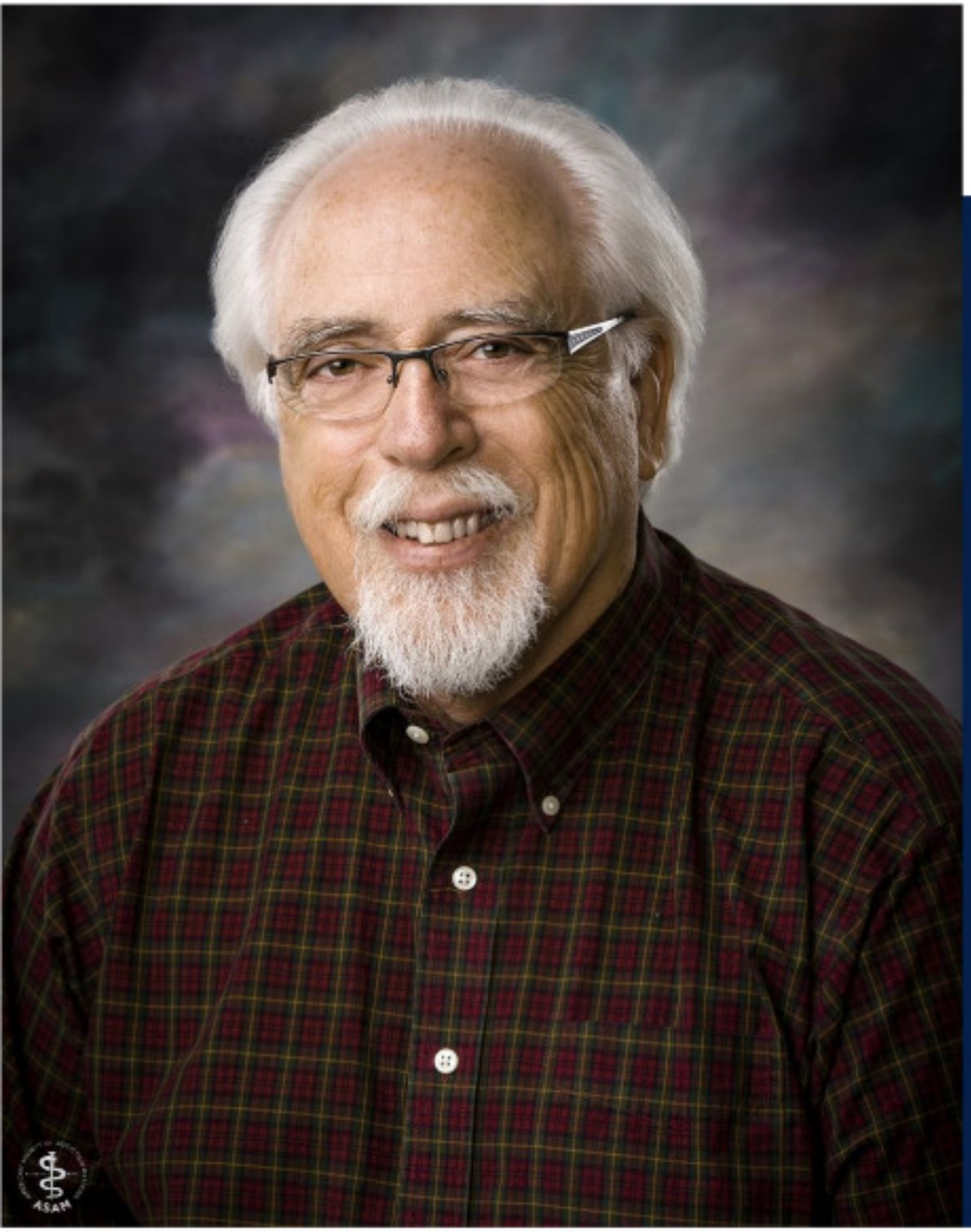
ASAM American Society *of* Addiction Medicine

THE ASAM FUNDAMENTALS™ of Addiction Medicine



Faculty

Dr. Daniel A. Nauts

Dr. Nauts completed his undergraduate and medical education at the University of Michigan and joined an internal medicine group practice in Bellingham, Washington. He left general internal medicine to develop his Addiction Medicine practice; since that time, he has been instrumental in the creation of inpatient programs for those suffering with substance use and co-occurring disorders, outpatient SUD programs, and medication assisted treatment services. Dr. Nauts is an independent contractor for the Montana Primary Care Association. He is a member of the Drug Utilization Board of Mountain Pacific Quality Health providing oversight to the Medicaid formulary, is recognized as a Fellow of the American Society of Addiction Medicine (FASAM) and is certified in the subspecialty of Addiction Medicine by the American Board of Preventive Medicine. He is the treasurer for the Northwest Society of Addiction Medicine, a Chapter of American Society of Addiction Medicine (ASAM) representing Montana, North Dakota, and Wyoming and is a faculty member of ASAM to provide Data 2000 MAT waiver trainings and The Fundamentals of Addiction Medicine.

Disclosure Information

Daniel A. Nauts, MD

Nature of Relevant Relationship: None

Faculty

Dr. Robert C. Sherrick

Dr. Robert Sherrick is Chief Medical Officer for Community Medical Services, a company that serves patients through over 40 Opioid Treatment Programs in 9 states. He also works at an inpatient addiction treatment facility in Kalispell, Pathways Treatment Center, treating all forms of Substance Use Disorders and dual diagnosis patients. Dr. Sherrick has been providing Medication Assisted Treatment for Opioid Use Disorder since 2003, initially in an office setting using buprenorphine and subsequently with methadone in Opioid Treatment Programs. He established a state-wide buprenorphine treatment program for VA Montana with extensive use of telemedicine. He is board certified in Addiction Medicine through the American Board of Preventative Medicine. He is currently the President of the Northwest Chapter of the American Society of Addiction Medicine.

Disclosure Information

Robert C. Sherrick, MD

Nature of Relevant Relationship: None

Collaboration Board:
Day 1 Reflections

Collaborate Board

Share your successes, surprises, and challenges from Day 1 of the workshop.

Day 1 Reflections

Session 3

For Every Ill There Must Be a Pill: Medications for Treating Substance Use Disorders

Session Learning Objectives

At the end of the session, you will be able to:

- Understand the role of medications in treating Substance Use Disorders involving opioids, alcohol, and nicotine.
- Know the medications that are available for treating SUDs and their appropriate uses.
- Prescribe medications or refer appropriately when they are indicated in treating SUDs.

How can medications help people with SUDs?

1. Managing symptoms of withdrawal
2. Helping clients with SUD cut down and/or control their substance use
3. Helping clients stop their substance use
4. Maintenance of remission
5. Treating comorbid medical and mental health problems

Download fact sheets: Medications for Withdrawal Medications for SUDs

Medications for Managing Substance Withdrawal

ASAM/MPCA Fundamentals of Addiction Medicine Course – 2021

Alcohol – Alcohol withdrawal may cause a life-threatening withdrawal syndrome, which if untreated can lead to delirium tremens, severe agitation, seizures, coma, and death. The initial focus should be to rapidly load patients with appropriate medication with the goal of preventing progression of withdrawal symptoms.

The foundation of treatment of alcohol withdrawal in the US is benzodiazepines. Most experts prefer longer acting BZs, such as chlordiazepoxide or diazepam, unless there is a specific indication for another choice.

Gabapentin has also been shown to be effective for alcohol withdrawal. In milder cases, gabapentin can be sufficient by itself, and in more severe cases it can be used as an adjunct to BZ treatment. Doses need to be start 00 mg per day or higher with a taper over several days as symptoms

Adjuvant medications, such ications for insomnia may also have a role, as well a d also be given supplemental thiamine.

For a complete treatm e ASAM guidelines:

https://www.asam.or
science/the_asam_cli

Opioids – While the w ing, it is associated with severe dysphoria. ng/diarrhea, achiness, insomnia, and severe res drawal can be difficult, since the only medications withdrawal symptoms are other opioids.

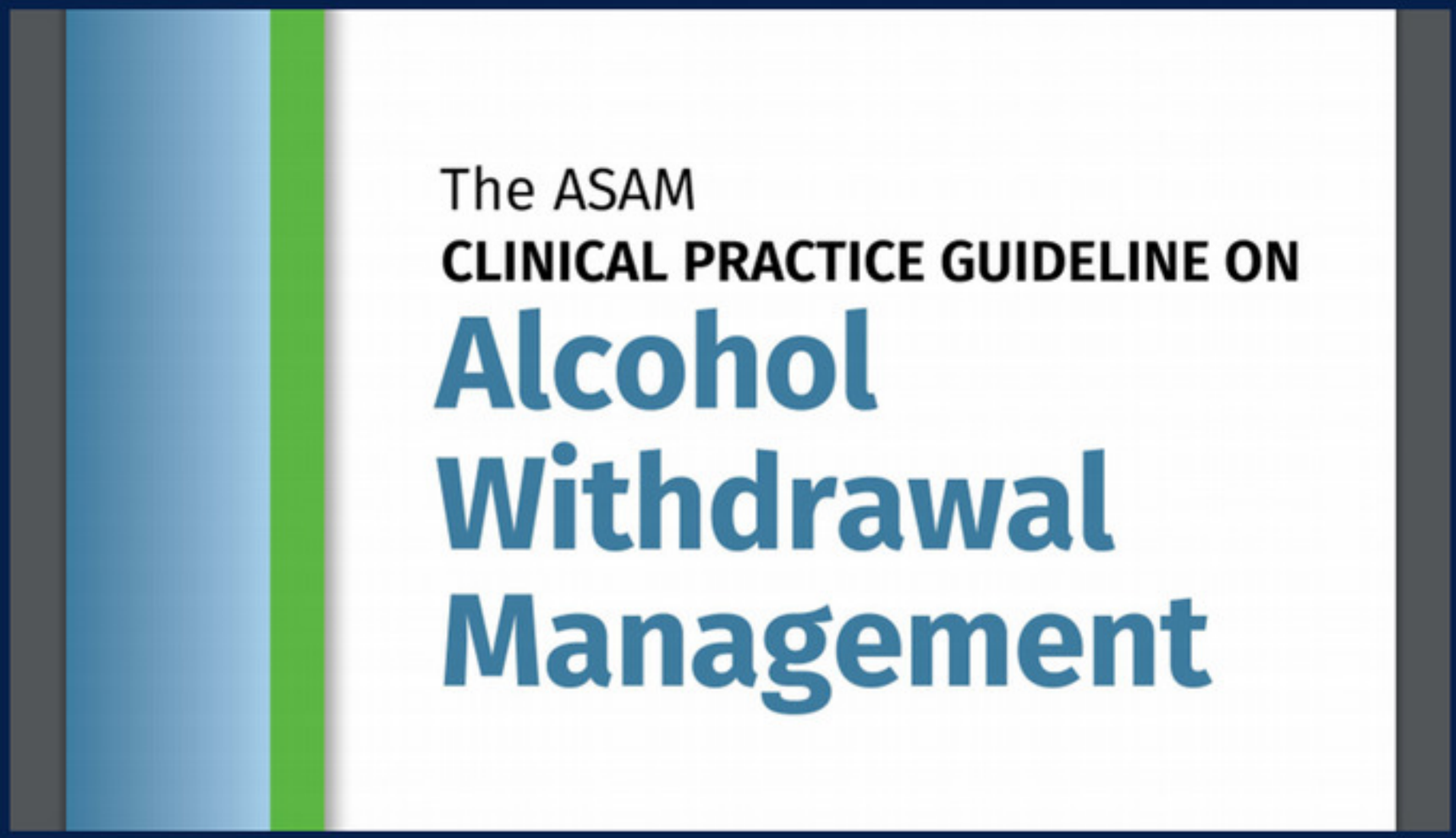
Once the acute phase of opioid w nt to address the increased risk of opioid overdose that continues for se nths. Consideration should be given in all cases to placing patients on MOUD, possibly followed by a slow taper, rather than acute withdrawal management. All patients should be offered a naloxone rescue kit and instructions.

Treatment for opioid withdrawal consists of using clonidine or lofexidine to help reduce sympathetic outflow from the CNS. Other medications may include anti-nausea, anti-

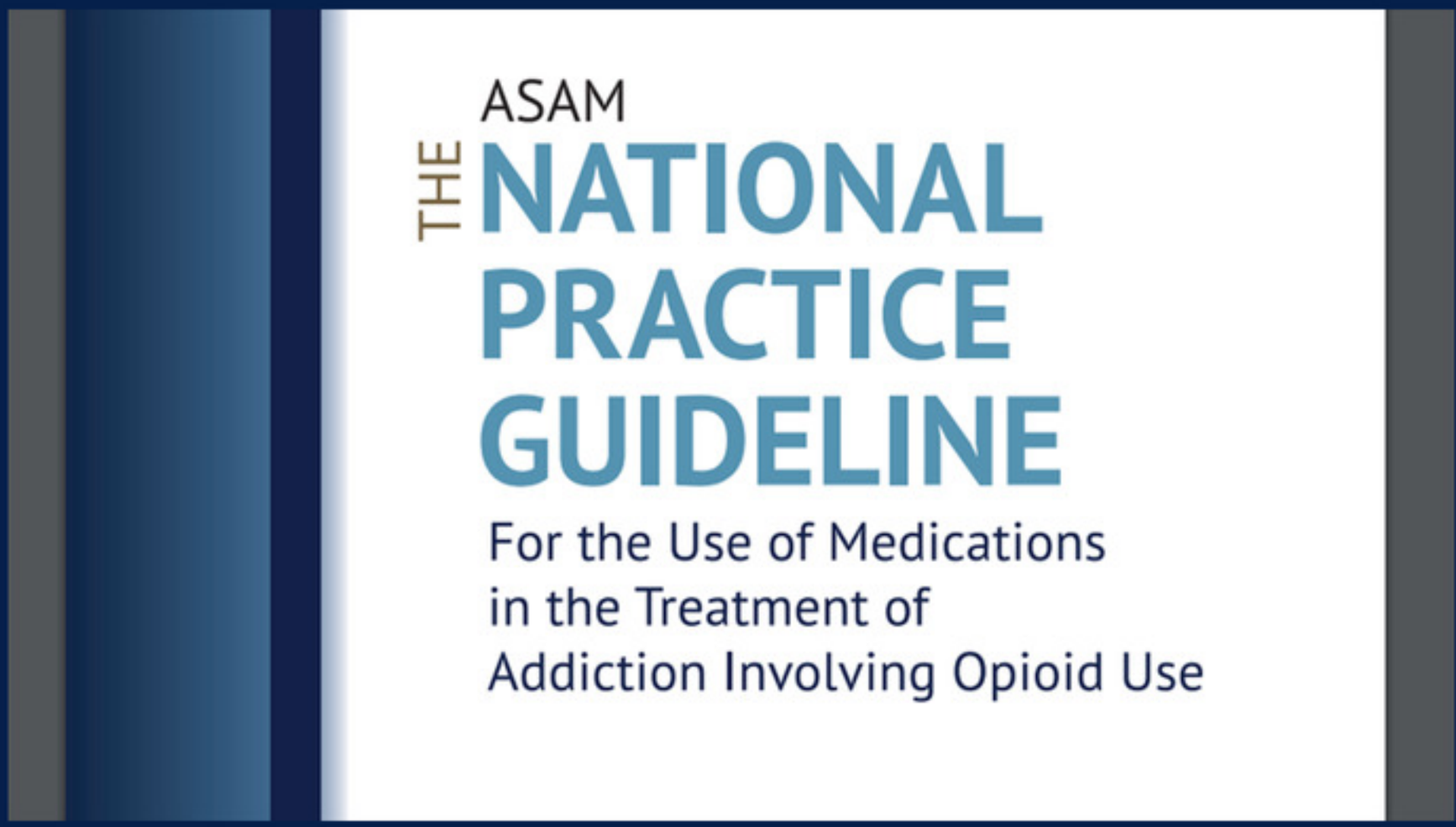
Refer to the ASAM National Practice Guidelines for more details:

Withdrawal Management

- Alcohol
- Opioids
- Stimulants
- Nicotine
- Cannabis

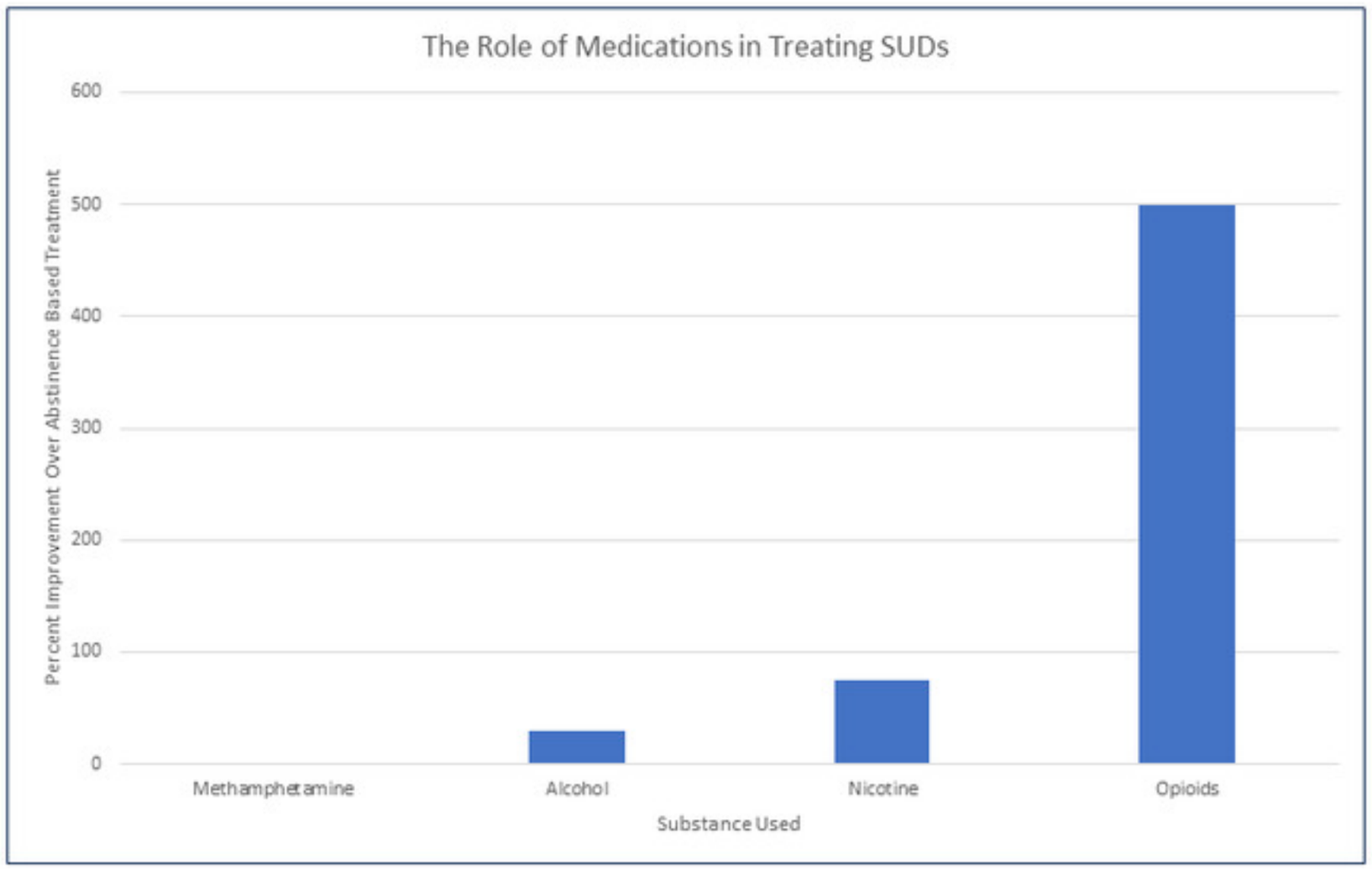


https://www.asam.org/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf



https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

The Role of Medication for Treating SUDs



PDF Instructions

Download the PDF on the next page:

1. Right-click on the gray space around the document or move your mouse to the top of the gray space and right-click on the dark gray drop-down bar.
2. Select the “Save as” option.
3. Rename the PDF using the title in the document.
4. Save the PDF in the FOAM folder you have created on your device.

ASAM/MPCA Fundamentals of Addiction Medicine Course – 2021

Alcohol Use Disorder Treatment Medications

FDA-Approved

Naltrexone is effective in reducing heavy drinking when used in the oral form (50mg/day) or the long-acting injectable form (Vivitrol®, 380 mg IM monthly). It reduces craving for alcohol and makes drinking alcohol less pleasurable. It is a mu-opioid antagonist which precludes its use in patients who take opioids. It can occasionally cause hepatic impairment and should be used cautiously in patients with liver disease.

Acamprosate (Campral®) is administered as an oral medication (666 mg TID), and acts at the GABA and glutamate receptors. It ap[illegible]e for maintaining abstinence, rather than decreasing heavy drinking. I[illegible]iety. It can be used in patients with significant liver disease b[illegible]d in renal failure.

Disulfiram (Antabuse®) a[illegible]hol is consumed. The medication interrupts th[illegible]d-up of acetaldehyde, which produces sympto[illegible]hers. A typical dose is 250 mg daily. Care mu[illegible]vash) in order to avoid symptoms. It is contra[illegible]psychosis. It works best when supervised[illegible]order to avoid non-adherence. It can cau[illegible]nonitoring of liver enzymes is recommen[illegible]

Off-label

Topiramate acts at both GA[illegible]ted with both a decrease in heavy drinking days and an inc[illegible]. The dose is slowly titrated up from 25 mg per day to a maximum[illegible] started while patients are still drinking and can cause a gradual reduct[illegible] effects include mental slowing, weight loss and paresthesias.

Gabapentin is thought to act as a calcium modulator at presynaptic terminals inhibiting the release of glutamate. Its use is associated with increased rates of abstinence and a decrease in heavy drinking. The preferred dose is 1800 mg/day. Side effects include sedation and dizziness.

Treatment Planning for Ben (Breakout Room Activity)

Case Study: Ben

Ben is a 38-year-old man, referred by Drug Court after multiple arrests for disorderly conduct. He has been drinking for many years, and his alcohol use disorder has resulted in his wife leaving him and the loss of his job in the film industry. He has poor social support. He has had multiple attempts at sobriety and has attended AA sporadically. He has also had several short stints in counseling. He knows that he will go to jail if he relapses, and he is asking for help to control his craving. He reports that his last drink was 6 days ago.

On his physical exam, Ben has normal vital signs but is mildly tremulous. He is mildly tender in the right upper quadrant of his abdomen.

Labs show elevated transaminases (approximately twice the upper limit of normal), with normal albumin, platelets, and PT/INR.

Treatment Plan for Ben

Things to Consider:

1. Would you treat Ben initially as an outpatient or an inpatient?
2. How would you treat withdrawal symptoms? Which medication(s) would you use?
3. Which medication(s) would you recommend for maintenance?
4. What is the proposed duration of treatment?
5. What other treatment(s) you would recommend in addition to medication?
6. What harm reduction options would you consider?

PDF Instructions

Download the PDF on the next page:

1. Right-click on the gray space around the document or move your mouse to the top of the gray space and right-click on the dark gray drop-down bar.
2. Select the “Save as” option.
3. Rename the PDF using the title in the document.
4. Save the PDF in the FOAM folder you have created on your device.

Treatment Planning for Ben

Knowledge Sharing

Participants will be pre-assigned into small groups within Zoom breakout rooms to discuss the case in 15 minutes and then conclude with a large group discussion.

Treatment Plan for Ben (Alcohol Use Disorder)

- Faculty will lead a brief overview of Ben's case.
- Work with your group to develop an appropriate treatment plan to propose for Ben. Refer to the information provided about **Medications for Withdrawal Management** and **Alcohol Use Disorder Treatment Medications**.
- Answer the questions below in relation to this case.
- Faculty will call "time" and bring the group together for discussion. Group leaders will be called upon to answer each of the questions below.

Ben – Treatment for Alco

Case Information

Ben is a 38-year-old man w for disorderly conduct. He has been drinking for n his wife leaving him and loss of his job in the film i attempts at sobriety and has attended AA sp ng. He knows that he will go to jail if he re orts that he has tapered his drinking to

On physical exam Ben ender in the right upper quadrant of his a y twice the upper limit of normal), with nor

Key Considerations

1. Would you treat Ben initia patient?
2. How would you treat withdrawal symptoms? Which medication(s) would you use?
3. Which medication(s) would you recommend for maintenance?
4. What is the proposed duration of treatment?

Large Group Discussion:

Share the treatment plan your team developed for the client.

AUD Medications

Medication	*Route*	*FDA*	*Mechanism*
Disulfiram	Oral	Y	Aldehyde dehydrogenase inhibitor
Naltrexone	Oral	Y	m opioid antagonist
Naltrexone	Injectable	Y	m opioid antagonist
Acamprosate	Oral	Y	NMDA antagonist
Topiramate	Oral	Y	GABA agonist/NMDA antagonist
Gabapentin	Oral	Y	Calcium modulator

Break

Treatment Planning for Jesse (Breakout Room Activity)

Case Study: Jesse

Jesse is a 30-year-old divorced woman who works as a bus driver. She has developed an opioid use disorder (OUD) after receiving a large quantity of opioid pain pills with several refills for her fractured clavicle during a soccer game.

Jesse's reason for coming to see you is that she wants help with medications to get control of her OUD. Recently she has started buying pain pills from friends and fears she will lose her job or lose custody of her two children. She has not had any treatment for her OUD previously, and states that she "doesn't believe" in 12-step programs.

On her physical exam, she has a mildly elevated heart rate, enlarged pupils, and moist skin. She has no track marks in her antecubital fossae or her neck.

In-office urine drug screening is positive for oxycodone, but otherwise negative. HCG test is negative. Metabolic panel, hepatitis testing, and HIV testing are pending.

Treatment Plan for Jesse

Things to Consider:

1. Would you treat Jesse initially as an outpatient or an inpatient?
2. How would you treat withdrawal symptoms? Which medication(s) would you use?
3. Which medication(s) would you recommend for maintenance?
4. What is the proposed duration of treatment?
5. What other treatment(s) you would recommend in addition to medication?
6. What harm reduction options would you consider?

PDF Instructions

Download the PDF on the next page:

1. Right-click on the gray space around the document or move your mouse to the top of the gray space and right-click on the dark gray drop-down bar.
2. Select the “Save as” option.
3. Rename the PDF using the title in the document.
4. Save the PDF in the FOAM folder you have created on your device.

Treatment Planning for Jesse

Knowledge Sharing

Participants will be pre-assigned into small groups within zoom breakout rooms to discuss the case in 15 minutes and then conclude with a large group discussion.

Treatment Plan for Jesse (Opioid Use Disorder)

- Faculty will lead a brief overview of Jesse's case.
- Work with your group to develop an appropriate treatment plan to propose for Ben. Refer to the information provided about **Medications for Withdrawal Management** and **Opioid Disorder Treatment Medications**.
- Answer the questions below in relation to this case.
- Faculty will call "time" and bring the group together for discussion. Group leaders will be called upon to answer each of the questions below.

Jesse – Treatment for Op

Case Information

Jesse is a 30-year-old divo oped an opioid use disorder (OUD) after rec fills after she fractured her clavicle in a soccer nts help with medications to get control of her OU nd fears she will lose her job or lose custody of h previously, and states that she "doesn't belie

On physical exam she skin. She has no track marks in her antecubita ve for oxycodone and otherwise negative. HCG HIV testing are pending.

Key Considerations:

1. Would you treat Jesse initially as
2. How would you treat withdrawal symptoms? Which medication(s) would you use?
3. Which medication(s) would you recommend for maintenance?
4. What is the proposed duration of treatment?
5. What other treatment(s) you would recommend in addition to medication?

Large Group Discussion:

Share the treatment plan your team developed for the client.

OUD Medications

Medication	*Route*	*FDA*	*Mechanism*
Methadone	Oral	Y	μ opioid agonist
Buprenorphine	Transmucosal	Y	μ opioid agonist
Buprenorphine	Subdermal	Y	μ opioid agonist
Buprenorphine	Injectable	Y	μ opioid agonist
Naltrexone	Oral	Y	μ opioid antagonist
Naltrexone	Injectable	Y	μ opioid antagonist

Treatment Planning for Harvey (Take Home Activity)

Case Study: Harvey

Harvey is a 58-year-old man who works as a truck driver and has a 30 pack-year smoking history. He currently smokes 30 cigarettes per day and smokes his first cigarette while sitting on the side of the bed when he wakes up.

He has tried to quit smoking many times using nicotine patches and has also utilized Quitline. He lacks confidence in his ability to quit but is asking for help because he recently learned that he has mild COPD. Harvey is married and has 3 adult children. He has mild intermittent depression.

His physical exam and labs are unremarkable.

Treatment Plan for Harvey

Things to Consider:

1. Would you treat Harvey initially as an outpatient or an inpatient?
2. How would you treat withdrawal symptoms? Which medication(s) would you use?
3. Which medication(s) would you recommend for maintenance?
4. What is the proposed duration of treatment?
5. What other treatment(s) you would recommend in addition to medication?
6. What harm reduction options would you consider?

PDF Instructions

Download the PDF on the next page:

1. Right-click on the gray space around the document or move your mouse to the top of the gray space and right-click on the dark gray drop-down bar.
2. Select the “Save as” option.
3. Rename the PDF using the title in the document.
4. Save the PDF in the FOAM folder you have created on your device.

Treatment Planning for Harvey

Practice at Home Activity

Knowledge Sharing

Participants will be pre-assigned into small groups within zoom breakout rooms to discuss the case in 10 minutes and then conclude with a large group discussion.

Treatment Plan for Harvey (Tobacco Use Disorder)

- Faculty will lead a brief overview of Harvey's case.
- Work with your group to develop an appropriate treatment plan to propose for Harvey. Refer to the information provided about **Tobacco Use Disorder Treatment Medications**.
- Answer the questions below in relation to this case.
- Faculty will call "time" and bring the group together for discussion. Group leaders will be called upon to answer each of the questions below.

Harvey – Treatment for Smoking Cessation

Case Information

Harvey is a 58-year old man wh ack-year smoking history. He currently smokes 30 ciga hile sitting on the side of the bed when he wakes

He has tried to quit smo is ability to quit but is asking for help be is married and has 3 adult children. H

His physical exam and

Key Considerations

1. Would you treat Harv
2. How would you treat wi d you use?
3. Which medication(s) would y
4. What is the proposed duration of trea
5. What other treatment(s) you would recommend in addition to medication?
6. What harm reduction options would you consider?

Large Group Discussion:

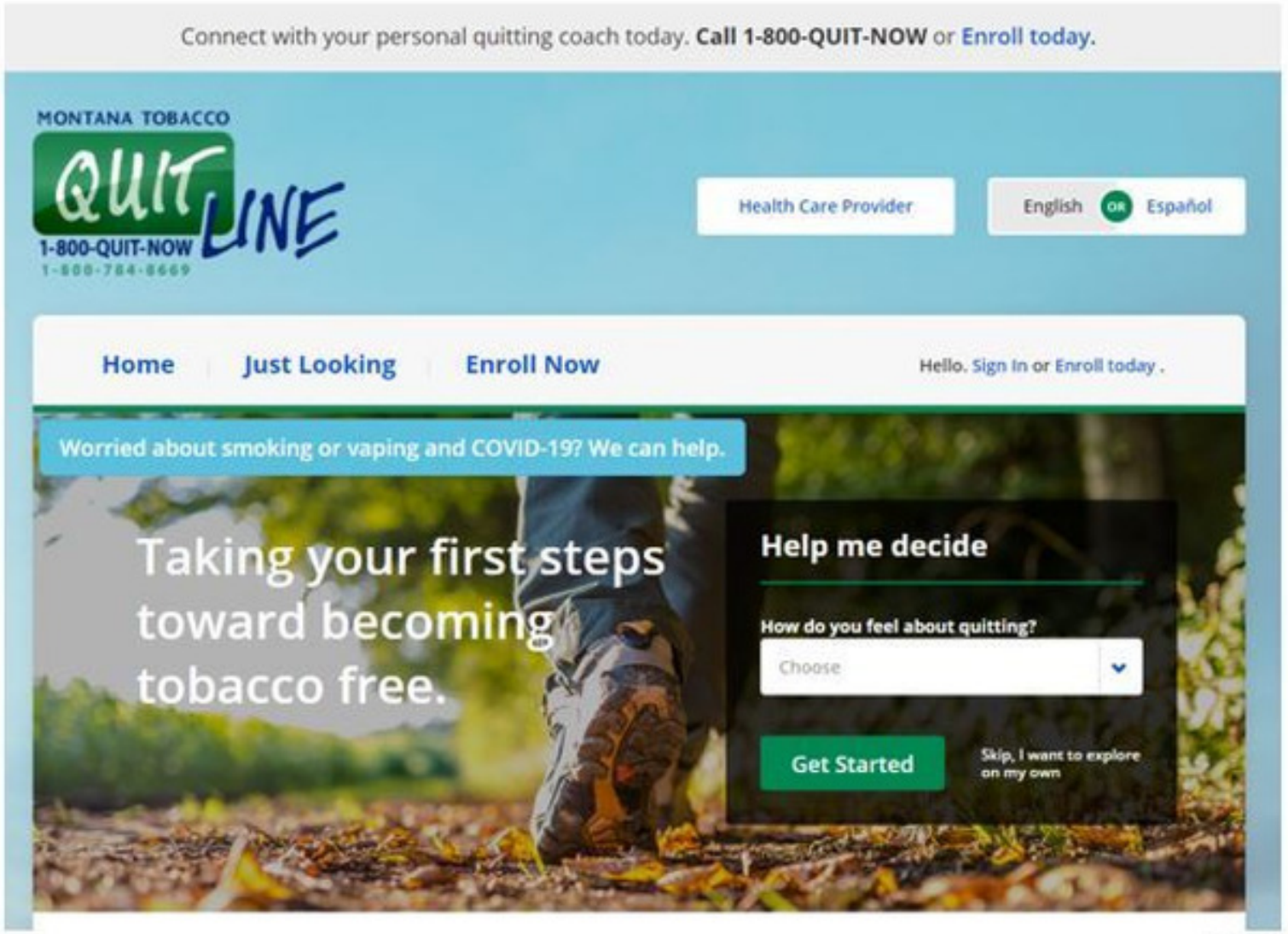
Share the treatment plan your team developed for the client.

Medications for Tobacco Cessation

Medication	*Route*	*FDA*	*Mechanism*
Nicotine	Transmucosal	Y	Nicotine Agonist
Nicotine	Transdermal	Y	Nicotine Agonist
Nicotine	Inhaled	Y	Nicotine Agonist
Nicotine	Intranasal	Y	Nicotine Agonist
Varenicline	Oral	Y	Nicotine Agonist
Bupropion	Oral	Y	Dopamine/NE reuptake inhibitor
Nortriptyline*	Oral	N	NE/serotonin reuptake inhibitor
Clonidine*	Oral	N	α-2 adrenergic agonist

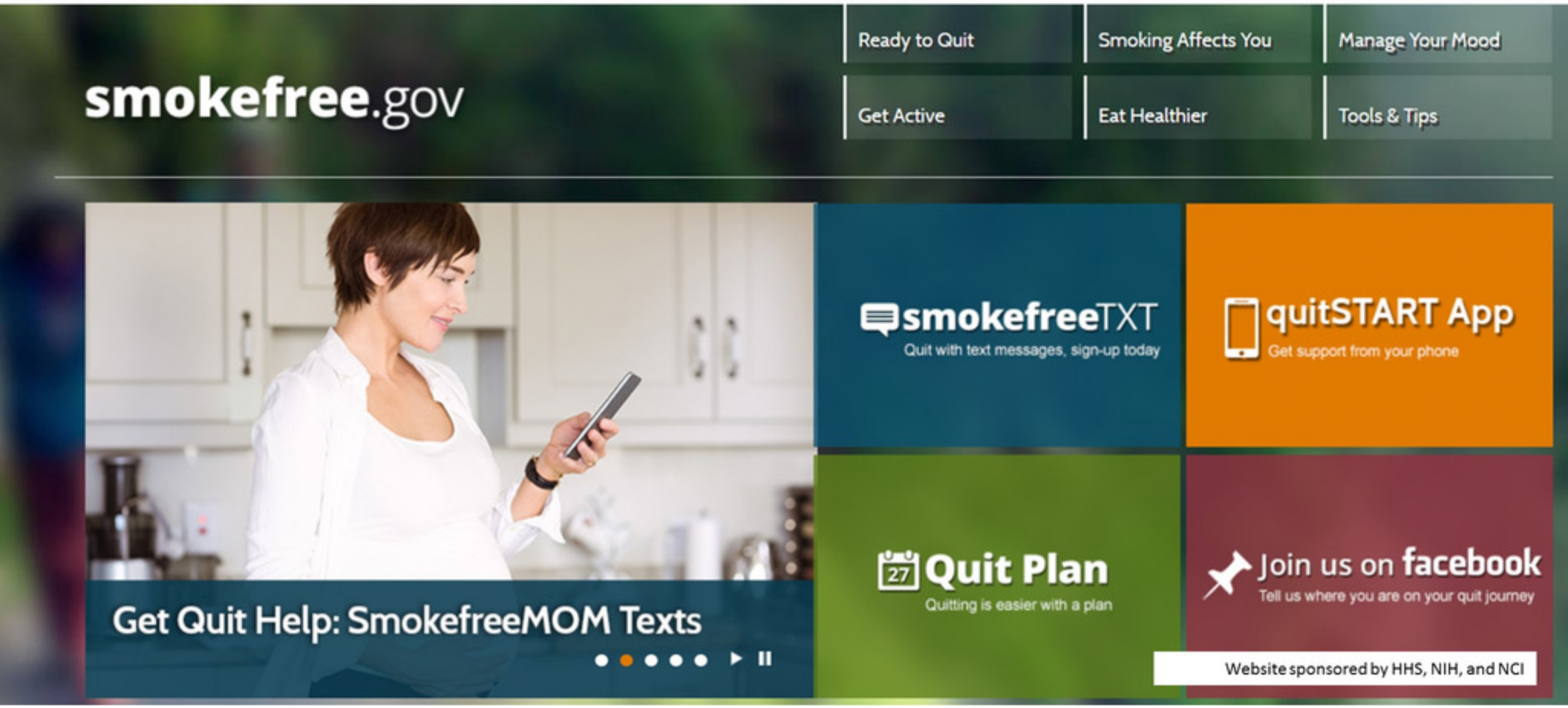
*Off-label, not FDA approved for this indication

1-800-QUIT-NOW State Tobacco Cessation Resources



Website sponsored by HHS, NIH, and NCI

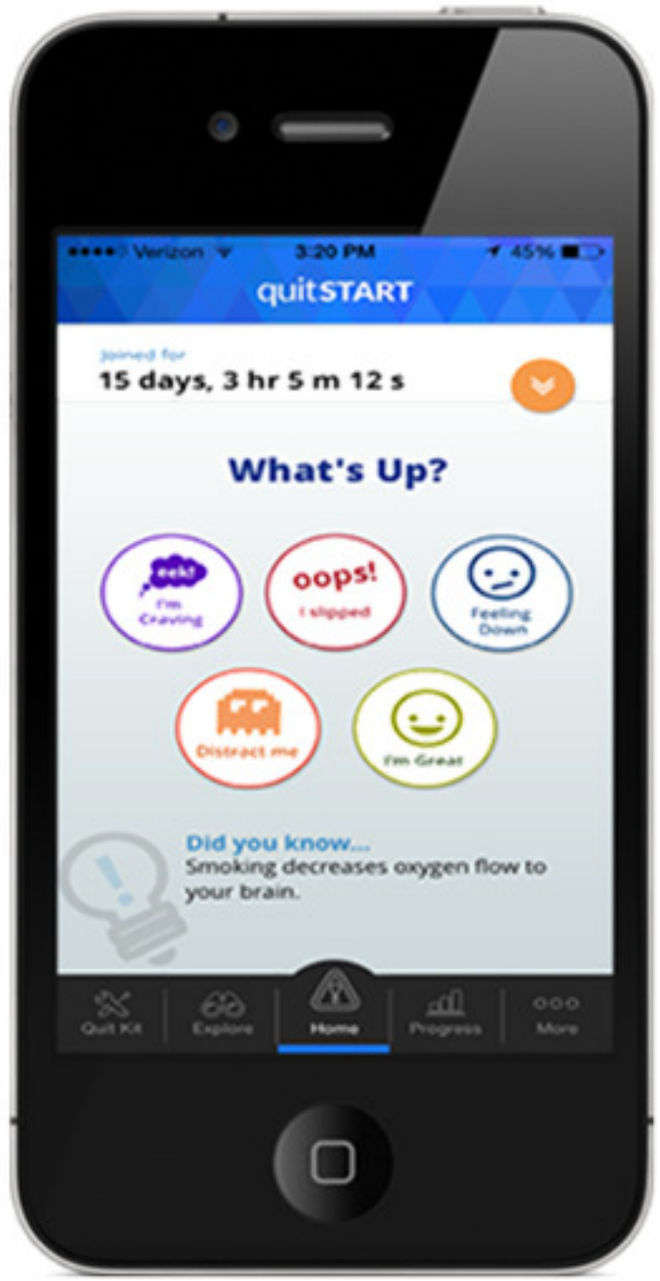
Tailored Online Help



Quitstart

App for teens and others: smokefree.gov

- Badges for milestones.
- Manage cravings and bad moods.
- Distract yourself with games and challenges.
- Share on social media.



Whittaker, Cochrane Database Syst Review, 2012

Knowledge Checks

Quiz

Which of the following medications for AUD is most effective for maintaining abstinence rather than reducing heavy drinking?

- Naltrexone
- Acamprosate
- Disulfiram
- Gabapentin

Quiz

Which of the following medications is an opioid antagonist?

- Methadone
- Buprenorphine
- Naltrexone

Quiz

Which of the following medications is FDA-approved for the treatment of tobacco use disorder?

- Clonidine
- Nortriptyline
- Varenicline

Quiz

Mr. Smith is a 52-year-old man who comes to your clinic requesting help with smoking cessation. He 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. Which of the following options would be the most likely to assist this patient in his quit attempt?

- Nicotine patch 7 mg TD daily + 2mg nicotine gum QID PRN.
- **Nicotine patch 14 mg TD daily.**
- Nicotine patch 14 mg TD daily + 2 mg nicotine gum QID PRN.
- **Nicotine patch 21 mg TD daily.**
- Nicotine patch 21 mg TD daily + 2 mg nicotine gum QID PRN.

Quiz

Ms. Miller is a 43-year-old woman with history of chronic alcohol use and epilepsy. She meets criteria for moderate alcohol use disorder. She has a history of alcohol withdrawal but has never had Delirium Tremens. She has completed Intensive Outpatient Treatment on two occasions and relapsed after less than a month both times due to overwhelming feelings of craving. She would like assistance in curbing her alcohol use. Which medication will most likely help with her alcohol craving?

- Disulfiram
- Clonidine
- Naltrexone
- Clonazepam
- Baclofen

Quiz

Mr. Carter is a 36-year-old man who comes in seeking assistance with chronic prescription opioid misuse. He 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 due in 3 months. 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. Which is the best treatment option for Mr. Carter?

- **Motivational interviewing.**
- **Comprehensive methadone maintenance program.**
- **Clonidine.**
- **Buprenorphine/naloxone treatment with adjunctive psychosocial treatment.**
- **No treatment necessary as he is using opioids for pain and hence does not qualify for a substance use disorder.**

Quiz

Alcoholics Anonymous (AA), as well as other 12-step programs, are best described as:

- **Recovery organizations open only to people who are abstinent from alcohol.**
- **Tax exempt religious organizations.**
- A fellowship of mutual-peer support for people with drinking problems.
- **Groups led by professionally trained therapists.**
- **Charitable organizations that support treatment for addictions.**

Quiz

To attend AA meetings or other 12-step meetings, it is expected that the person will:

- **Have been referred by the courts or by a professional.**
- **Have a desire to not drink alcohol/use drugs.**
- **Be motivated to never drink again.**
- **Agree that his or her sponsor can contact family members for further information.**
- **Share their entire story of alcohol or drug use.**

Session Feedback

Poll

Presenters were knowledgeable, unbiased, engaging.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Poll

This session enhanced my current knowledge and/or skill base.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Poll

The small group breakout work allowed me to apply the learning objectives for this session.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Session 4

Identifying Unhealthy Substance Use: Assessment

Session Learning Objectives

At the end of the session, you will be able to:

- Use a systematic approach to diagnose, assess and develop a treatment plan for people substance use disorders
  - Review the DSM–5 Criteria for Substance-Use Disorders.
  - Introduce and apply the ASAM Placement Criteria as a framework for a comprehensive assessment.
  - Offer the interventions that are appropriate to specific substances and severity of usage pattern.

Session Outline

- Address considerations for assessment and treatment planning.
  - Harm reduction.
  - Strengths and weaknesses of Urine Drug Testing (UDT) as an assessment tool.
  - Non-pharmacological treatment options.

Addiction is a Complex Chronic Disease

- Improve patient experience
- Improve outcomes
- Improve systems of care

https://www.bettercareplaybook.org/

Assessment: Identify, Connect, Plan

- Relationships are our best tools
- Mutual understanding and trust build over time

Does this patient have a substance use disorder?

- DSM-5

If so, how severe is it?

- DSM-5
- ASAM Criteria

What is *our* plan to address it?

- ASAM Criteria
- Evidence Based Interventions
- Harm Reduction

Case Discussion: Kim

Kim presents to her primary care clinician reporting headaches, trouble sleeping, anxiety, and heart palpitations for the past week.

- She reports in that she was drinking 4 or more times a week, about 2-3 drinks per day with 3oz of tequila per drink. She describes measuring out her tequila: “That is exactly how I like my evening juice.”
- She reports that over the years she has preferred to have her drinks stronger and has gone from 2oz to 3oz per drink but does not see that as an issue.
- She reports she has been drinking like this since all of her kids left the house about 5 years ago.

Case Discussion: Kim

- Kim is retired. She checks on her elderly mother at home daily and has no problem doing so.
- She states she does not worry about her drinking and she does not have plans to stop. Her husband jokes that she is an expensive retiree because she likes expensive Tequila and certainly can go through some bottles.
- She reports that at least one time a week she does not remember what happened the night before, which typically is the result of her waking up somewhere in the house asleep the next morning and her husband and dogs coming down the stairs to find her passed out.

Case Discussion: Kim

- For the last three weeks she has been unable to get to the liquor store due to closings related to COVID-19. She ran out of alcohol 1 week ago.
- She is excited that later tonight she will be able to get takeout drinks from a local restaurant.
- She begins to ask the doctor when they will begin to address her anxiety and sleeping problems and other symptoms. Kim feels anxious to get the session moving back to why she came in today.

Does our patient have a substance use disorder?

The DSM-5 defines a substance use disorder as the presence of at least 2 of 11 criteria.

Criterion	Category
1. Taking more or for longer than intended	Impaired Control
2. Unsuccessful efforts to stop or cut down use	
3. Spending a great deal of time obtaining, using, or recovering from use	
4. Craving for substance	
5. Failure to fulfill major obligations due to use	Social Impairment
6. Continued use despite relationship problems caused or exacerbated by use	
7. Important activities given up or reduced because of substance use	
8. Recurrent use in hazardous situations	Risky Use
9. Continued use despite physical or psychological problems	
10. Tolerance to effects of the substance*	Physiologic Adaptation
11. Withdrawal symptoms when not using or using less.*	

* Persons who are prescribed medications are not necessarily to be considered to have a substance use disorder
Mild = 2-3 criteria, Moderate = 4-5 criteria, Severe = 6 or more criteria

Quiz

What is the diagnosis?

- Mild Substance Use Disorder
- Moderate Substance Use Disorder
- Severe Substance Use Disorder
- Has a Substance Use Disorder, need more information for severity
- No Substance Use Disorder

ASAM Criteria

Acute Intoxication &/or Withdrawal Potential

Biomedical Conditions & Complications

Emotional, Behavioral or Cognitive Conditions & Complications

Readiness to Change

Relapse, Continued Use, or Continued Problem Potential

Recovery Living Environment

ASAM's Criteria uses 6 dimensions to create a holistic, biosocial assessment of an individual to be used for service planning and treatment across all services and levels of care.

ASAM Criteria

ASAM Dimension	*Levels of Care*			
	I. Outpatient	II. Intensive Outpatient	III. Monitored Inpatient	IV. Medically Managed Inpatient
1: Acute Intoxication and /or Withdrawal Potential	no risk	minimal	mild-moderate	severe
2: Biomedical Conditions & Complications	no risk	manageable	monitoring needed	24-hr acute medical needs
3: Emotional, Behavioral, or Cognitive Conditions & Complications	no risk	mild	monitoring needed	24-hr acute psych needs
4: Readiness to Change	Action	Preparation/ Action	Contemplation	
5: Return to Use, Continued Use, Continued Problem Potential	Maintains abstinence	More symptoms	Unable to stop using	
6: Recovery/ Living Environment	Supportive	Can cope with structure	Actively undermining recovery	

Case Discussion: Kim

- Kim returns to the office six months later. She reports that after the last visit she was angry and had no intention of ever returning.
- However that night she and her husband argued when he challenged her to cut down
- She started picking up takeout drinks on her way to care for her mother. She frequently felt anxious about her drinks and cut her time with her mother short. She occasionally started to drink in the car.
- Last week she almost got in an accident and her husband threatened to leave her if she didn't come in to get help for her drinking.

Case Discussion: Kim

- Kim does not make eye contact, and answers question in short phrases.
- During intake, her PHQ9 scores 3 (trouble sleeping almost every night, otherwise negative)
- She states that she is no longer bothered by headaches.
- Her blood pressure 12 144/82, HR 90
- Her physical exam is unremarkable.

- How would you assess Kim ?

D1. Acute Intoxication or Withdrawal Potential

- What are the risks from the patient's current intoxication?
- What risks are associated with this patient's withdrawal management?
  - Is there a risk for seizures and/or delirium tremens?
- Are there comorbid conditions that may complicate withdrawal management?
- Can the patient's withdrawal be successfully and safely managed as an outpatient?
- **Does this patient need to be admitted?**

D2. Bio-medical Conditions and Complications

- Are there unstable comorbid conditions that threaten the patient's life and health acutely?
- What are the medical consequences of substance use?
    - HIV, hepatitis, and endocarditis
    - Chronic liver, lung, heart, renal, cognitive disease
    - Traumatic injuries
    - Overdose
- **Does this patient need to be admitted?**

D3. Emotional, Behavioral, or Cognitive Conditions/Complications

- Does the patient have a mood, anxiety, or thought disorder?
  - Does the history suggest it preceded the SUD or is it substance induced?
  - If medicated, how do these medications interact with the substance use?
  - Are there high-risk behaviors such as use by injection, trading sex for drugs, etc.?
  - May there be cognitive or developmental problems contributing to risk?
  - **Does this patient need to be admitted?**

Kim C ussion

Considering what we know so far, what would an appropriate setting for Kim be?

Collaborate Board

Kim Case Discussion

Kim C ussion

What else would we want to know to really assess dimensions 1-3?

Collaborate Board

Kim Case Discussion

Case Discussion: Kim

- Kim says she doesn't know why everyone is ganging up on her. Everyone is stressed out during the pandemic. There's nothing wrong with her. She does everything for everybody and they should be more appreciative.
- She was a little rattled by the near accident, but states that won't happen again. She was just distracted thinking about all the things she needs to do at home.
- She just wants things to go back to normal.

D4. Readiness to Change

The scope and specifics of the treatment plan should match not just the patient's severity, but the patient's readiness.

D5. Relapse (Return to Use), Continued Use, Continued Problem Potential

What are the external factors leading to the above?

- In AA jargon, "people, places, and things" or a variety of social determinants putting the person at risk.
- What strategies/skills does individual have in addressing these factors?
- What role does transportation, childcare, employment, poverty, and insurance have in following a treatment plan?

What are the internal processes in coping with negative and positive emotional states?

- Is coping affected by existing mood, anxiety, trauma, and rarely, thought disorder? Has coping been overwhelmed by loss, or trauma.
- What behavioral and/or pharmacological interventions have previously been effective? Treatment adherence?
- Are there cognitive or developmental problems contributing to impaired skill development?

What skills have worked in the past? Have there been attempts at re-establishing their skill set ?

D6. Recovery / Living Environment

- Are there social strengths/recovery capital? Are there barriers to treatment and risk reduction?
    - Social support
    - Interpersonal violence
    - Legal involvement
    - Poverty
    - Housing
    - Transportation
    - Family and work responsibilities

Kim C ussion

How do you assess her dimensions 4-6? What strengths does she have to draw on? What concerns do you have for her?

Collaborate Board

Kim Case Discussion

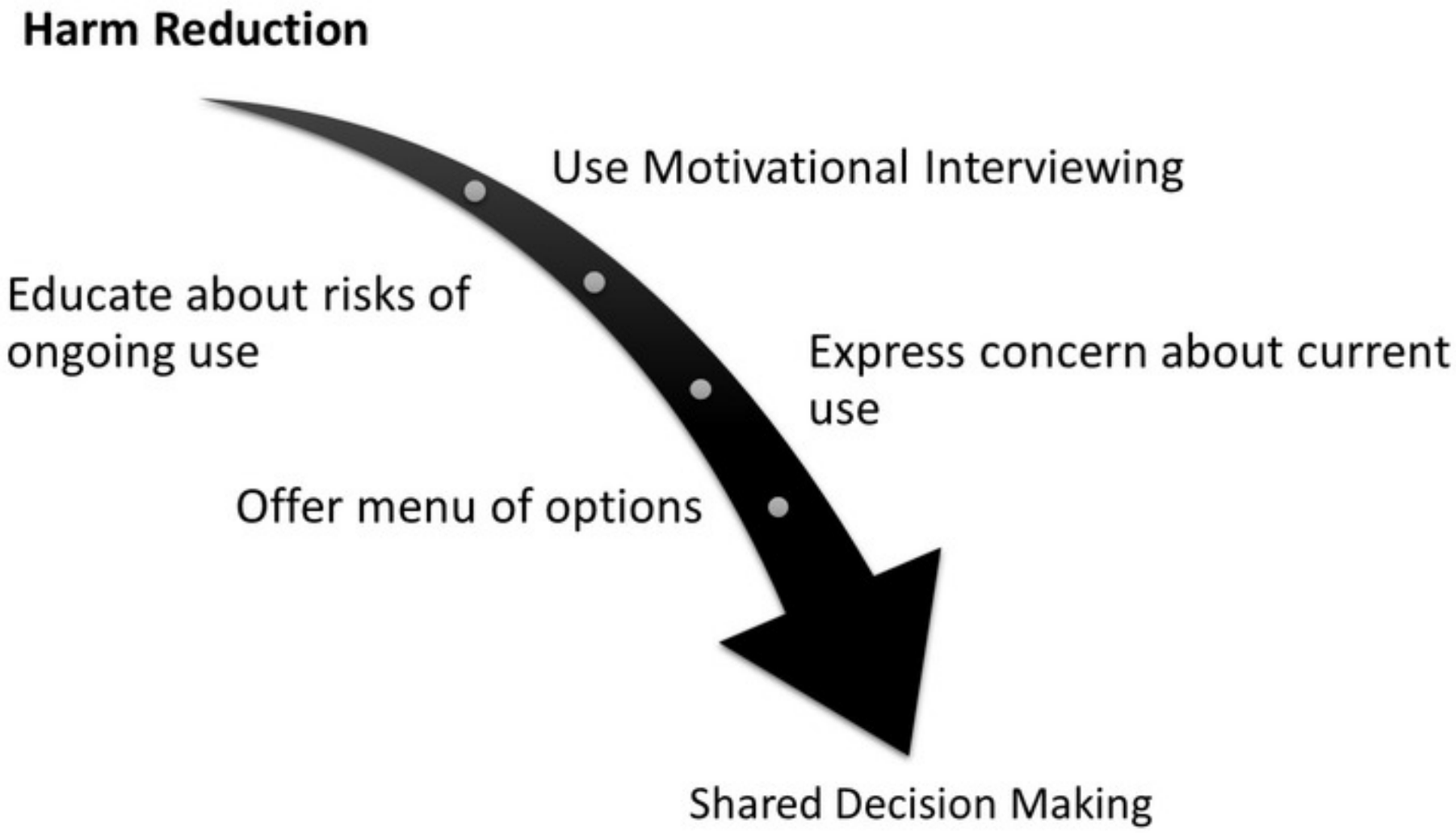
ASAM Criteria Assessment

What does our ASAM Criteria Assessment lead us to recommend for Kim's treatment? Do you foresee any difficulties?

Collaborate Board

ASAM Criteria Assessment

Building a Treatment Plan



Harm Reduction

- Philosophy:
  - Dignity and Respect for each person
  - Non-abandonment
  - Low barrier access to evidence based care
- Practice:
  - Educating patients about tolerance, polysubstance use, risk of withdrawal and overdose
  - Overdose prevention and naloxone rescue kits
  - Designated driving
  - Safe storage of psychoactive substances
  - Sexual safety counseling, contraception
  - Shelter-based alcohol administration
  - Syringe exchange, supervised injection sites and safer-injecting practices for people who inject drugs

www.Prescribetoprevent.org

Substance Testing as a Monitoring Tool

- Guideline recommended
  - Weak evidence-base
  - Requires practice to use well
  - Confirmatory testing should be used when results are not as expected
- Pay attention to potential harm
  - Practice associated with policing use
  - May be traumatizing or interfere with relationship building
- For monitoring, not diagnosis
  - May illustrate progress/challenges over time
  - Informs patient safety
  - Encourages truth telling – start with conversation

Behavioral Interventions and Approaches

Behavioral Interventions and Approaches	Substance Use Disorder(s)	Mental Health Condition(s)	Availability by Profession and Training
Motivational Enhancement Therapy (MET): Is a counseling approach that helps individuals resolve their ambivalence about engaging in treatment and stopping their drug use.	Alcohol, Marijuana, and Nicotine. Mixed results for heroin, cocaine, and nicotine *Effective at engaging all individuals in treatment	Mental health and chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health.	MINT Training available across multiple professions.
Cognitive Behavioral Therapy (CBT): is designed to modify harmful beliefs and maladaptive behaviors.	Substance Use Disorders (Alcohol, Cocaine, Nicotine, Marijuana, Methamphetamines)	Depression, Anxiety Disorders, Adjustment Disorders, and Mood Disorders	LPC, LCSW, LMFT, Psychologists, some Licensed Alcohol and Drug Abuse Counselors
Dialectical Behavioral Therapy (DBT): is designed specifically to reduce self-harm behaviors including suicidal attempts, thoughts, or urges; cutting; and drug use.	Substance Use Disorders (all)	Borderline personality disorder, depression, bipolar, PTSD, Bulimia, binge eating.	LPC, LCSW, LMFT, and Psychologist. The Linehan Board of Certification has developed certification standards for clinicians.
Seeking Safety (SS): A present-focused therapy where patients learn behavioral skills for coping with trauma/post-traumatic stress disorder and substance use disorder.	Substance Use Disorders (all)	Trauma and PTSD	Anyone can conduct Seeking Safety. It does not require any specific degree, licensure, or certification Manualized Training is available.
Contingency Management Interventions/Motivational Incentives: Involves giving patients tangible rewards to reinforce positive behaviors such as abstinence.	Alcohol, stimulants, marijuana, opiates, and nicotine	None	Program progress tracked by team. Voucher based reinforcement or prize incentives

Behavioral Interventions and Approaches

Behavioral Interventions and Approaches	Substance Use Disorder(s)	Mental Health Condition(s)	Availability by Profession and Training
Digital Therapy: ReSET ReSET-O: The Food and Drug Administration approved to treat substance use disorders. The intention is for patients to use it with outpatient therapy to treat. The device delivers CBT to patients to teach skills that aid in the treatment in substance use disorders and increase retention in outpatient therapy program.	Alcohol, cocaine, marijuana, stimulant, and opioid use disorders	None	A licensed clinician prescribes reSET via the enrollment form, which includes an email address for the patient.
Matrix Model (MM): A framework for engaging people with stimulant use disorders in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support.	Methamphetamine and Cocaine	None	LPC, LSW, LMFT, Psychologist and licensed/certified alcohol and drug counselors, case workers
Assertive Community Treatment (ACT): Integrates behavioral treatments for severe mental illnesses co-occurring substance use disorders. ACT has a smaller caseload size, team management, outreach emphasis, a highly individualized approach, and an assertive approach to maintaining contact with patients.	Substance Use Disorders (co-occurring with other mental illness or problems)	Schizophrenia, Bipolar, Depression, and Anxiety Other: homelessness, criminal justice systems, frequent hospitalizations	Mobile mental health treatment teams often include a team leader, psychiatrist with nurse practitioner or physician assistance, substance abuse specialist, vocational specialists, and peer specialist.
Exposure Therapy: A behavioral treatment that involves repeated exposure to a feared situation, object, traumatic event, or memory. Exposure can be real, visualized, or simulated, and is always contained in a controlled therapeutic environment. This is treatment for Post-Traumatic Stress Disorder (PTSD) that frequently co-occurs with cocaine use disorder.	Cocaine Use Disorder	Anxiety disorders (phobias and PTSD)	LPCs, MSW, LMFT, Psychologist training in exposure therapy needed for required dosage and experience setup.

Team treatment support

- Medication management
- Residential or outpatient treatment
- Evidence based behavioral therapies
- Management of co-morbidities
- Community supports
- Mutual Support/ e.g. 12 step groups; SMART Recovery
- Peer Support
- Community re-enforcement and family training

Interdisciplinary Team Treatment Planning

Objective	Treatment Method	Responsible Person	Date Est.	Target Date	Outcome
Over the 30 days stabilize opioid withdrawal symptoms and abstain from using opiates or opioids by increasing awareness of external and internal triggers for drug use.	• Medical Doctor Buprenorphine • Behavioral Health Specialist Contingency Management and Internal and External Triggers • Urine Drug Screens, medication management, showing up for appointment: Medical Assistant or Nurse Care Manager	Medical Doctor Behavioral Integration Specialist or Collaborative Care Team Approach	1/1/2020	2/1/20	Patient completed home or office induction. COWS score was ___ at intake and current score_____ Patient received immediate contingency management incentives for completing CBT material and for attending 1 online SMART recovery groups. Patient shared about internal and external triggers in visit. 2 Random Urine drug screens: 1 positive at intake, 1 negative for additional opioids besides buprenorphine and positive for cannabis.

Interdisciplinary Team Treatment Planning

Objective	Treatment Method	Responsible Person	Date Est.	Target Date	Outcome
Over the next 90 days increase coping skills for trauma and substance use disorder.	• Medical Doctor: Check-in with Seeking safety coping skills during monthly check-in or using telehealth. • Behavioral Health Specialist: Will engage patient with seeking safety curriculum during doctor's visit, via telehealth.	Collaborative Care Team Approach	1/1/20	4/1/20	Patient completed 5 sections of the seeking safety manual. Bi-monthly check in using either telehealth, in office meetings with collaborative care team. Patient reported using 3 of the learned coping skills.

Knowledge Checks

Ask the Audience

Anne is a 37-year-old female who presents for a full physical. She has no reported concerns but on exam you notice many track marks in her right antecubital fossa. Upon further questioning Anne reluctantly discloses that for the past 2 years she has been using intravenous heroin daily. She admits to many occasions of trying to stop "cold turkey" but each time she ended up relapsing due to severe withdrawal symptoms. She states initially she used to use about a quarter gram daily but over time her use has escalated to almost two grams daily. She has strong cravings for heroin.

Anne was employed as a waitress but, as of five months ago, she was fired because she "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."

Quiz

Ask the Audience

Anne is a 37-year-old female who presents for a full physical. She has no reported concerns but on exam you notice many track marks in her right antecubital fossa. Upon further questioning Anne reluctantly discloses that for the past 2 years she has been using intravenous heroin daily. She admits to many occasions of trying to stop "cold turkey" but each time she ended up relapsing due to severe withdrawal symptoms. She states initially she used to use about a quarter gram daily but over time her use has escalated to almost two grams daily. She has strong cravings for heroin.

Anne was employed as a waitress but, as of five months ago, she was fired because she "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."

What is the most likely diagnosis?

- Mild opioid use disorder
- Moderate opioid use disorder
- Severe opioid use disorder
- Pharmacologic opioid dependence
- Opioid induced hyperalgesia

Quiz

Ask the Audience

Anne is a 37-year-old female who presents for a full physical. She has no reported concerns but on exam you notice many track marks in her right antecubital fossa. Upon further questioning Anne reluctantly discloses that for the past 2 years she has been using intravenous heroin daily. She admits to many occasions of trying to stop "cold turkey" but each time she ended up relapsing due to severe withdrawal symptoms. She states initially she used to use about a quarter gram daily but over time her use has escalated to almost two grams daily. She has strong cravings for heroin.

Anne was employed as a waitress but, as of five months ago, she was fired because she "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."

What ASAM dimensions do you have information about in Anne's case?

- Acute Intoxication and /or Withdrawal Potential
- Biomedical Conditions & Complications
- Emotional, Behavioral, or Cognitive Conditions & Complications
- Readiness to Change
- Relapse, Continued Use, Continued Problem Potential
- Recovery/ Living Environment

Quiz

Ask the Audience

Anne is a 37-year-old female who presents for a full physical. She has no reported concerns but on exam you notice many track marks in her right antecubital fossa. Upon further questioning Anne reluctantly discloses that for the past 2 years she has been using intravenous heroin daily. She admits to many occasions of trying to stop "cold turkey" but each time she ended up relapsing due to severe withdrawal symptoms. She states initially she used to use about a quarter gram daily but over time her use has escalated to almost two grams daily. She has strong cravings for heroin.

Anne was employed as a waitress but, as of five months ago, she was fired because she "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."

What is your recommendation?

- Discuss local needle exchange programs and safe-injecting practices.
- **Refer her to an addiction medicine specialist for opioid agonist therapy initiation.**
- Refer her to a self-help/12 step group e.g., Narcotics Anonymous.
- **Assist her in applying for residential treatment programming.**
- **Assist her in applying for residential treatment programming.**

Ask the Audience

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.

- ***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.

He denies cravings for hydromorphone, ever needing early refills or altering the route of administration. He is 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.

Quiz

Ask the Audience

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.

- **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.

He denies cravings for hydromorphone, ever needing early refills or altering the route of administration. He is 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.

What is the most likely diagnosis?

- Mild opioid use disorder
- Moderate opioid use disorder
- Severe opioid use disorder
- Pharmacologic opioid dependence
- Opioid induced hyperalgesia

Session Feedback

Poll

Presenters were knowledgeable, unbiased, engaging.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Poll

This session enhanced my current knowledge and/or skill base.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

End of Session 4

Session 5

Harm Reduction and Non-medication Treatment of SUDs

Harm Reduction—not a new concept in integrated health care.

Paradigm Shift Needed


PARADIGM
SHIFT

What is the shift?

- Moving from moralistic, judgmental, punitive, critical, stigmatizing, discriminatory attitudes, and perceptions of impaired responsibility;

- Toward accepting substance use disorders as chronic brain diseases with neurobiological mechanisms with genetic vulnerabilities, and profoundly effected by social determinants of health, particularly trauma and poverty.

Historical Elements of the Shift

- The schism between SUD care and mainstream medicine.
- The benefits and consequences of insurance, managed care, carve outs, and parity issues.
- Belief that outcomes are dismal though evidence shows outcomes are not unlike other common chronic diseases.
- Evolving pharmacologic interventions.

Harm Reduction

- The best should never be allowed to be the enemy of the good! This applies to all chronic diseases or conditions.
- Approach is person-centered, meet people where they are.
- Reduce harms of SUDs to individuals and communities.
- The primary goal is to improve the health and function of the patient.
- Harm reduction interventions should be integrated into the continuum of SUD prevention and treatment.

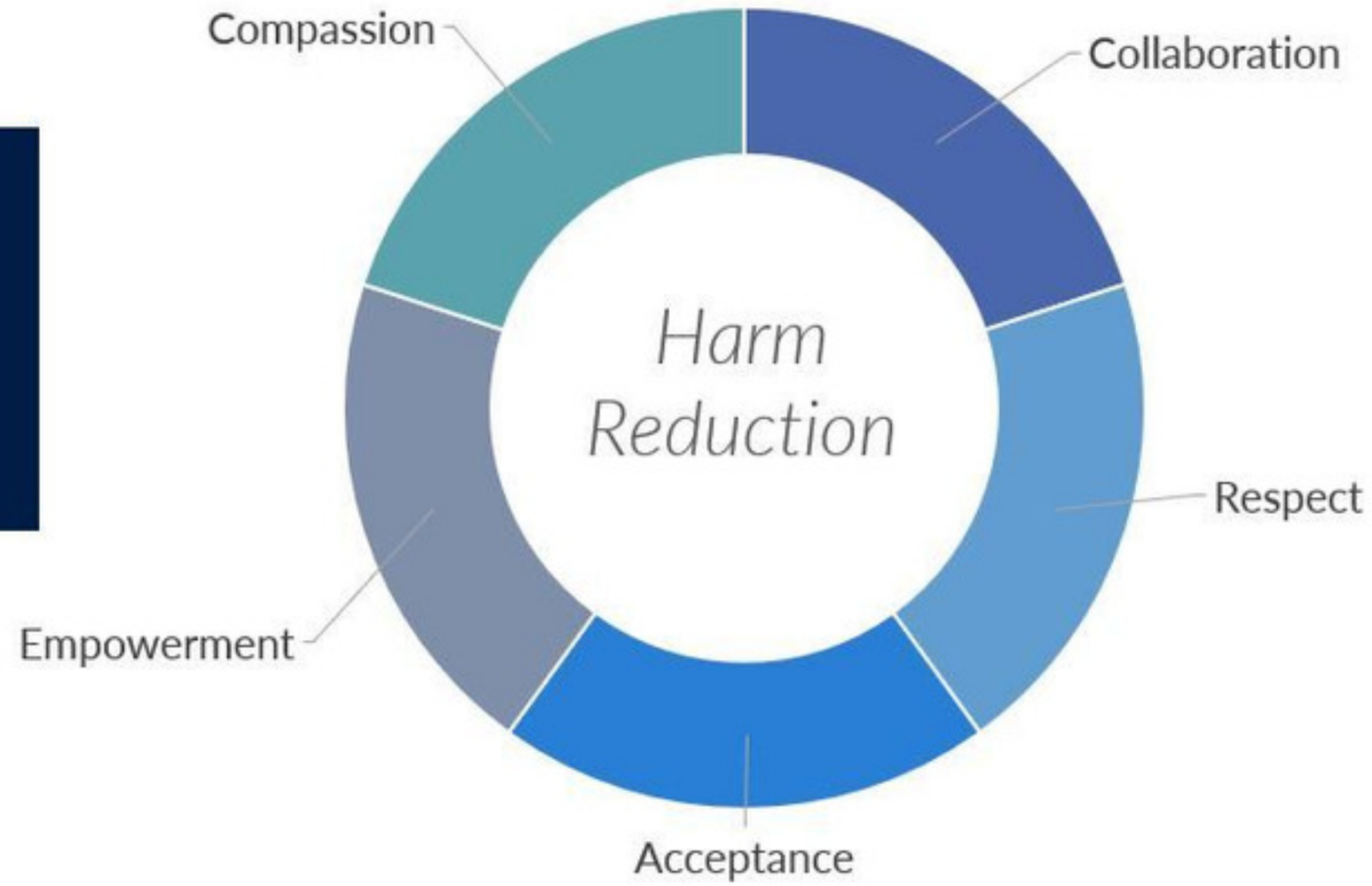
Chronic disease management has always had elements of harm reduction.

- Diabetes
- Coronary heart disease and other vascular diseases
- Hypertension
- Chronic lung disease

5 Principles of HR

- Pragmatism
- Humanistic values
- Focus on harm
- Balancing cost vs. benefits
- Importance of immediate goals

Key HR Elements of Patient-Centered Care



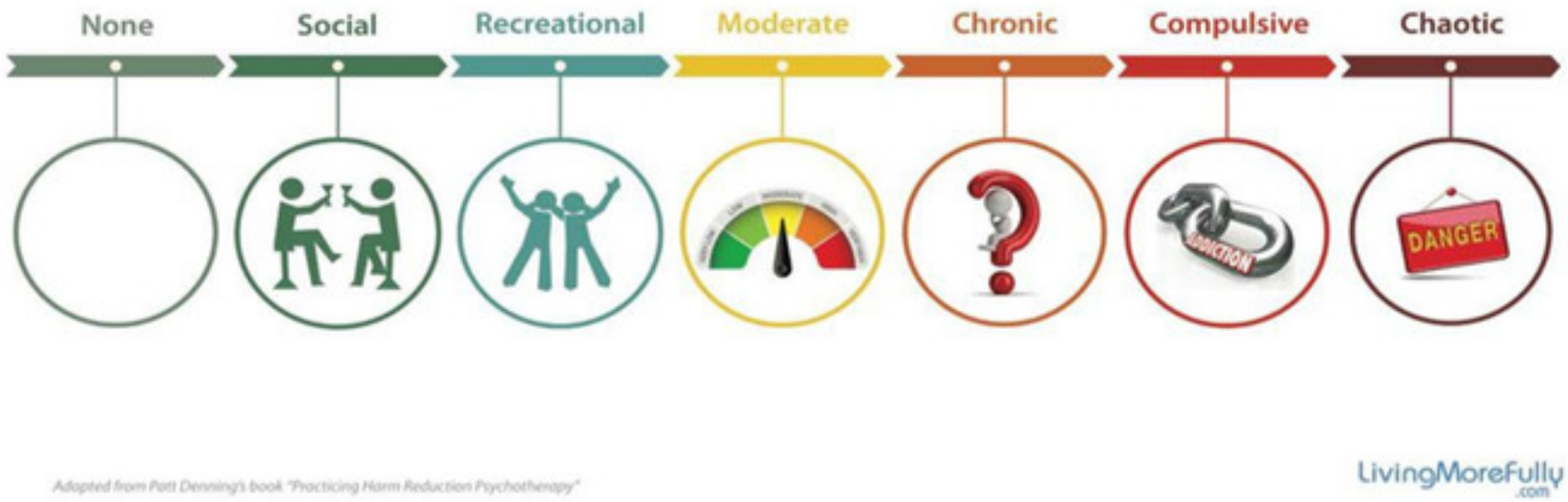
Meeting People "Where They Are"

- Engagement is a primary goal.
- Building a trusting and welcoming environment.
- Balance risks and benefits.

Treatment Goals – A Continuum

Harm Reduction Continuum

- Substance use and behaviors along a continuum from no use to chaotic use



Adapted from Patt Denning's book "Practicing Harm Reduction Psychotherapy"

LivingMoreFully.com

Minimization of Harm

- Accept less engagement.
- Accept less compliance.
- Accept less adherence.
- Accept the use of other substances.
- Define the minimum, realizing the challenge for team buy-in.

What is low threshold of care?

What is a higher level of care?

Old V. New

Session Feedback

Poll

Presenters were knowledgeable, unbiased, engaging.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Poll

This session enhanced my current knowledge and/or skill base.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Day 3 Reminders

THANK YOU