Companion Materials
1. Overview of Addiction Medicine for Primary Care (62 Slides)  
2. Overview of Addiction Medicine for Primary Care: Supplement (30 Pages)  
   http://bit.ly/1eQNIrS
3. Addiction Medicine: Closing the Gap between Science and Practice (573 Pages)  
   http://www.casacolumbia.org/addiction-research/reports/addiction-medicine

Contents
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Info
2. Case Studies: Asthma and Bipolar Disorder in Primary Care
3. Reference List

Suggested Methods of Use
- Lecturers and/or trainees may utilize this supplement to cover additional details not included in the slide set. This supplement includes slide-by-slide background information and references.
- This supplement also contains two case studies which can be used for small group discussions and/or self-directed learning.

Acknowledgements
- Margot Cohen contributed much of the research and writing for these materials.
- The following subject-matter experts served as external reviewers for these materials: Kevin Kunz, M.D., M.P.H., Frances Levin, M.D., David Lewis, M.D., Michael Miller, M.D., Charles O’Brien, M.D., Ph.D.
- Funding was provided by The Joseph A. Califano, Jr. Institute for Applied Policy.

All materials reflect the findings of the CASAColumbia® report, Addiction Medicine: Closing the Gap between Science and Practice.
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

Slide 1: These materials were prepared by CASAColumbia® for use by medical students, primary care resident physicians, and primary care physicians. Other physicians and healthcare providers may also benefit. These materials are appropriate for classroom sessions or for self-directed learning.

Slide 2: All materials reflect the findings of the CASAColumbia® report, Addiction Medicine: Closing the Gap between Science and Practice. [#1 on slide] The report synthesized information from over 7,000 publications as well as CASAColumbia® original research including national and state surveys, analysis of multiple national data sets, focus groups and subject-matter expert interviews. This document is the Primary Care Clinical Guide Supplement. [#2 on slide]

Slide 3: These materials provide an overview of the major elements required for effectively addressing addiction and risky use of addictive substances within the primary care setting.
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

<table>
<thead>
<tr>
<th>Slide 4: Addiction and risky use should be addressed in clinical settings to improve length of life and quality of life for patients and their families.</th>
</tr>
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<tbody>
<tr>
<td>Slide 5: Professionals, policymakers and the public use a variety of terms to describe levels of substance use. These terms are often imprecise and can be pejorative, e.g., “substance abuse.” The lack of standardized terminology leads to confusion and compromises effective care. As with other medical conditions physicians should use precise language with respect to substance use. Definitions of addiction and risky use are provided here on Slide 5 while diagnostic criteria for addiction are on Slides 31-35.</td>
</tr>
<tr>
<td>Slide 6: Addiction is a complex brain disease related to reward, motivation and memory. The disease processes are reflected in pathological pursuit of reward or relief by substance use and other behaviors. Tobacco/nicotine use, alcohol use and other drug use represent different manifestations of the same underlying disease. A comprehensive approach should be taken to avoid replacement of one substance with another.</td>
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### Importance of Topic

### Addiction & Risky Use

- Addiction: disease requiring treatment
- Risky use:
  - Substance use that threatens health & safety
  - Does not meet addiction criteria
  - Both require medical care

### Brain Disease

Tobacco/nicotine, alcohol & other drugs:

- All affect similar regions of the brain
- Common neurochemistry (e.g., dopamine)
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

<table>
<thead>
<tr>
<th>Slide 7: Structural and functional differences in the brain characterize the disease. These differences may result from substance use, or these differences may predispose certain individuals to acquire the disease. These differences may be manifested in symptoms involving judgment and behavior.</th>
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<tr>
<td>Brain Disease</td>
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<tr>
<td>Structural &amp; functional differences in brain:</td>
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<tr>
<td>• May result from continued substance use</td>
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<tr>
<td>• May predispose certain individuals to addiction</td>
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<tr>
<td>• May affect judgment &amp; behavior</td>
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<tr>
<th>Slide 8: Biological, psychological and environmental factors impact the initiation of substance use. Examples include family history, mental illness, trauma, access to substances and influence from peers and the media. Genetic factors often determine progression to addiction or risky use. Research studies suggest that genetics account for over half the risk of addiction. Earlier age of first use also increases risk for addiction; substance use begins before age 21 in the vast majority of cases of addiction.</th>
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<tbody>
<tr>
<td>Risk Factors</td>
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<tr>
<td>• Genetic</td>
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<td>• Biological</td>
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<tr>
<td>• Psychological</td>
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<tr>
<td>• Environmental</td>
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<tr>
<td>• Age of first use</td>
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<tr>
<th>Slide 9: Patients and their families face challenges and barriers on multiple levels. Physicians can help overcome barriers by providing patient education and addressing addiction and risky use in a clinical setting.</th>
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<tr>
<td>Treatment Barriers</td>
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<tr>
<td>• Misunderstanding of the disease</td>
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<tr>
<td>• Negative public attitudes &amp; behaviors</td>
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<tr>
<td>• Lack of information on how to get help</td>
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<td>• Limited availability of services</td>
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<tr>
<td>• Conflicting time commitments</td>
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<tr>
<td>• Insufficient social support</td>
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<tr>
<td>• Privacy concerns &amp; cost</td>
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</table>
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**Slide 10:** Addiction and risky use are mutually exclusive categories. Therefore, one out of every two individuals 12 years and older either has the disease of addiction or engages in risky use. Furthermore, these rates may be underestimates due to incomplete identification of cases. Physicians have a substantial role in helping to address these highly prevalent medical conditions.

**Slide 11:** For this figure addiction refers to meeting diagnostic criteria for past month nicotine dependence (NDSS) or past year alcohol and/or other drug abuse or dependence (DSM-IV). Prevalence estimates for heart disease, diabetes, and cancer are from the CDC.

![Mortality](https://www.cdc.gov/nchs/fastats/heart.htm)
![Mortality](https://www.cdc.gov/diabetes/pubs/estimates11.htm)
![Mortality](https://www.cdc.gov/nchs/data/sr_10/sr10_252.pdf)

**Slide 12:** Addiction and risky use is the leading cause of preventable deaths in the United States. Supporting data are available on Pages 55-56 of the CASAColumbia® report, *Addiction Medicine: Closing the Gap between Science and Practice*. The direct link to the relevant pages is

### Slide 13: Addiction and risky use cause or contribute to multiple diseases requiring medical attention. In addition to the effects on morbidity and mortality, addiction and risky use impose tremendous financial costs to governments and taxpayers. Medical conditions due to risky use and addiction account for 11% of federal and state government spending; of every $1 spent, only 2¢ addresses prevention and treatment while 96¢ addresses consequences.

### Slide 14: Physicians should educate all patients about prevention and medical care for addiction and risky use.

### Slide 15: Effective patient education should incorporate the various elements listed. Patients should also be taught about the distinction between addiction and risky use. Furthermore, patients should appreciate the importance of comprehensively addressing tobacco/nicotine, alcohol, and other drugs to prevent replacement of one substance with another. This information can help frame patients' understanding of the dangers of risky substance use and addiction.

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**Morbidity**

Addiction & Risky Use

- Tobacco/nicotine, alcohol & other drugs:
  - Cause, contribute to & exacerbate numerous diseases
  - Examples include cardiovascular disease, cancers, cerebrovascular disease, respiratory disease, cirrhosis, pancreatitis, HCV, HIV/AIDS, STDs, birth defects, depressive disorders, anxiety disorders

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**UNIVERSAL PATIENT EDUCATION**

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**Facts for Patients**

- Health consequences are severe & deadly
- Quality of life suffers from disease impact
- Addiction & risky use are preventable
- Known risk factors should be reduced
- Interventions can lower risky use
- Addiction is treatable
# 1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

## Risk Reduction
- Recommend no tobacco/nicotine use
- Recommend guidelines for safe alcohol use
- Recommend no illicit drug use
- Consider H&P when prescribing controlled drugs
- Assure medications taken only as prescribed
- Remain vigilant for signs & symptoms
- Offer evidence-based medical care early

## Slide 16: Patients should receive positive reinforcement for abstinence from tobacco/nicotine and staying within guidelines for safe alcohol use. They should also receive positive reinforcement for using medications only as prescribed and for abstinence from illicit drugs. Furthermore, physicians should clearly describe common risk factors, signs and symptoms.

## UNIVERSAL SCREENING

## Slide 17: Universal screening for tobacco/nicotine, alcohol and other drugs is an evidence-based approach with support from NIH, VA/DoD and APA. Numerous organizations have recommended routine screening including USPSTF, AMA, AAFP, AAP and ACOG. Routine screening serves to increase patient awareness while identifying addiction and risky use. This facilitates early detection and prompt medical care when necessary.

## Screen All Patients for Tobacco/Nicotine, Alcohol & Other Drugs
- Screen routinely
- Be demographically & culturally appropriate
- Use sensitive, non-judgmental tone & language

## Slide 18: Research studies support the effectiveness of screening for tobacco/nicotine, alcohol and other drugs. Universal and routine screening can help assure that effective interventions and treatments are provided early when necessary. Screening comprehensively for tobacco/nicotine, alcohol and other drugs allows for greater utility and efficiency in the clinical encounter. NIDA/NIH recommends this comprehensive approach.
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**Slide 19**: Questions can be incorporated into different elements of the history and physical (H&P). When relevant to the chief complaint the history of present illness (HPI) would be appropriate. Past medical history (PMH) would be particularly appropriate when there is a known history of addiction or risky use. Family history (FH) should always be assessed given its importance in determining the risk for addiction and risky use.

**Integration into H&P**

*Addiction & Risky Use*

- Tobacco/nicotine, alcohol & other drugs:
  - Consider in HPI
  - Include in PMH rather than SH
  - Include in FH

**Slide 20**: Review of systems (ROS) can include screening questions if not covered elsewhere. In addition to the history the physical exam (PE) can be useful in determining a diagnosis related to substance use. Examples include pupil size, conjunctival injection, nystagmus, nasal mucosa or septum damage, murmurs suggestive of endocarditis, needle tracks, cellulitis, impaired cognition, etc.

**Integration into H&P**

*Addiction & Risky Use*

- Tobacco/nicotine, alcohol & other drugs:
  - Consider in ROS & PE
  - Examples include vital signs; HEENT (pupils, injection, nasal mucosa, breath); CV (endocarditis); RESP (smoking effects); DERM (needle tracks, infections, yellow finger stains); MSE (cognition, memory, affect)

**Slide 21**: By medicalizing addiction and risky use patients may be more comfortable with the topics. Language such as “disease of addiction” rather than “addiction” might help patients appreciate the medical nature of the condition. Routine substance use screening can complement other preventive health topics such as nutrition and exercise.

**Transition Tips**

- Develop comfortable way to introduce topic
- Frame discussion within the context of medicine
- Emphasize medical consequences
- Consider language (e.g., “disease of addiction”)
- Normalize the subject (e.g., “routine questions”)
- Integrate into preventive care
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

Sample Transitions

"I would like to ask you some routine questions I ask all of my patients."

"Would you mind taking a few minutes to talk with me about your use of tobacco/nicotine, alcohol & other drugs?"

"It is important to know that you can prevent a lot of health & related problems by addressing the use of tobacco/nicotine, alcohol & other drugs."

Slide 22: Consider each patient individually and tailor your language based on specific characteristics. This slide includes sample language which you can draw from when initiating the conversation with a patient. Emphasizing confidentiality may help patients to remain open and honest.

Screening: Tobacco/Nicotine

Positive Screen = in the past 30 days any use of tobacco/nicotine

Slide 23: No safe level of tobacco/nicotine use has been established. Any use of tobacco/nicotine increases risk for other health problems. Also, it is important to distinguish between tobacco/nicotine use and nicotine replacement therapy.

Screening: Alcohol

Positive Screen = in the past 30 days:
- Women: >1 drink/day
- Men: >2 drinks/day

Slide 24: One standard drink equates to:
- 12 fl oz. beer: typically one can (~5% etoh)
- 5 fl oz. wine: typically one glass (~12% etoh)
- 1.5 fl oz. liquor: typically one shot (~40% etoh)

Greater potency of alcohol in women may be due to less total body water and lower activity of gastric alcohol dehydrogenase than in men.

These thresholds are based on the Dietary Guidelines for Americans, 2010.
1. Overview of Addiction Medicine for Primary Care:
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Screening: Alcohol
Positive Screen = in the past 30 days any alcohol use for persons:
• <21
• Pregnant
• Taking meds which interact with alcohol
• With certain specific medical conditions (e.g., liver disease, hypertriglyceridemia, pancreatitis)

Slide 25: If a patient is under 21 or pregnant, any of use of alcohol constitutes a positive screen. Substance use during the period of brain development significantly increases the risk of addiction. No safe level of alcohol use has been established for pregnant women or those under 21.

Screening: Alcohol
Positive Screen = in the past 30 days any alcohol use:
• While driving, operating machinery or taking part in other activities that require attention, skill or coordination
• In situations that could cause injury or death (e.g., swimming)

Slide 26: Any use of alcohol in these situations constitutes a positive screen.
These criteria are based on the Dietary Guidelines for Americans, 2010.

Screening: Other Drugs
Positive Screen = in the past 30 days any misuse of:
• Controlled prescription drugs (e.g., not as prescribed)
• Other medications for non-medical reasons (e.g., intoxicating effects, getting high, etc.)

Slide 27: Patients misuse medications when they take them in ways not prescribed or directed. For example, patients may misuse by taking greater quantities, more frequent doses, or via routes not prescribed or directed. Misuse also occurs when patients take medications not prescribed for them. CASAColumbia® maintains a list of commonly misused prescription drugs at http://www.casacolumbia.org/addiction/commonly-misused-prescription-drugs

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**Screening: Other Drugs**

*Positive Screen* = in the past 30 days any use of:

- Illicit drugs
- Other substances for the purpose of intoxicating effects, getting high, etc.

**Slide 28:** Numerous substances can be misused via multiple routes of administration. Common examples include marijuana, heroin, MDMA, cough medicine, etc. CASAColumbia® maintains a list of commonly used illicit drugs at [http://www.casacolumbia.org/addiction/commonly-used-illegal-drugs](http://www.casacolumbia.org/addiction/commonly-used-illegal-drugs)

**DIAGNOSTIC EVALUATION**

**Slide 29:** A diagnostic evaluation should be completed for all positive screens to distinguish between addiction and risky use.

**Diagnostic Evaluation**

- All patients with positive screens
- Determine: risky use or addiction

**Slide 30:** Determination of addiction or risky use will shape the appropriate medical care indicated.
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Slide-by-Slide Supplemental Information

<table>
<thead>
<tr>
<th>Diagnosis of Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DSM-5 released May 2013</td>
</tr>
<tr>
<td>• Addiction = DSM-5 “Substance Use Disorder”</td>
</tr>
<tr>
<td>• Addiction diagnosed for a 12-month period:</td>
</tr>
<tr>
<td>• Mild addiction: 2-3 symptoms</td>
</tr>
<tr>
<td>• Moderate addiction: 4-5 symptoms</td>
</tr>
<tr>
<td>• Severe addiction: 6 or more symptoms</td>
</tr>
</tbody>
</table>

| Slide 31: Given the absence of biomarkers addiction is diagnosed by behavioral criteria published in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). DSM-5 criteria for “Substance Use Disorder” apply to addiction involving tobacco/nicotine, alcohol and other drugs. Similar DSM-5 criteria for “Gambling Disorder” apply to addiction involving gambling. |

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
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</thead>
<tbody>
<tr>
<td>• 11 Criteria</td>
</tr>
<tr>
<td>• Mnemonic: “CHEW THAT COP”</td>
</tr>
<tr>
<td>Cut Down</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Excessive Use</td>
</tr>
<tr>
<td>Withdrawal*</td>
</tr>
<tr>
<td>* not all substances</td>
</tr>
</tbody>
</table>

| Slide 32: A total of 11 diagnostic criteria exist for addiction. This mnemonic may help in remembering the criteria in the same vein as SIGECAPS for depression and DIGFAST for bipolar. |

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cut Down: there is a persistent desire or unsuccessful efforts to cut down or control use of the substance</td>
</tr>
<tr>
<td>• Health: use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance</td>
</tr>
<tr>
<td>• Excessive Use: the substance is often taken in larger amounts or over a longer period than was intended</td>
</tr>
<tr>
<td>• Withdrawal*</td>
</tr>
<tr>
<td>* not all substances</td>
</tr>
</tbody>
</table>

| Slide 33: This slide includes the DSM-5 language for criteria related to: Cut Down, Health, Excessive Use and Withdrawal. |
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Diagnostic Criteria

- **Time**: a great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects
- **Hazardous Use**: recurrent use of the substance in situations in which it is physically hazardous
- **Activities**: important social, occupational or recreational activities are given up or reduced because of use of the substance
- **Tolerance**

*Slide 34*: This slide includes the DSM-5 language for criteria related to: Time, Hazardous Use, Activities and Tolerance.

Diagnostic Criteria

- **Craving**: craving, a strong desire or urge to use the substance
- **Obligations**: recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school or home
- **Personal Problems**: continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use

*Slide 35*: This slide includes the DSM-5 language for criteria related to: Craving, Obligations and Personal Problems.

Risky Use

= All positive screens not meeting addiction criteria

*Slide 36*: All patients with positive screens not meeting addiction criteria for mild (2-3 symptoms), moderate (4-5 symptoms) or severe (6 or more symptoms) are risky users.
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**Slide 37**: All risky users should receive brief interventions to reduce substance use. The level of intensity should be determined with clinical judgment. Two video demonstrations of brief interventions can be accessed here.

Adolescent Patient (4 min, 26 sec): [www.youtube.com/watch?v=fX90j4jD9Sc](http://www.youtube.com/watch?v=fX90j4jD9Sc)

Adult Patient (6 min, 37 sec): [www.youtube.com/watch?v=ebsqETBWEdQ](http://www.youtube.com/watch?v=ebsqETBWEdQ)

**Slide 38**: Brief interventions (BI’s) of 5-10 min are as effective as 20 min.\(^\text{12}\) With BI’s tobacco/nicotine quit rate is three times as likely.\(^\text{13}\) Average drinks per week are reduced by 13-34%.\(^\text{14}\) 10-19% more patients report drinking within recommended levels.\(^\text{15}\) 80% attempt to cut down use of other drugs.\(^\text{16}\) Evidence-based frameworks are available for brief interventions for tobacco/nicotine,\(^\text{8,3;13}\) alcohol\(^\text{10;14;15}\) and other drugs.\(^\text{11;16}\) Training is recommended for more effective delivery.

**Slide 39**: Discuss the results of the positive screen in a personalized manner. Initiate the brief intervention by reemphasizing the substance use continuum (Slide 10) and discussing patient-specific consequences of risky use. Make concrete recommendations which capitalize on the patient’s strengths and express confidence in the patient. Comprehensively discuss tobacco/nicotine, alcohol and other drugs informing about the risk for replacing one substance with another.
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**Slide 40:** Focus on achievable goals and specific, concrete methods to attain them. Recommend continued follow-up and use of a social support system. Discuss the difficulty yet achievability of the goals. Offer a supportive, collaborative therapeutic alliance irrespective of failures or successes.

**Brief Intervention for Risky Use**

- Practice patient-centered care
- Ask open-ended questions
- Elicit responses from patient on risks/benefits
- Facilitate realization of how life can be improved
- Support patient's motivation with empathy

**Slide 41:** All patients who meet criteria for addiction should receive a comprehensive assessment.

**COMPREHENSIVE ASSESSMENT**

**Slide 42:** Similar to other complex and chronic medical conditions more detailed assessment is required to evaluate the nature and severity of the disease as well as the appropriate treatment options.

**Comprehensive Assessment**

- Severity of disease
- Need for medical management of withdrawal
- Route of administration for substances
- Likelihood of continued use/relapse
### Comprehensive Assessment

- History of substance use & previous treatment
- Comorbidities which may affect treatment
- Family & social support for treatment
- Impact of home environment
- Housing, child care, employment & legal issues
- Readiness & willingness for treatment
- Need for tailored treatment (age, gender, sexual orientation, other)

**Slide 43:** The comprehensive assessment also incorporates other important factors which may influence treatment. The complete biopsychosocial assessment should be used to develop a treatment plan with the patient.

### TREATMENT PLANNING

**Slide 44:** Treatment planning for addiction should be tailored based on the comprehensive assessment.

### Patient Placement Criteria

**American Society of Addiction Medicine**

- Comprehensive set of guidelines
- For patients with addiction & comorbidities
- For placement, continued stay, transfer & discharge
- Typically utilized under the supervision of an addiction physician specialist

**Slide 45:** These guidelines incorporate six dimensions to determine the appropriate level of care required. Dimensions include:
1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use or continued problem potential
6. Recovery environment
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Slide 46: The appropriate treatment setting should specifically be determined for each patient. ASAM Patient Placement Criteria (Slide 45) tailor recommendations to levels and sublevels of care. The levels include early intervention (Level 0.5), outpatient services (Level I), intensive outpatient/partial hospitalization services (Level II), residential/inpatient services (Level III), and medically managed intensive inpatient services (Level IV).

Slide 47: All patients with addiction should receive evidence-based treatments. Addiction should be approached as a primary disease. Primary care providers should provide basic treatment for uncomplicated addiction as is done for uncomplicated hypertension or diabetes. Complicated cases can be treated with specialist consultations or referrals.

Slide 48: Effective treatments for addiction include medications, psychosocial therapies and combinations. Several medications for addiction are FDA-approved and effective with good side-effect profiles. Treatment options should be considered comprehensively across tobacco/nicotine, alcohol and other drugs to avoid replacement of one substance with another. Treatment should be tailored to the age, gender and health of each patient.
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**Slide 49:** Medications for treating addiction vary by the substances involved. Addiction involving tobacco/nicotine can be treated with several medications.

**Medications for treating addiction involving tobacco/nicotine**
- varenicline (Chantix®)
- bupropion (Zyban®, Wellbutrin®)
- nicotine replacement therapy (e.g., patch, gum, lozenge, inhaler, nasal spray)
- combinations

**Slide 50:** Different medication options can be used for treating addiction involving alcohol. Naltrexone has been FDA-approved for both addiction involving alcohol and addiction involving opioids (Slide 51).

**Medications for treating addiction involving alcohol**
- acamprosate (Campral®)
- disulfiram (Antabuse®)
- naltrexone (ReVia®, Depade®, Vivitrol®)

**Slide 51:** Note that naltrexone is not a controlled substance and requires no special training or certification. Methadone may only be administered in licensed facilities. To prescribe medications containing buprenorphine providers must undergo training and acquire the necessary DEA waiver. More details can be found under “For Physicians” at the following website. buprenorphine.samhsa.gov
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**Psychosocial Therapies**

Primary Individual or Group Therapies

- Motivational Interviewing (MI)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Community Reinforcement Approach (CRA)
- Contingency Management (CM)
- Couples/Family Therapy

**Slide 52:** Psychosocial therapies are designed to alter patient attitudes and behaviors regarding substance use. Detailed information on these therapies is available on Pages 102-106 of the CASAColumbia® report, *Addiction Medicine: Closing the Gap between Science and Practice*. The direct link to the relevant pages is [http://www.casacolumbia.org/sites/default/files/Addiction-medicine-closing-the-gap-between-science-and-practice_0.pdf#page=115](http://www.casacolumbia.org/sites/default/files/Addiction-medicine-closing-the-gap-between-science-and-practice_0.pdf#page=115)

**Combined Treatment**

- Medications & psychosocial therapies
- Can increase retention in treatment
- Can decrease relapse rates

**Slide 53:** Research studies illustrate the effectiveness of various combinations of treatment. Combined treatments typically have greater effectiveness than individual treatments alone.

**Specialist Referral**

Consider for Complex Cases

- Addiction medicine physicians [find a doctor near you](http://www.addictionmedicine.net/find-a-doctor)
- Addiction psychiatrists [find a doctor near you](http://www.addictionpsychiatry.com/find-a-psychiatrist)

**Slide 54:** For complicated hypertension or diabetes primary care providers may require cardiologist or endocrinologist consultation or referral. Similarly, for complicated cases of addiction primary care providers may require addiction physician specialist consultation or referral. Such specialists should be board certified in addiction medicine or addiction psychiatry.
1. Overview of Addiction Medicine for Primary Care: Slide-by-Slide Supplemental Information

**Slide 55:** The concept of disease management has been successfully applied to several chronic diseases for better patient outcomes. Disease management is crucial in treating patients with addiction for better outcomes and sustained results.

**Slide 56:** Addiction is a chronic disease similar to diabetes and heart disease. Disease management can improve outcomes for addiction as it does for other chronic diseases. Primary care providers should coordinate care across physicians and other healthcare providers to assure integrated, effective care.

**Slide 57:** Physicians should collaboratively develop realistic, achievable goals with patients.

**DISEASE MANAGEMENT**

**Disease Management**

- Chronic care model similar to diabetes
- Transdisciplinary, team-based care
- Patient-centered with patient as part of team

**Management Goals**

- Maintain or improve patient functioning
- Control symptoms (e.g., craving)
- Address comorbidities
- Reduce relapse
- Prevent replacement addiction
- Provide support services
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### Slide 58: Physicians should lead the interdisciplinary treatment team of qualified professionals while providing or arranging all elements of disease management. Both medical and psychiatric comorbidities should be considered.

**Physician Role**
- Coordinate care with team
- Provide/arrange psychosocial therapy
- Manage relevant medications
- Continue patient education
- Address comorbidities
- Monitor progress
- Adjust treatment as needed

### Slide 59: Participation in mutual support programs can bolster disease management efforts and help avoid the recurrence of symptoms. Participation has been associated with improved psychological functioning, reduced substance use and reduced healthcare utilization.

**Physician Role**
Assist with & coordinate mutual support, e.g.:
- Alcoholics Anonymous (AA), LifeRing, Narcotics Anonymous (NA), Secular Organizations for Sobriety, SMART Recovery, Women for Sobriety

### Slide 60: Additional support to address legal, educational, vocational, housing, parenting and childcare issues can decrease the risk of relapse.

**Physician Role**
Assist with & coordinate other support:
- Legal
- Educational
- Vocational
- Housing
- Parenting
- Childcare
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Acknowledgements

- Margot Cohen contributed much of the research and writing for these materials.
- The following subject-matter experts served as external reviewers for these materials: Kevin Kunz, M.D., M.P.H., Frances Levin, M.D., David Lewis, M.D., Michael Miller, M.D., Charles O’Brien, M.D., Ph.D.
- Funding was provided by The Joseph A. Califano, Jr. Institute for Applied Policy.

Slide 61: These materials provide an overview of important topics in addressing addiction and risky use. More detailed information is available in the CASAColumbia® report, Addiction Medicine: Closing the Gap between Science and Practice. http://www.casacolumbia.org/addiction-research/reports/addiction-medicine

Slide 62: Other important resources in addressing addiction and risky use are available from the CASAColumbia® website at http://www.casacolumbia.org.
2. Case Studies: 
Asthma in Primary Care

Case Presentation
CC: shortness of breath, decreased exercise tolerance 
HPI: 26yom with a history of mild asthma. Has noticed worsening shortness of breath with exertion for the past month. Denies new allergen exposures. Denies other symptoms. 
SH: Drinks 2 beers 2-3X per week. Denies cigarette or illicit drug use. Married with one child. Recently lost his job. 
PMH: asthma 
Meds: albuterol inhaler PRN 
FH: father: addiction involving alcohol; mother: anxiety

Discussion Questions
1. What risk factors for addiction and risky use does this patient have? 
2. Where would you integrate screening questions into his clinic visit? 
3. How would you transition into the topic? 
4. How would you phrase screening questions to ensure that you are capturing all substances?

Sample Answers
1. Known risk factors for this patient include family history of substance use and a recent life stressor. Other possible risk factors to consider in any patient include psychiatric diagnosis, peer pressure, lack of family involvement and use of drugs with high addictive potential (e.g., heroin and cocaine). 
2. Screening questions can be incorporated into different parts of the H&P. When relevant to the chief complaint the history of present illness would be appropriate. Past medical history would be particularly appropriate when there is a known history of addiction or risky use. Review of systems can include screening if not covered elsewhere. In addition to history the physical exam can be useful in determining a diagnosis related to substance use. Examples include pupil size, conjunctival injection, nystagmus, nasal mucosal or septum damage, murmurs suggestive of endocarditis, needle tracks, cellulitis, impaired cognition, etc.
3. Transition into the topic of substance use with sensitive, non-judgmental language which frames the discussion within the context of medicine. Consider integration with other preventive care topics such as nutrition and exercise. Normalize by using phrases like “routine questions.” Medicalize by focusing on medical consequences of substance use and using phrases like “disease of addiction.”
4. “Tell me more about how often and how much you drink.”
   “You said you don’t smoke. Do you use other tobacco/nicotine products like chew, snuff, hookah or e-cigarettes?”
   “You said you don’t use drugs. Do you ever use painkillers not as directed? Do you ever try to get high from using any medications or substances?”
2. Case Studies: 
Asthma in Primary Care

Further Information
Upon asking further screening questions the patient reports smoking hookah 3-4X per week for the past 3 months. He denies using medications other than as prescribed or directed. He also denies other substance use. Following diagnostic evaluation (i.e., addiction criteria based on DSM-5) the patient endorses craving (1 of 11 criteria).

Discussion Question
Based on the information from the diagnostic evaluation how would you categorize this patient’s substance use?

Sample Answer
Tobacco: Positive Screen + 1 of 11 Addiction Criteria => Risky Tobacco Use
Alcohol: Negative Screen
Other Drugs: Negative Screen

Sample Language
“You are currently within safe limits of alcohol use based on what you told me. I encourage you to continue to have no more than 2 drinks a day. Although you don’t smoke cigarettes, your smoking of hookah means that you engage in risky tobacco use. Is it ok to further discuss these issues to see how we might improve your health and well-being?”

Discussion Question
Having informed the patient of his risky use what is your next step in management?

Sample Answer
Patients with risky use involving one or more substance should receive a brief intervention of 5 to 10 minutes. This effective, evidence-based intervention may be offered by primary care providers.

Sample Language
“You can probably reduce your shortness of breath which has been concerning you if you stop smoking hookah. Stopping hookah will definitely lower your chances of getting lung cancer... I feel confident that you can achieve this, and I am here to help you through the process... Let’s set goals together to gradually reduce your hookah use... Please see me again in 4 weeks to check on your goals and reevaluate.”

Follow-up Visit
The patient returns in 4 weeks for a follow-up visit. He has cut back on hookah use to 1-2X per week and continues to drink alcohol within safe limits. He still denies misuse of medications and other substance use. He reports that his shortness of breath has been improving. He agrees to continue to decrease hookah use and return in another month.
2. Case Studies: Bipolar Disorder in Primary Care

Case Presentation
CC: intermittent heart palpitations, elevated mood
HPI: 43yof with a history of bipolar disorder. Recent depressive episode. Previously only had 1 beer 3-4X per week. Now using substances more frequently. Mood over the past week has been slightly elevated compared to baseline.
SH: Now drinking 4-5 beers per day 3X per week. Now using cocaine 5-7X per month. Denies tobacco use or misuse of medications. Lives with her boyfriend of 6 years.
PMH: bipolar I disorder, overweight, dyslipidemia
Meds: lithium ER 300mg TID, atorvastatin 20mg QD
FH: father: bipolar

Discussion Questions
1. Does this patient screen positive for use of tobacco, alcohol or other drugs?
2. Based on the results of this screening what is the next step in this patient’s evaluation and management?

Sample Answers
1. Tobacco: Negative Screen
   Alcohol: Positive Screen (>1 drink/day for a woman)
   Other Drugs: Positive Screen (use of cocaine)
2. Based on the patient’s positive screen for alcohol and cocaine use a diagnostic evaluation (i.e., addiction criteria based on DSM-5) is now required for each substance to determine whether she engages in risky use or has addiction.

Further Information
Additional questions from the diagnostic evaluation yield the following information. For alcohol the patient endorses Cut down, Health, Excessive Use, Tolerance and Personal problems (5 of 11 addiction criteria). For cocaine the patient endorses Health, Excessive Use and Craving (3 of 11 addiction criteria).

Sample Language
“Based on what you told me you have the disease of addiction with moderate addiction involving alcohol and mild addiction involving cocaine. Your addiction may be affecting your mood and symptom of palpitations. Is it ok to further discuss these issues to see how we might improve your health and well-being?”

Discussion Question
Does the patient’s bipolar disorder affect your assessment or impression; if so, how?
2. Case Studies: Bipolar Disorder in Primary Care

Sample Answer
There is a high prevalence of co-occurring psychiatric disorders with addiction and risky use. These can be difficult to both diagnose and treat effectively due to similarities between primary psychiatric disorder symptoms and substance intoxication or withdrawal symptoms. Of all psychiatric diagnoses bipolar disorder has the highest rate of co-occurrence. A co-occurring psychiatric disorder does not change the general treatment approach to addiction, but particular focus should be given to transdisciplinary care and care coordination across providers.

Sample Language
- “How long have you been using alcohol and cocaine with this quantity and frequency?”
- “Have you ever been hospitalized for reasons related to your substance use or withdrawal?”
- “Have you ever tried to reduce your substance use in the past?”
- “How do you think your substance use is affecting your mood and bipolar disorder?”
- “Is there anything that makes you use substances more or less often?”

Further Information
The patient reports feeling depressed for the past few months. She began to use cocaine and alcohol in an attempt to cope with her mood symptoms. The patient also notes that she has been less consistent with her lithium lately. For the past week her mood has been more elevated with a decreased need for sleep. She denies ever experiencing withdrawal symptoms or hospitalizations related to substance use. She sees her boyfriend as a protective factor regarding substance use especially since he does not use substances.

Discussion Questions
1. What factors in a case would impact your decision regarding level of care for treatment (i.e., outpatient, intensive outpatient, partial hospitalization, non-hospital residential, hospital inpatient)?
2. What is your next step in treatment and management as her primary care physician?
3. What medications would you consider using in this setting?
2. Case Studies:
Bipolar Disorder in Primary Care

Sample Answers
1. In determining treatment level consider the following factors among others: presence or risk of withdrawal; co-existing medical or psychiatric conditions and complications; potential for relapse or continued use; recovery environment; etc. The American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) can help determine appropriate treatment venue.

2. Primary care physicians should provide ongoing patient education, address co-morbidities, coordinate patient care and augment with peer (e.g., AA, SMART Recovery®) and other support services. They have the option of providing medications and psychosocial therapy for addiction or referring to an addiction physician specialist for care.

3. FDA-approved medications for alcohol addiction include acamprosate (Campral), disulfiram (Antabuse) and naltrexone (ReVia, Depade, Vivitol).

Sample Language
- “I would like to start you on 25mg of naltrexone per day to help you reduce your drinking. Can we talk about this medication and how it should be used?”
- “Although no medications have been FDA-approved to treat your addiction involving cocaine, talk therapy can help addiction involving many substances including cocaine.”
- “I would also like to refer you to an addiction psychiatrist for cognitive behavioral therapy. This kind of treatment can jointly address your drinking and your cocaine use while helping to assure that you do not replace one substance with another.”
- “People with bipolar disorder or other mental illnesses have higher chances of developing risky use and addiction. Your substance use and bipolar disorder may affect each other in a number of complex ways.”
- “Your addiction psychiatrist and I can collaborate to assure that both of your diagnoses are being treated in an integrated way.”

Follow-up Visit
Your patient returns in 4 weeks for a follow-up visit. She reports that her new addiction psychiatrist has been very helpful with her substance use. The patient indicates that she has successfully reduced her cocaine use to 2X this past month. She has also reduced her alcohol use to 2-3 beers per day 3X per week. Her palpitations have improved, but her mood is still not at her baseline. Her addiction psychiatrist is now managing the patient’s medications for bipolar disorder, and the patient has been taking her lithium more regularly. She is more hopeful and is feeling more in control of her bipolar disorder. She agrees to follow up with you and her addiction psychiatrist in the following 4 weeks.
3. Reference List


3. Reference List


