

- 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

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

- Pharmacologic dependence:
  10. Tolerance to effects of the substance*
  11. Withdrawal symptoms when not using or using less.*
Factors to be accounted for in a comprehensive assessment

- The patient’s readiness frames the treatment plan
- Co-morbid substance use, psychiatric, medical, and social problems impact the treatment plan
- UDT as an assessment tool
- Illustrative “sample” of an assessment instrument(s)

ARS-What is this patient’s readiness to change?

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Relapse

The scope and specifics of the treatment plan should match not just the patient’s severity but the patient’s readiness
Co-morbid substance use, psychiatric, medical, and social problems impact the treatment plan

- Does the patient have a mood, anxiety, or thought disorder?
  - If medicated, how do these medications interact with the substance use
  - Do you need help from a mental health provider?
  - Be sure to collaborate
- What are the medical consequences of substance use?
  - Risk for HIV, hepatitis C, sexually transmitted infections
  - Chronic liver, lung, heart, renal, cognitive disease
  - Traumatic injuries
  - Overdose
- Social strengths and barriers to treatment and risk reduction?
  - Social support
  - Interpersonal violence
  - Poverty
  - Housing
  - Family and work responsibilities

UDT as a monitoring tool

- Guideline recommended
  - Weak evidence-base
- For monitoring, not diagnosis
  - A tool that contributes information over time
  - Require practice to use well
- Helpful in verifying self-report
  - Improves truth telling
**ASAM PPC-2 Worksheet**

<table>
<thead>
<tr>
<th>ASAM Dimension</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) No Problem</td>
</tr>
<tr>
<td>Dimension 1: Acute Intoxication and/or Withdrawal Potential</td>
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<tr>
<td>Dimension 2: Biomedical Conditions &amp; Complications</td>
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<tr>
<td>Dimension 3: Emotional, Behavioral, Cognitive Conditions &amp; Complications</td>
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<tr>
<td>Dimension 4: Readiness to Change</td>
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<tr>
<td>Dimension 5: Relapse, Continued Use, Continued Problem Potential</td>
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</tr>
<tr>
<td>Dimension 6: Recovery Environment</td>
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</tbody>
</table>

**Outpatient Levels of Care**

- Level 0.5 – Early Intervention
- Level 1 - Outpatient
  - Less than 9 Contact Hours/Week
- Level 2 - Intensive Outpatient/Partial Hospitalization
  - Level 2.1 - 9 or More Contact Hours/Week in a *Structured Program* (6 hrs. for adolescents)
  - Level 2.5 - 20 or More Contact Hours/Week in a *Structured Program*

**Residential/Inpatient Levels of Care**

- Level 3: Residential/Inpatient Services
  - Level 3.1- Clinically Managed Low-Intensity Residential Services (e.g. halfway house)
  - Level 3.3- Clinically Managed, Population- Focused, High-Intensity Residential Services
  - Level 3.5- Clinically Managed High-Intensity Residential Services (e.g., therapeutic community, *Residential Treatment Center*)
  - Level 3.7- Medically Monitored Intensive Inpatient Treatment
- Level 4: Medically Managed Intensive Inpatient Treatment
Illustrative “sample” of an assessment and treatment plan

Assessment:
28 yo woman with prescription opioid use disorder, likely severe with impaired control, risky use and pharmacological dependence. Her readiness to address is between contemplation and preparation. Biopsychosocial factors include chronic shoulder pain, likely PTSD from interpersonal violence history, and financial stress. She is housed and has supportive family and friends she knows in recovery.

Plan:
1. Ongoing motivational interviewing to bolster readiness
2. Explain pharmacologic options – bup/nal, methadone maintenance, and naltrexone
3. Referral for non-pharm options – NA, counseling, residential treatment, CRAFT
4. Monitoring
5. Harm reduction –
   a. Educate about tolerance and overdose prevention, including safe storage of psychoactive substances
   b. Prescribe naloxone rescue kit
   c. Safer sex counseling
6. Contact and collaborate with PTSD therapist and psychiatrist – release signed

Non-pharmacological treatment options that can be incorporated into the treatment plan

Depends on what is available in your community
- Brief Intervention
- Self-help/12 step groups e.g. Alchoholics Anonymous
- Group or individual cognitive behavioral counseling
- Residential Treatment
- Contingency management
- Community re-enforcement and family training

Harm reduction that can be incorporated into the treatment plan

- Educating about how tolerance changes impacts the risk of withdrawal and overdose
  - for opioid and alcohol users
- Needle exchange and safe-injecting practices
  - for people who inject drugs
- Overdose prevention and naloxone prescriptions
  - Prescribetoprevent.org
- Safe storage of psychoactive substances
- Sexual safety counseling
The following 2 ARS questions pertain to the case below:

- Anne is a 37 year-old female who presents for a full physical.
  - No reported concerns but on exam you notice many track marks in her right antecubital fossa.
  - Anne reluctantly discloses that for the past 2 years she has been using IV heroin daily.
  - Admits to many occasions of trying to stop "cold turkey" but each time ended up relapsing due to severe withdrawal symptoms.
  - Initially she used to use about ¼ gram daily but over time her use has escalated to almost 2 grams daily.
  - Endorses strong cravings for heroin.
  - Formerly employed as a waitress but fired 5 months ago because "I kept getting high".
  - She feels that people in her life "keep butting in and telling me to stop using, but I really don’t see a problem with my heroin use."
  - "I don’t want to go to a treatment program or use methadone or buprenorphine"

ARS-Question 1: What is the most likely diagnosis?
1. Mild opioid use disorder
2. Moderate opioid use disorder
3. Severe opioid use disorder
4. Pharmacologic opioid dependence
5. Opioid induced hyperalgesia

ARS-Question 2: What is the next best step in Anne’s management?
1. Discuss local needle exchange programs and safe-injecting practices
2. Refer her to an addiction medicine specialist for opioid agonist therapy initiation
3. Refer her to a self-help/12 step group e.g. Narcotics Anonymous
4. Assist her in applying for residential treatment programming
5. Refer her to an addiction medicine specialist to start naltrexone therapy
Gerry is a 38 year-old who presents to a walk-in clinic for a refill of his hydromorphone. His regular doctor is ill and his scheduled appointment for that day was cancelled.

- He denies cravings for hydromorphone, ever needing early refills or altering the route of administration.
- He is quite concerned about getting a prescription today because the last time he ran out of this medication he experienced “the worst flu ever”.
- He is employed as a high school principal and has been at the same job for the past 5 years.
- He is happily married to his wife of 12 years.
- The secretary at his doctor’s office and she confirms the above information.

Medical History
- Sickle cell anemia
- Avascular necrosis of both shoulder joints daily pain=8/10. 2/10 with medication.

Current Medications
- Hydromorphone 6mg PO Q6 hours for the past 3 years for pain. It was 2mg PO Q 6 hourly 8 years ago.

ARS CASE QUESTION

ARS- What is the most likely diagnosis?

1. Mild opioid use disorder
2. Moderate opioid use disorder
3. Severe opioid use disorder
4. Pharmacologic opioid dependence
5. Opioid induced hyperalgesia

REFRESHMENT BREAK

3:20 pm – 3:30 pm
Session 6
Matching the Treatment to the Patient: Diagnosing Substance Use Disorders and Developing an appropriate Treatment Plan
(Additional slides for Participants)

Facilitators:
Alexander Walley, MD, MSc
Peter D. Friedmann, MD, MPH, FASAM, FACP
Mario San Bartolome, MD, MBA

Learning Objectives:
• Conduct a biopsychosocial and developmental ambulatory assessment of an adult with a SUD to match the patient to an appropriate level of care
  - Note this session focuses on the diagnosis of substance use disorders and does not address the diagnosis of substance intoxication or withdrawal.

DSM 5

![DSM 5 Table](image)

* One or more symptom criteria within a 12-month period and no dependence diagnostic applicable to all substances except nicotine, for which criteria always apply even if not present.
* 2 or more symptom criteria within a 12-month period.
* 3 or more symptom criteria within a 12-month period.
* Withdrawal not included for cannabis, inhalants, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.
ASAM PPC-2R Assessment

• Dimension 1: Acute Intoxication/Withdrawal Potential
• Dimension 2: Biomedical Condition & Complications
• Dimension 3: Emotional/Behavioral/Cognitive Conditions & Complications
• Dimension 4: Readiness to Change
  – Insight (cognitive) and Compliance (behavioral)
• Dimension 5: Relapse/Continued Use/Problem Potential
  – History (chronicity) and Acute symptoms (e.g. craving)
• Dimension 6: Recovery Environment
  – Supportive and Structured

ASAM PPC-2R Dimension 2:
Biomedical Conditions and Complications

• Sample Questions
  – Are there current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment?
  – Are there chronic illnesses which might be exacerbated by withdrawal, e.g., diabetes, hypertension?
Opioid Treatment Services (OTS)

- OTS includes agonists, antagonists and aversive drugs
- New criteria for Level I Outpatient OTS
  - OTS can be in all levels of service
  - Can be inpatient

12-Step Facilitation

- Recovery groups like AA/NA
  - Cost-effective
  - Widely available
- Spiritual and practical program
- 12-step facilitation does reduce relapse

Going to Meetings

- Stating clearly the benefit of recovery groups
- Recommending and monitoring regular meeting attendance
  - Help identify specific meetings
- “The 90 in 90” for struggling patients
  - esp. for < 3 months sober or high-risk
  - Negotiate down to what patient will accept
- Monitoring participation
  - Home group
  - Strategies to get and work with sponsor
  - Working the program
Relapse Prevention

• Coping skills:
  – What coping skills has the patient already been using (e.g., medication, AA, family support)?
  – How can the physician reinforce them?
• High risk situations:
  – Ask about previous and current high-risk situations (triggers) in a neutral, non-threatening manner
  – Develop plans for potential slips

Monitoring

• Regularly scheduled follow-up
• Routinely evaluating:
  – Medication adherence
  – Compliance with counseling & recovery groups
  – Behavioral, medical and psychosocial stability
  – Health, well-being and functioning
  – Feedback of relevant labs, eg. GGT
• Routine toxicological screens

Harm Reduction

• Resistance to treatment common
• If not ready for treatment, then harm reduction:
  – cutting down on use can reduce consequences
  – needle exchange reduces HIV risk by 33-50%
    • syringe prescription available in RI
  – hepatitis B and tetanus vaccination
  – thiamine for heavy drinkers
• Support “any positive change”
Red Flags

RED FLAGS

• Trauma
• Infectious Diseases (HIV, HBV, HCV)
• Stigmata of Injection Drug Use
• Seizures
• Psychiatric Symptoms
• Drug-seeking behaviour
• Chronic pain syndromes

RED FLAGS

• Unexplained weight loss
• Infertility
• Frequent miscarriage
• Premature delivery
• SGA
• Family violence
• Poor compliance
• Absenteeism
Red flags - ALCOHOL

- Pancreatitis, GE reflux, dyspepsia, gastritis
- Fatty liver, alcoholic hepatitis, cirrhosis
- Hypertension, cardiomyopathy, arrhythmias
- Dementia, cerebellar disease, peripheral neuropathy, Wernicke-Korsakoff syndrome
- Dupuytren’s contractures

Red flags - ALCOHOL

- Depression, anxiety
- Anorexia, dyspepsia, diarrhea, vomiting, hematemesis, hematochezia, melena
- Menstrual abnormalities, impotence
- Tremors, stocking/glove pain or anesthesia, headaches, seizures
- Palpitations, syncope
- Frequent falls
Session 7
For Every Ill, There May Be a Pill: Treating Substance Use Disorders with Medication

Facilitators:
Jeanette M. Tetrault, MD, FACP
Peter D. Friedmann, MD, MPH, FASAM, FACP

Learning Objective:
• 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.

Medications approved for treatment of substance use disorders

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Alcohol</th>
<th>Opioids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine replacement</td>
<td>Disulfiram</td>
<td>Methadone</td>
</tr>
<tr>
<td>Bupropion</td>
<td>Acamprosate</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Varenicline</td>
<td>Naltrexone</td>
<td>Naltrexone</td>
</tr>
</tbody>
</table>

Patients with substance use disorders die from tobacco related illness
• Smoking 4x more prevalent in SUD patients
  – 8x more likely to be heavy smokers
• 51% of deaths related to tobacco
• >60% SUD treatment clients somewhat or very interested in quitting smoking
• Fewer than 5% of SUD programs offer smoking cessation medications

Hurt et al., 1996; Hser et al., 1994; McCarthy et al., 2002; Richter 2001; Clemmey 1997; Froesch 1998; Friedmann et al 2007
Medications approved for treatment of tobacco use disorders

- Nicotine replacement therapies
  - Gum
  - Patch
  - Lozenge
  - Spray
  - Inhaler
- Bupropion
- Varenicline

Odds of receiving a medication for a chronic condition (NAMC 2005-2007)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Visits Receiving Condition-Specific Medication, %</th>
<th>AOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>37.4</td>
<td>2.8 (2.7, 39.5)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>36.2</td>
<td>2.9 (2.6, 25.8)</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>37.1</td>
<td>2.5 (1.3, 20.1)</td>
</tr>
<tr>
<td>Asthma</td>
<td>32.4</td>
<td>2.1 (1.7, 3.1)</td>
</tr>
<tr>
<td>Depression</td>
<td>33.3</td>
<td>2.4 (2.0, 3.1)</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>4.4</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Bernstein et al., Am J Public Health, 2013

Nicotine replacement therapy

- 1 cigarette = 1 mg nicotine
- >10 cpd → 21 mg patch
- 5-10 cpd → 7-14 mg
- Multiple delivery systems safe, effective
  - “Basal-Bolus” dosing
  - patch + spray, gum or lozenge
- Synergistic with bupropion
Bupropion

- Mechanism of action
  - Enhancing CNS noradrenergic and dopaminergic release
- Dosing and duration
  - Start one week prior to quit date
  - 150 mg/day X 3 days, then increase to 300 mg/day
  - Suggested duration 7-12 weeks
- Adverse effects
  - Common: agitation, dry mouth, insomnia, headache
  - Seizure (0.1%)

Bupropion: Efficacy

- Meta analysis bupropion monotherapy compared to placebo 2007
  - 36 trials included in systematic review and meta-analysis
  - OR for smoking cessation = 1.94 (95% CI 1.72-2.19)

Hughes JR. Cochrane Database Sys Rev. 2007
Rates of Confirmed Continuous Abstinence from the Target Quitting Date through the End of Treatment

Mean Change in Weight from Base Line through the End of Treatment among 103 Subjects Who Were Continuously Abstinent

Varenicline

- Mechanism of action
  - Partial agonist at alpha-4 beta-2 subunit of nicotinic acetylcholine receptor
- Dosing and duration
  - 0.5 mg/day X 3 days, 0.5 mg BID X 4 days, 1 mg bid X 12 weeks; start one week prior to quit date
- Adverse effects
  - CV events—2012 meta-analysis no increase risk over placebo (0.63% vs. 0.47%; risk difference 0.27%, 95% CI -0.10 to 0.63%)
  - Neuropsychiatric—Multicenter RCT, over 500 patients—varenicline increased continuous abstinence rates without increasing suicidal ideation, anxiety or depression

Prochaska JJ. BMJ 2012
Anthenelli RM, Ann Int Med 2013
Varenicline: Efficacy

- Meta-analysis of RCTs 2012
  - OR of continuous abstinence at 6m = 2.27 (95% CI 2.02-2.55) compared to placebo
- Three trials found varenicline superior to bupropion
- Two trials found varenicline superior to NRT

Cahill, K et al. Cochrane Database Sys Rev. 2012

Varenicline vs. Bupropion vs. Placebo

Medications approved for treatment of alcohol use disorders
- Disulfiram
- Acamprosate
- Naltrexone
  - Oral
  - Depot
- Consider addition of group or individual counseling, 12-step facilitation, SMART recovery, etc.
Disulfiram: Mechanism of action

ADH
Ethanol → Acetaldehyde → Acetate

Build up of acetaldehyde causes:
- Flushing
- Headache
- Nausea
- Dizziness
- Palpitations

Disulfiram: Prescribing information

- Start at 500 mg daily for 1-2 weeks then decrease to 250 mg daily
- Contraindications:
  - Recent alcohol use; Only use in those seeking total abstinence
  - Pregnancy class C
  - Cognitive impairment
  - Caution against "hidden" alcohol—mouthwash, cologne, etc
  - Duration up to 14 days after last pill
  - Cirrhosis, cvd, psychosis, diabetes mellitus, epilepsy, hypothyroidism, renal impairment
- Drug Interactions:
  - Warfarin
  - Anti-convulsants (phenytoin)
  - INH
  - Metronidazole
- Adverse effects:
  - Hepatotoxicity
  - Neuropathy

Disulfiram: Efficacy

- Overall mixed results
- Large VA study of 605 Veterans of 250 mg disulfiram vs. 1 mg disulfiram
  - No more effective than placebo in maintaining abstinence or time to first drink
  - May have efficacy for reduction in heavy drinking days
  - High rate of non-adherence
### Monitored Disulfiram

<table>
<thead>
<tr>
<th>Author, Yr</th>
<th>Follow-up</th>
<th>Disulfiram</th>
<th>Abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerrein, 1973</td>
<td>85%, 39%</td>
<td>Monitored</td>
<td>40% 4%</td>
</tr>
<tr>
<td>Azrin, 1976</td>
<td>90%</td>
<td>Monitored</td>
<td>90-98% 55%</td>
</tr>
<tr>
<td>Azrin, 1982</td>
<td>100%</td>
<td>Monitored</td>
<td>73%* 47%*</td>
</tr>
<tr>
<td>Liebson, 1978</td>
<td>78%</td>
<td>Monitored</td>
<td>98% 79%</td>
</tr>
</tbody>
</table>

Length of follow-up: Gerrein 1973: 8 weeks; Azrin 1976: 2 years; Azrin 1982: 6 months; Liebson 1976: 6 months. * Thirty-day abstinence at 6 months

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### Acamprosate: Mechanism of action

- Alcohol is an agonist at the inhibitory GABA receptors and antagonist at excitatory glutamate receptors
- Acamprosate modulates neurotransmission at glutamate metabotropic-5 glutamate receptor

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### Acamprosate: Prescribing information

- 666 mg po TID; start as soon as possible following period of alcohol withdrawal
- Contraindications
  - CrCl < 30 cc/min
  - Pregnancy category C
- Adverse effects
  - Diarrhea
Acamprosate: Efficacy

- Meta analysis of 24 RCTs contributing 6915 subjects comparing acamprosate to placebo or active control
  - Reduced rate of subjects returning to any drinking (RR 0.86, 95% CI 0.1-0.9; NNT 9)
  - Increased cumulative abstinence duration by 11%
  - No effect on heavy drinking
- Mixed results in literature

Naltrexone: Mechanism of action

Anton RF, NEJM 2008

Naltrexone: Prescribing information

- 25 to 50 mg daily taken after a meal for at least 3-4 months
- Depot form available doses studied 380 mg
  - 25% reduction in heavy drinking days
  - Recent FDA concern (8/12/08) for injection site reactions
- Contraindications:
  - Opioid use
  - Pregnancy
  - Cirrhosis
- Adverse Effects:
  - Nausea
  - Headache
  - Increased LFTs
Naltrexone: Efficacy

- Meta analysis of 50 RCTs contributing data from 7793 subjects comparing naltrexone or nalmefene to placebo or active control
  - RR 0.83 (95% CI 0.76-0.90) in heavy drinking days and decreased drinking days by 4% MD -3.89 (95% CI -5.75 to -2.04).
- May be genetic variation in naltrexone effect due to variability at the OPRM-1 gene
- Depot naltrexone improves adherence

COMBINE: Time to First Heavy Drinking Day by Naltrexone (NTX) and Combined Behavioral Intervention

Combining NTX/MM with CBI did not further improve these outcomes.

Depot Naltrexone Decreases Heavy Drinking

Heavy drinking decreased significantly in the 380 mg group (hazard ratio 0.8 vs. placebo).
Medications approved for treatment of opioid use disorders

- Opioid agonist treatment
  - Methadone
  - Buprenorphine/naloxone and buprenorphine
- Opioid antagonists
  - Naltrexone
- Consider addition of group or individual counseling, 12-step facilitation, SMART recovery etc.

Poor Outcomes without Maintenance

Kakko et al. Lancet, 2003

Pharmacology overview
Methadone

- Full opioid agonist
- Onset of action 30-60 minutes
- Duration of action
  - 24-36 hours to prevent opioid withdrawal
  - 6-8 hours analgesia
- Proper dosing
  - Acute withdrawal 20-40 mg
  - craving, "narcotic blockade" >80 mg
- Adverse effects
  - Constipation, edema, sweating, hyperalgesia
  - Secondary hypogonadism
  - QTc prolongation—high doses due to hERG blockade

Methadone: Eligibility for treatment

- Physical dependence on opioids for at least one year of continuous use or intermittent use spanning a longer period of time. Exceptions to this criterion include:
  - On methadone maintenance within the past two years
  - Recently released from incarceration or hospitalization with clinician documentation of likelihood of relapse to dependence
  - Pregnant women even if dependent for less than one year, if a return to dependence is likely during pregnancy
- An age of 18 years or older
  - Younger individuals eligible with the consent of a parent, guardian, or designated responsible adult — if they have current physical dependence and have at least two previous attempts at detoxification or psychosocial substance abuse treatment

Methadone: Dosing

![Figure 1 — Heroin Use in Past 30 Days](source)

**Percentage Heroin Use**

*Adapted from a study of 487 methadone maintenance patients.*
Methadone: Efficacy

- Methadone as part of a comprehensive treatment program, compared with placebo or no treatment
  - Increases treatment retention
  - Decreases illicit opioid use
  - Decreases hepatitis C and HIV seroconversion
  - Decreases criminal activity
  - Increases employment
  - Improves birth outcomes
  - Increases survival


Buprenorphine

- Partial opioid agonist at the µ-opioid receptor
- Listed as a schedule III drug
- Sublingual tablet or film either alone or in combination with naloxone (4:1 ratio)
  - Comes in 2, 4, 8 and 12 mg doses
  - Typical doses range from 8-16 mg
  - Ceiling effect at 32 mg
- Adverse effects
  - Constipation, sedation
  - Transaminitis
  - No known effect on QTc

Buprenorphine: Prescribing information

- Need to have obtained special DEA waiver
  - 8-hour in-person or online course
- Limits to prescribing
  - 30-100 patients per physician
Buprenorphine: Induction

- Full Agonist (Heroin, Oxycodone, Methadone) Precipitated Withdrawal
- Partial Agonist (Buprenorphine)

Buprenorphine: Efficacy

- Studies (RCT) show buprenorphine more effective than placebo and equally effective to moderate doses of methadone on primary outcomes of:
  - Abstinence from illicit opioid use
  - Retention in treatment
  - Decreased opioid craving
  - HIV outcomes in HIV+, opioid dependent patients

Naltrexone

- Opioid antagonist for relapse prevention
- Initiate after a period of opioid abstinence
- Administered in oral or depot formulation
- Adherence improved with close monitoring or with depot formulation
Naltrexone: Efficacy

- Systematic review of naltrexone vs. placebo - 2011
  - 1158 subjects included
  - No differences in all primary outcomes
  - Only difference in secondary outcome of re-incarceration (RR 0.47, 95% CI 0.26-0.94)
  - When adherence was forced, improvement noted in retention and abstinence (RR 2.93, 95% CI 1.66-5.18)

Minozzi S et al. Cochrane database sys rev. 2011

Overdose Intervention

- Naloxone (Narcan) Distribution
  - IM or intranasal opioid antagonist
  - Reverses opioid effects, restores breathing
  - Available by prescription only
- MA trained >10,000 lay people since 2007 (Walley, 2011)
  - >100 reversals to date
  - Protective when >1.5/1000 persons enrolled
- Good Samaritan bills
  - Protect people who call 911 from prosecution for possession
  - Liability protection for lay people who give naloxone
Annual rates* of unintentional drug overdose deaths and number of overdose prevention programs distributing Narcan — U.S., 1979–2010

Who might benefit most from Narcan rx?

- History or suspected history of substance abuse
- Treated for opioid poisoning or intoxication at ED
- Beginning methadone or buprenorphine therapy
- Higher-dose prescriptions (>50 mg MSO₄ equiv./day)
- Rotated from one opioid to another
- Concurrent opioid and:
  - Benzodiazepine prescription
  - Anti-depressant prescription
  - Smoking, COPD, asthma, or other respiratory illness
  - Renal dysfunction, hepatic illness, cardiac disease, HIV/AIDS
  - Concurrent alcohol use

Conclusions

- Substance use disorders are chronic diseases
- Effective pharmacologic treatment options available for tobacco, alcohol, and opioid use disorders
- Understanding of treatment options and referral sources important skills for primary care physicians and general psychiatrists
ARS- CASE QUESTION

• Mr. Smith is a 52 year-old man who comes to your clinic requesting help with smoking cessation.
  – Smokes 1 ½ packs per day.
  – He decides he will set a quit date in 7 days and would like to try nicotine replacement therapy.

ARS- Which of the following options would be the most likely to assist this patient in his quit attempt?

1. Nicotine patch 7 mg TD daily + 2mg nicotine gum QID PRN
2. Nicotine patch 14 mg TD daily
3. Nicotine patch 14 mg TD daily + 2 mg nicotine gum QID PRN
4. Nicotine patch 21 mg TD daily
5. Nicotine patch 21 mg TD daily + 2 mg nicotine gum QID PRN
ARS- CASE QUESTION

Ms. Miller is a 43 year-old woman with history of chronic alcohol use and epilepsy.

- Meets criteria for moderate alcohol use disorder.
- History of alcohol withdrawal but has never had Delirium Tremens.
- Has completed Intensive Outpatient Treatment on 2 occasions and relapsed after less than a month both times.
- She would like assistance in curbing her alcohol use.

ARS - Which medication will most likely help with her alcohol craving?

1. Disulfiram
2. Clonidine
3. Naltrexone
4. Clonazepam
5. Baclofen

ARS- CASE QUESTION

Mr. Carter is a 36 year-old man who comes in seeking assistance with chronic prescription opioid misuse.

- Reports he was prescribed Percocet 4 years ago after a traumatic injury to his right knee.
- After about 6 months of using the medications as prescribed, he noticed he started using them more frequently because he “liked the feeling it gave me.”
- Since that time, he saw multiple providers to obtain prescription opioids and more recently has been buying opioids on the street, spending up to $200 per day on “whatever I could get my hands on.”
- His wife is pregnant and is due in 3 months and the patient reports he wants to “start fresh before the baby is born.”
- He works 9-10 hour days as a branch manager at a local bank.
ARS- Which is the best treatment option for him?
1. Motivational interviewing
2. Comprehensive methadone maintenance program
3. Clonidine
4. Buprenorphine/naloxone treatment with adjunctive NA support groups
5. No treatment necessary as he is using opioids for pain and hence does not qualify for a substance use disorder

Course Wrap Up & Evaluation Peter Selby, MD
• Q & A - Feedback from Attendees
• Feedback is important, you will receive emails at the end of the course today
• Please complete the Post-Test
• Please complete the Evaluation
• Thank you for coming!