



Wisconsin Opioid Project ECHO Agenda

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Session Date: Friday September 21, 2018

Didactic Topic and Presenter: Clinic flow for OBOT by Elise Wessol, DO

- 12:30 PM: **Attendance text-in & Introductions**
- 12:45 PM: Case #1 & discussion
 - **Presenter:** Randall Ambrosius, MSW, LCSW, CSAC, ICS
 - **Question:** Types of treatment modalities used to aid in pain management of a Suboxone patient. Cultural values make it a struggle to utilize evidence based treatment modalities.
- 1:00 PM: Case #2 & discussion
 - **Presenter:** Eun Ha Kim, MD
 - **Question:** Using Suboxone for patient with polysubstance use, what is an appropriate target dose or dosing strategy? What other options for treatment would help make treatment successful?
- 1:15 PM Didactic Presentation
- 1:30 PM: End of Session



WI Opioid Project ECHO 2018-2020

Clinic flow for OBOT
September 21, 2018
Elise Wessol, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:

As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices
2. Participate in office-based management of opioid use disorders
3. Seek overdose prevention education with greater frequency.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Elise Wessol, Presenter	No relevant financial relationships to disclose	No
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	No
Elizabeth Collier, Content Expert, Social Worker	No relevant financial relationships to disclose	No
Paul Hutson, Content Expert, Pharmacy	No relevant financial relationships to disclose	No
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

CONTINUING EDUCATION INFORMATION:

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JA0000358-9999-18-095-L04-P

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 09/21/18

2-Presenter: Randall Ambrosius, MSW, LCSW, CSAC, ICS Family Health/La Clinica

3-ECHO ID: 9874

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Types of treatment modalities used to aid in pain management of a Suboxone patient. Cultural values make it a struggle to utilize evidence based treatment modalities.

Demographic Information:

6-Age: 67

7-Gender: Female

8-Education/Literacy: Highschool

9-Income source:

10-Insurance:

11- HPI:

12-Social History:

- Patient was born in Poland and moved to the Chicago Area when she was 19. Patient married and was able to start their own business. The business required a great deal of heavy lifting materials and machinery. When she was in her 30's she had injured her back. She was prescribed Vicodin to deal with the pain. After a while she stops taking the Vicodin. She divorces her first husband and within a short time married a second husband. The business in Chicago was sold and patient had bought a restaurant/Tavern in Wisconsin. While owning this business she had begun to drink heavily (3 to 12 drinks daily). Second husband was very abusive and she divorce him. In her early 50's she went to her physician relating the back pain had return and also joint pain. Patient states she was diagnose with Arthritis and was again prescribed Vicodin for the back pain. In her early 60's patient sold the Restaurant/Tavern and bought a small house in Wisconsin to retire. She states once she sold the restaurant/Tavern she stops drinking. She states she has abstained from drinking for the past seven years. She had started a relationship with another male. She stated when her physician stops prescribing the Vicodin her boyfriend had gotten her some off the streets. At times when boyfriend could not get Vicodin he would get her oxycodone. She went on to say "I also tried using Marijuana and on one occasion use Crack Cocaine to deal with pain". Her boyfriend was also addicted to opiates. Approximately five years ago the boyfriend had died of a drug overdose. Patient stated by then she had contacts who she could buy Oxycodone/Vicodin. However, within a short time she realizes she could not afford the high street drug cost. In January 2018 she had found out our clinic offered a Medical Assisted Treatment program. In early March she had one slip (used an Oxycodone because the pain was very high). Since that time she has been compliant with the program.

13-Housing: Homeowner

14- Substance Use History:

- Age 30 started to be prescribed Vicodin for back pain. Within a short time began to abuse them. For several years' patient had also abused alcohol. However patient states for the past few years she has been able to abstain. From Alcohol.

15- Consequences of Substance Use:

- Social/occupational/educational:
- Physical (including evidence of tolerance/withdrawal):

16- Behavioral Health Interventions that have been tried:

- Patient is in our medical Assisted Treatment program (Suboxone program). Writer has attempted CBT and 12 step principals but patient struggles with these concepts. Patient does appear to be able to engage through motivational interviewing, however with the language barrier (she speaks mainly polish) uncertain if she is fully grasping concepts.

17- Medications Tried for Relapse Prevention? (Specify):

- Patient has only been on the Medical Assisted program. (Suboxone).

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Buprenorphine-Naloxone (Zubsolv) 5.7-1,4 mg subl	F11.20 Opioid use disorder

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Despite living a great distance from the clinic patient makes it to all appointments. Patient states she has a supportive church that also aids her.	Patient states no significant childhood issues, but did state all her past husbands were physical and emotionally abusive.

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

- Patient originally from Poland. At times she struggles with understanding what writers is discussing. Patient also struggles with utilizing resources (example transportation, housing and utility programs).

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

- All drug screen has been negative with the exception of one positive for oxycodone in March 2018. Patient admitted to taking the Oxycodone due to severe pain that weekend.

22-Prescription Monitoring Program Pertinent Findings:

- All pill count has been accurate. One positive U/A.

23-Proposed Diagnoses:

- F11, 20 Opioid use disorder (severe).

24-Patient Goals for Treatment:

- Patient would like to manage the pain so she would not need to return to using street opioids.
- Patient would like to engage in activities with individuals she can enjoy life with who are not involved in substance use.

25- Proposed Treatment Plan:

- Engage patient in resources and activities that would enhance her sobriety.
- Educate patient on methods and procedures to reduce pain.
- Encourage patient to set up clear boundaries to avoid individuals that would enhance her relapse.

By initialing here ___RA___ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)



Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 8/17/18

2-Presenter: Eun Ha Kim, MD addiction psychiatry fellow

3-ECHO ID: 6436

4-Have you presented this patient during this teleECHO clinic before? no

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Using suboxone for patient with polysubstance use, opioid is not currently primary drug of choice. What is an appropriate target dose or dosing strategy? What other options for treatment would help make treatment successful?

Demographic Information:

6-Age: 57

7-Gender: M

8-Education/Literacy: associate degree.

9-Income source: working at VA thru VA TSES (therapeutic supported employment service), ex-girlfriend has been giving money when he asked for living expenses.

10-Insurance: VA patient

11- HPI:

- Patient is a 57-year-old Caucasian male with long history of opioid, alcohol and cocaine use disorder.
- Patient was referred from psychiatric inpatient unit for possible opioid maintenance therapy.
- He was brought into the hospital by his ex-girlfriend, requested detox from alcohol and crack cocaine, also endorsed depressed mood, low energy, poor sleep, decreased appetite with significant weight loss (20+ lbs since May), and hopelessness.
- He reported that he's been drinking a fifth of vodka daily since March this year, crack cocaine "almost every day" past 2-3 months, he spent about 100 dollars per each time. He was using heroin when it was available, most of time someone offered him "couple times a week", not regular using, last use was beginning of July. Also, he smoking cigarette 1ppd past 3 months and chewing tobacco prior. Last drinking was earlier day of admission; he was in psychiatric inpatient unit for 4 days.
- During inpatient treatment, he asked to restart Suboxone because when he was on Suboxone, he was "feeling good enough not to use other drugs". He was offered naltrexone, but he declined as he "failed" in the past. He accepted trial on Acamprosate.

12-Social History:

- Currently unemployed, Divorced, no child, worked as a housekeeper at VA hospital, split up from long term partner last fall due to his drug use, but ex-girlfriend is still main support system.
- Consistent work history; worked at VA as a housekeeper 2001-2013
- Since, short stint at UW health or VA in housekeeping or labor as part of TSES.

13-Housing:

- Living alone with a dog, apartment which his friend owned, he's supposed to help out him to managing apartment facility.

14- Substance Use History:

- Started using cannabis at age 13, then speed, acid, PCP and alcohol. Consistent thru high school year. Drinking became prominent since joining the military at age 18. Started Crack cocaine age 25, and heroin 30 or 31 years old, using was intermittent mostly due to incarceration. He started using heroin again in 2000 (age 39). He overdosed on heroin and cocaine in 2003, "accidental overdose".
- He reported he started Suboxone treatment in 2000 at VA hospital in MN, transferred his care to Madison VA in 2004. He's been on Suboxone, highest dose of 24mg / day until 2010. It seems he was compliant with medication between 2003-2008. From 2008, He's used extra dose of Suboxone daily, ran out medication early, had experienced withdrawal between appointment or used other opioid to avoid withdrawal. Also continuously used cannabis and chewing tobacco while in treatment. Treatment ended in 2010 as patient requested "sick of having withdrawal".
- Since 2010, he has been using alcohol, crack cocaine, heroin and cannabis, several hospital visit for detox. Since 2017, he visited hospital three times for detox.

15- Consequences of Substance Use:

- Social/occupational/educational:
 - Hit and run and OWI last year, prison time September 2017, currently on probation until October, 2018
 - Numerous DUI/DWI; 7-8 times per records. 7months of prison for DWI 2015-2016.
- Physical (including evidence of tolerance/withdrawal):
 - Per records, CIWA score never above 4 during inpatient detox. No history of withdrawal seizure or DT.

16- Behavioral Health Interventions that have been tried:

- He is currently in IOP at VA ADTP.
- He has history of multiple inpatient and outpatient drug rehab, residential at building 5 for 2 years in 2013-14. Most recent inpatient drug rehab was November – December, 2017.
- He had 12 weeks of treatment at Meriter in 2009,
- Individual counseling at VA and outside of VA.

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17- Medications Tried for Relapse Prevention? (Specify):

- Suboxone 8mg/2mg TID for 10 years
- Naltrexone 2010- 2011 discontinued due to noncompliance, continuous drinking.
- Gabapentin tried while and after suboxone 2000-2010

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Acamprosate 666mg tid Trazodone 100mg hs Lexapro 10mg qd Gabapentin 600mg tid	Depressive disorder, unspecified Personality disorder, Cluster B

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Have place to stay Ex-girlfriend still supportive for his recovery	Legal issue Isolation unemployment Personality trait

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):**21- Labs (as indicated): Include summary of urine testing or last urine drug screen result**

- Blood alcohol on admission; 248 mg/dl
- UDS negative for all tested 3rd hospital day; amphetamine, barbiturates, benzodiazepine, opiates, cannabinoids, methadone, ETOH, Cocaine

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22-Prescription Monitoring Program Pertinent Findings:

23-Proposed Diagnoses:

- Alcohol use disorder
- Cocaine use disorder
- Opioid use disorder
- Tobacco use disorder
- Depressive disorder, Unspecified

24-Patient Goals for Treatment:

- Being sober
- Employed
- Restore relationship with ex-girlfriend

25- Proposed Treatment Plan:

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3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)



Office-based Opioid agonist Treatment (OBOT)

Elise Wessol, DO
Addiction Medicine Fellow
Project ECHO
9/21/2018

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Overview

- ▶ OBOT refers to models of opioid agonist treatment that seek to integrate the treatment of opioid addiction into the general medical and psychiatric care of the patient.
- ▶ The foundation of OBOT is the conceptualization of opioid addiction as a chronic medical condition with similarity to many other chronic conditions.
- ▶ An important feature of OBOT is that it allows primary care physicians to provide addiction treatment services in their usual clinical settings, thus expanding the availability of care.
 - ASAM Public Policy Statement on Office-based Opioid Agonist Treatment (OBOT)
- ▶ OAT is underutilized at a time when the need for it is increasing

Medication Assisted Treatment (MAT) Used in OBOT

- ▶ MAT is primarily used for the treatment of addiction to opioids – heroin, prescription opioids.
- ▶ Methadone, buprenorphine
- ▶ Operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug.
- ▶ Common misconception is belief of substituting one drug for another*

Additional Therapy in Conjunction with MAT

- ▶ Under federal law, MAT patients must have access to counseling, which could include different forms of behavioral therapy (CBT, psychotherapy). These services are offered along with medical, vocational, educational, and other assessment and treatment services.
- ▶ NA, AA, CA, HA, PA, other 12 step-programs, meditation , yoga
- ▶ Other Considerations
- ▶ Residential, partial hospitalization, IOP

Patient Assessment

- ▶ Acute intoxication and withdrawal potential
 - Outpatient vs medically supervised
- ▶ Biomedical conditions and complications
 - Pregnant? Risk for NAS
 - Communicable disease?
 - Comorbidities?
- ▶ Emotional, behavioral, or cognitive condition and complications
 - SI? HI?
 - Mental health problem co-occurring or independent of addiction?
- ▶ Readiness to change
- ▶ Relapse, continued use, or continued problem potential
- ▶ Recovery environment
 - Need for services related to family/significant-other, housing, vocational, legal, transportation, or child care?



Clinical Opioid Withdrawal Scale (COWS)

► SCORE

- 5 to 12 = mild
- 13 to 24 = moderate
- 25 to 36 = moderately severe
- more than 36 = severe withdrawal



Resting pulse rate: _____ beats/minute Measured after patient is sitting or lying for one minute	GI upset: Over last half-hour
0 pulse rate 80 or below 1 pulse rate 81 to 100 2 pulse rate 101 to 120 4 pulse rate greater than 120	0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: Over past half-hour not accounted for by room temperature or patient activity	Tremor: Observation of outstretched hands
0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: Observation during assessment	Yawning: Observation during assessment
0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size	Anxiety or irritability
0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored	Gooseflesh skin
0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing: Not accounted for by cold symptoms or allergies	Total score: _____ The total score is the sum of all 11 items
0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Initials of person completing assessment: _____

Score: 5 to 12 = mild; 13 to 24 = moderate; 25 to 36 = moderately severe; more than 36 = severe withdrawal.

Buprenorphine

- ▶ Partial mu agonist with high affinity for opioid receptor
- ▶ Dose dependent ceiling effect
 - therefore reducing risk of overdose and misuse
 - OD can occur with concomitant BZ use
- ▶ High street value/diversion potential so combined with naloxone
 - E.g. Suboxone
- ▶ Subutex – buprenorphine only

OBOT

Phase 1

The Induction Phase

- ▶ Is the medically monitored startup of buprenorphine treatment performed in a qualified physician's office or certified OTP using approved buprenorphine products.
- ▶ Administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal (mild to moderate withdrawal; COWS ≥ 12).
 - It is important to note that buprenorphine can bring on acute withdrawal for patients who are not in the early stages of withdrawal and who have other opioids in their bloodstream.

Induction

- ▶ Prior to induction
 - UDS
 - LFT's
 - Pregnancy test
 - Social support/living situation
 - Review agreement
 - Pick up and bring opioid agonist to visit
 - Arrive in moderate withdrawal

Induction

- ▶ Appropriate COWS score
- ▶ Observe patient taking ½ film or 4mg Suboxone
 - Instruct to keep in mouth for full 5 minutes without swallowing for best absorption
- ▶ Monitor for 1-2hrs
- ▶ Instruct patient to take remaining half of film or another 4mg four hours later
- ▶ Check in the next day. Assess for side effects. Increase dose or keep dose same.
- ▶ Close follow up

OBOT

Phase 2

The Stabilization Phase

- ▶ Begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, side effects.
- ▶ The buprenorphine dose may need to be adjusted during this phase.

OBOT

Phase 3

The Maintenance Phase

- ▶ Occurs when a patient is doing well on a steady dose of buprenorphine.
- ▶ The length of time of the maintenance phase is tailored to each patient and could be indefinite.
- ▶ Once an individual is stabilized, an alternative approach would be to go into a medically supervised withdrawal, which makes the transition from a physically dependent state smoother. People then can engage in further rehabilitation—with or without MAT—to prevent a possible relapse.

Complications

- ▶ Withdrawal precipitated by buprenorphine is often quicker in onset and more severe than spontaneous withdrawal.
 - Complications can require hospitalization; even ICU admissions have been described
- ▶ Patient elopement during supervised withdrawal.
- ▶ Resumption of opioid use in the context of severe craving and desire to ameliorate remaining withdrawal symptoms.
- ▶ Home-based induction has diversion potential

Primary Care and Addiction Treatment

- ▶ Some primary care practices provide an alternative to addiction treatment centers as a setting in which to receive continuing care for addiction.
- ▶ Primary care physicians can receive training in continuing care at CME courses and in workshops or courses at meetings of the American Society of Addiction Medicine
- ▶ PCP can obtain buprenorphine waiver via online/ in person training
- ▶ Primary care clinicians without specialized training in continuing care can participate in such care for selected patients, such as stable patients who are doing well, or check-ins with patients with more severe SUDs who have successfully completed more intensive continuing care.
- ▶ PREVENTION

Discontinuation vs indefinite treatment with MAT

- ▶ Chronic disease
- ▶ Needs to be routinely evaluated and discussed with patient

Questions and Discussion

References

- ▶ DUPONT, ROBERT M. D. SELFISH BRAIN: Learning from Addiction. HAZELDEN, 2017.
- ▶ Lembke, Anna. Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's so Hard to Stop. Johns Hopkins University Press, 2016.
- ▶ Teresi, Louis, and Harry L. Haroutunian. Hijacking the Brain: How Drug and Alcohol Addiction Hijacks Our Brains ; the Science behind Twelve-Step Recovery. AuthorHouse, 2011.
- ▶ Dennis M, Scott CK. Managing addiction as a chronic condition. Addict Sci Clin Pract 2007; 4:45.
- ▶ The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed., Mee-Lee D, Shulman GD, Fishman MJ, et al (Eds), The Change Company, Carson City, NV 2013.
- ▶ McKay JR, Cacciola JS, McLellan AT, et al. An initial evaluation of the psychosocial dimensions of the American Society of Addiction Medicine criteria for inpatient versus intensive outpatient substance abuse rehabilitation. J Stud Alcohol 1997; 58:239.
- ▶ Volkow, Antonello Nora D. Bonci, and David Goldman. "The Genetic Basis of Addictive Disorders." Neurobiology of Mental Illness, 2013, pp. 696–705., doi:10.1093/med/9780199934959.003.0052.
- ▶ Blum, Kenneth, et al. "Association of the A1 Allele of the D2 Dopamine Receptor Gene with Severe Alcoholism." Alcohol, vol. 8, no. 5, 1991, pp. 409–416., doi:10.1016/0741-8329(91)90693-q.

DSM-5 Substance Use Disorder ("Addiction")

- ▶ Tolerance
 - ▶ Withdrawal
- } **Physical Dependence ≠ Use Disorder**
- ▶ Larger amts/longer periods than intended
 - ▶ Persistent desire/failed attempts to quit/control use
 - ▶ Much time obtaining/using/recovering
 - ▶ Important activities sacrificed
 - ▶ Continued use despite known adverse effects
 - ▶ Failure to fulfill major obligations
 - ▶ Recurrent hazardous use
 - ▶ Craving
 - ▶ Ongoing use despite interpersonal problems

2–3 = mild

4–5 = moderate

≥ 6 = severe