Diagnose Substance Use Disorder (DSM-5)

Impaired CONTROL	1. Larger amounts/longer periods of time 2. Repeated attempts to quit/control use 3. Much time spent using drug 4. Cravings, urges
SOCIAL Impairment	5. Activities given up to use 6. Neglected major roles 7. Interpersonal problems related to use
RISKY USE	8. Hazardous use 9. Use despite knowledge of physical/psychological problems
Pharmacologic Criteria	10. Withdrawal 11. Tolerance

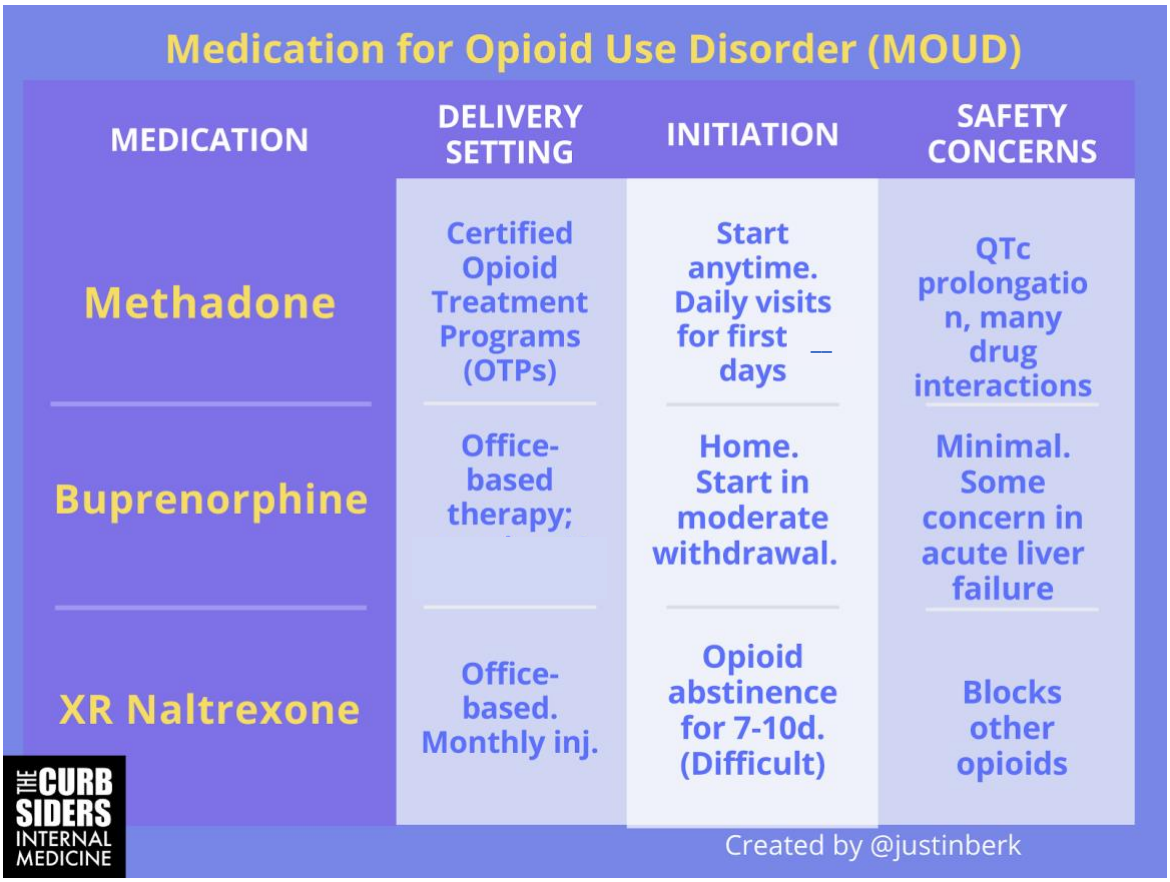
5 "C's"
Control
Cut back
Cravings
Compulsion
Consequences

Mild = 2-3
Moderate = 4-5
Severe = 6+

FDA-Approved Medications for AUD

	DISULFIRAM	ACAMPROSATE	NALTREXONE	VIVITROL
Dosage	250-500mg/day	1996mg/day	50mg/day	380mg/month intramuscular
Most common adverse effects	Drowsiness Rare→ hepatitis, psychosis, neuropathy, optic neuritis, confusional states	Diarrhea	Somnolence, nausea, vomiting, ↓appetite, abdominal pain	Same as naltrexone plus injection site reaction
Clinical notes	**Only makes sense if patient's goal is sustained remission**	**Need to take multiple times per day→ not ideal for unsheltered folks** **FDA-approved to sustain remission from AUD in those who are in remission at Tx initiation**	**Can block the effects of opioid** **Precipitated withdrawal in patients with physical dependence to opioids** **Efficacy in reducing risk of recurrence and heavy drinking**	**Same as naltrexone**

Source:



Buprenorphine Initiation Strategies

	STANDARD	LOW DOSE NON-OVERLAP	LOW DOSE OVERLAP
Wash-out period	8-72 hours	6 hours	n/a (continue agonist until day 7)
Dosing	Standard: 4-8mg, give additional 4-8mg if tolerating Macro: 16-32mg	Day 1: -0.5mg q2hrs x 4 doses (first 6 hours) -1mg q2hrs x 2 doses (next 4 hours) -2mg q2hrs x 2 doses (next 4 hours) -8mg (2 hours after last 2mg dose) Day 2: -8mg BID	Day 1: 0.5mg daily Day 2: 0.5mg BID Day 3: 1mg BID Day 4: 2mg BID Day 5: 4mg BID Day 6: 4mg TID (STOP agonist) Day 7: 8mg BID
Clinical notes	**Simplest, careful with standard regarding precipitated withdrawal.**	**Anecdotal data says works well with fentanyl, reduces time not using. Simpler than overlap.**	**Best for patients on prescribed agonist. Good for methadone transition to buprenorphine.**
Handout/more info			