THE CARLAT REPORT
ADDICTION TREATMENT
A CE/CME Publication
CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Bachaar Arnaout, MD
Editor-in-Chief
Volume 7, Issue 1
January/February 2019
www.carlataddictiontreatment.com

IN THIS ISSUE

Focus of the Month:
Board Certification in Addiction Medicine

- Introducing CRAFT: A Non-Confrontational Intervention We Can Recommend to Families — 1
- Expert Q&A: — 1
  Michael Weaver, MD, FASAM
  Becoming a Board-Certified Addiction Clinician
- Coffee: Healthy Study Aid or the Addiction We Hate to Acknowledge? — 3
- Table: The Effects of Caffeine — 3
- Table: Addiction Medicine Resources — 5
- Research Update: — 6
  - More Evidence of Lives Saved by Medications for Opioid Use Disorder
- CME Test — 7

Learning Objectives
After reading these articles, you should be able to:

1. Identify the benefits of using the CRAFT approach to help families of loved ones with substance use disorders.

2. Describe the process of obtaining board certification in addiction medicine.

3. Summarize some of the current findings in the literature regarding addiction treatment.

Introducing CRAFT: A Non-Confrontational Intervention We Can Recommend to Families

Thomas Jordan, MD, MPH. Contributing writer to the Carlat newsletters.

Dr. Jordan has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In Summary

- CRAFT is an evidence-based intervention for families of persons with substance use disorders.
- CRAFT offers a practical, skills-based approach to help get the person into addiction treatment while increasing the well-being of the concerned significant other.
- CRAFT success rates in getting persons involved in addiction treatment are as high as 55%–70%.

How should families help their loved ones who are struggling with addiction? Should they be accommodating, firm, or confrontational? The Community Reinforcement and Family Training (CRAFT) approach is a good strategy that you should become familiar with.

Before we describe CRAFT, though, you should know about two other frequently used approaches to helping family members intervene: The Johnson Institute intervention and Al-Anon.

The concept of a confrontational "intervention" was originally invented in the 1960s by Vernon Johnson, who was an Episcopal priest and in recovery from alcohol. He believed people struggling

Continued on page 2

Becoming a Board-Certified Addiction Clinician

Michael Weaver, MD, FASAM

Professor and medical director at the Center for Neurobehavioral Research on Addictions at the University of Texas Medical School. Author of Addiction Treatment *(Carlat Publishing, 2017).*

Dr. Weaver has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: To start off, could you tell us why a psychiatrist or any other physician would want to be board-certified in addiction?
Dr. Weaver: Patients with addiction are common in psychiatric or any other practice. You're going to see patients who have these issues, so it's good to be prepared and able to focus on treating addiction, as well as to be part of a growing group of specialists.
CATR: Are there opportunities that may open up for practitioners as a result of certification?
Dr. Weaver: The opioid crisis has opened the doors to an array of federal funding. And with funding for additional treatment outlets, there are going to be more positions for folks who are knowledgeable about addiction, and certification will eventually become a requirement for that. You can have practice opportunities in a variety of venues, from the more traditional residential focus to the currently popular medication treatment focus. You can also work with other formats such as multilevel specialty programs, freestanding addiction clinics, or even

Continued on page 4

Introducing CRAFT: A Non-Confrontational Intervention We Can Recommend to Families
Continued from page 1

with addiction are unable to see their own disease clearly unless confronted at a crisis point, and he created the Johnson Institute, a major training site for addiction professionals. Studies of Johnson Institute interventions (Liepman MR et al, *Am J Drug Alcohol Abuse* 1989;15(2):209–221) have shown success rates over 85% for getting the person into treatment when the intervention does take place. However, confrontational intervention is hard on families, and only about 30% of loved ones follow through with one, yielding an overall success of around 25%.

Al-Anon and Nar-Anon are modeled after the 12 steps of Alcoholics Anonymous—but rather than catering to people using substances, these groups cater to their families and friends. The focus is to promote well-being for group members in dealing with the repercussions of addiction. Getting the person into addiction treatment is often not a stated goal, and studies of Al-Anon that measure treatment engagement are discouraging—as few as 13% of people start treatment over a 1-year period (Miller WR et al, *J Consult Clin Psychol* 1999;67(5):688–697).

The CRAFT modality was first developed in the 1980s by Robert J. Meyers, PhD and colleagues (for more info, see www.robertjmeyersphd.com/craft.html). The theory behind CRAFT is that people with addiction are more likely to take advice from someone they are already close to than from others, such as clinicians. In the CRAFT jargon, close friends and family are termed concerned significant others (CSOs). The two primary outcomes of CRAFT are getting the loved one into addiction treatment and increasing the well-being of the CSO. CRAFT therapy sessions focus on increasing the CSO's awareness of how substance use has affected the person's life ("awareness training") and on helping the CSO use positive reinforcement strategies to change the person's behavior ("contingency management"). The CSO is encouraged to provide positive support for healthy behavior and to withdraw that support upon instances of substance misuse. For example, CSOs can plan a positive activity for themselves and their loved ones during a time the person would otherwise spend using substances. If the loved one abstains from substances, then the activity proceeds as planned. But if the person uses, the activity is cancelled.

At the same time as learning positive contingency management techniques, CSOs explore how to increase their own well-being—planning activities for themselves to rest and recharge. The therapist and CSO also work on communication skills, safety planning, when to separate from the relationship and when to reunite, and how to bring the person into treatment when the person is ready. This can take the form of CSOs bringing their loved ones to meet the CRAFT therapist, then linking to the appropriate community resources.

Does CRAFT work?

The CRAFT treatment model has been studied and adapted to various populations and treatment settings. In research trials, the primary outcome is getting the loved one into addiction treatment. The rate often quoted for this outcome with CRAFT is up to 70% over 1 year. A head-to-head analysis of CRAFT, the Johnson Institute intervention, and Al-Anon was performed in 1999 involving 130 total CSO participants with follow-up at 12 months (Miller WR et al, *J Consult Clin Psychol* 1999;67(5):688–697). All three of the treatment arms showed similar improvements in CSO well-being, but the CRAFT group outperformed the other arms in getting participants into treatment (64% for CRAFT, 30% for Johnson intervention, 13% for Al-Anon). Treatment engagement with participants happened on average after 4–6 sessions, and engagement rates were higher for CSOs who were parents than those who were spouses. Another trial in 2002 compared standard CRAFT individual sessions, standard CRAFT plus group aftercare sessions, and Al-Anon and Nar-Anon facilitation therapy (Al-Nar FT) with 90 randomized CSOs (Meyers RJ et al, *J Consult Clin Psychol* 2002;70(5):1182–1185). The percentage of participants entering treatment was 58.6% for traditional individual CRAFT sessions, 76.7% for CRAFT plus group aftercare, and 29.0% for Al-Nar FT.

Where to find CRAFT therapy

As more focus is placed on addiction treatment, access to a wide array of therapies has become more important. While Al-Anon and other 12-step style interventions are widespread, certified CRAFT therapists are not as accessible. Even though CRAFT originated 30 years ago in the US, it's gained more traction internationally. There is an online list of CRAFT therapists in the US and abroad (www.robertjmeyersphd.com/download/CertifiedTherapists.pdf), but only 9 states have any therapists

Continued on page 8

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Mailing Information

The Carlat Addiction Treatment Report (ISSN 2473-4454) is published 8 times per year by Carlat Publishing, LLC; 29 Water Street, Newburyport, MA 01950. Application to mail at periodicals postage prices is pending at Newburyport, MA and additional mailing offices.

POSTMASTER: Send address changes to The Carlat Psychiatry Report, P.O. Box 626, Newburyport, MA 01950

Coffee: Healthy Study Aid or the Addiction We Hate to Acknowledge?

Rehan Aziz, MD. Associate professor of psychiatry and neurology, Rutgers Robert Wood Johnson School of Medicine.

Dr. Aziz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Caffeine permeates our society. It comes in many forms, including coffee and increasingly popular energy drinks. We consume it, and so do our patients. So, is it a harmless habit or a potentially harmful addiction? Let's take a sip and find out.

Is it addictive?

The WHO in ICD-10 recognizes the diagnosis of substance dependence due to caffeine, and the DSM-5 has listed caffeine use disorder under "Conditions for Further Study." In order to qualify for the diagnosis of caffeine use disorder, individuals must meet all of the following criteria: attempts to regulate their intake, continued use despite negative physical or psychological consequences, and a history of caffeine withdrawal.

The prevalence of caffeine use disorder in the population is estimated to be around 9%, making it more common than we might think. Even in the absence of a formal diagnosis, caffeine use may be clinically distressing for many, and up to 14% of the public continues to consume caffeine despite developing adverse physical and psychological consequences (Meredith SE et al, *J Caffeine Research* 2013;3(3):114–130).

Is it risky?

The DSM-5 specifies four caffeine-related disorders: caffeine intoxication, caffeine withdrawal, caffeine-induced anxiety disorder, and caffeine-induced sleep disorder. (See the table below on "The Effects of Caffeine.") For reference, 85% of the U.S. population consumes at least 1 caffeinated beverage per day, and the average daily caffeine intake from all beverages is 186 mg for all ages combined. One cup of coffee contains 50–100 mg of caffeine. A can of soda has 40 mg of caffeine. Energy drinks have up to 500 mg in a single can! To look up the caffeine content of specific products, check out http://bit.ly/QzWxrR.

Beyond the discrete DSM-5 disorders, caffeine can increase anxiety symptoms in those with panic disorder, GAD, or social anxiety disorder. In high doses, it may precipitate mania or psychosis, although in our experience this is very rare. Some large epidemiological studies have found a correlation between very high coffee use (greater than 8 cups per day) and an increased risk of suicide (Tanskanen A et al, *Eur J Epidemiol* 2000;16(9):789–791), while other studies have linked 2–6 cups per day and a lower risk of suicide (Lucas M et al, *World J Biol Psychiatry* 2014;15(5):377–386). Finally, in any patient with caffeine use disorder, you should also screen for daily cigarette smoking and alcohol use disorder, since these conditions often run together.

Caffeine has been linked to concerning medical outcomes. Toxic doses have been associated with serious events, like cardiac arrhythmias, seizures, and death. It is especially dangerous when combined with alcohol, as the mixture can lead to rapid and severe intoxication. As a result, the FDA began taking action on combo drinks such as Four Loko in 2010. Caffeine can also increase total cholesterol and LDL, as well as cause elevations in blood pressure and variations in heart rate. Coffee can worsen GERD, though this is controversial and may be due to other coffee constituents beyond just caffeine (Grosso G et al, *Ann Rev Nutr* 2017;37:131–156).

In pregnant women, caffeine crosses the placenta and reaches levels in the fetus similar to the mother's. When large amounts are ingested, this can cause spontaneous abortions, intrauterine growth restriction, low birth weight, and preterm delivery. You should recommend that reproductive-age women consume less than 300 mg caffeine per day, if they consume any at all (Kuczkowski KM, *Arch Gynecol Obstet* 2009;280:695). Caffeine also increases calcium excretion and may be a risk factor for osteoporosis, especially in women with low calcium but high caffeine intake (Hallström H et al, *Osteoporos Int* 2006;17(7):1055–1064).

Is it good for you?

Coffee has some potential health benefits. For example, in men and women, moderate coffee consumption (1–2 cups per day) or high decaf coffee consumption (2–4 cups per day) were associated with reduced total mortality (Je Y et al, *Br J Nutr* 2014;111(7):1162–1173). Other studies have linked coffee with decreased risk of a variety of diseases, including cancer and heart disease (Grosso G et al, *Ann Rev Nutr* 2017;37:131–156). A major limitation of coffee research, though, is that most of the data come solely from observing coffee drinkers. Only a few studies are RCTs, the gold standard, which makes these findings subject to change.

Does it enhance performance?

Coffee drinkers swear that java improves functioning, but is this due to caffeine or placebo? It seems that caffeine is in fact effective for improving physical and cognitive functioning in rested or fatigued

Continued on page 7

The Effects of Caffeine

	Time Course	Symptoms
Caffeine intoxication	Following recent heavy caffeine consumption.	Anxiety, restlessness, tachycardia, insomnia, frequent urination, stomach upset, muscle twitches
Caffeine withdrawal	Begins within 24 hours after the last caffeine dose in those with prolonged, heavy consumption. Duration is 2–9 days.	Headache, fatigue/sleepiness, dysphoric or irritable mood, trouble concentrating, flu-like symptoms
Caffeine-induced anxiety disorder	Develops during or quickly after caffeine intoxication or withdrawal. Duration is < 1 month.	Predominant symptoms of panic or anxiety, thought to be due to caffeine use
Caffeine-induced sleep disorder	Develops during or quickly after caffeine intoxication or withdrawal. Duration is < 1 month.	Predominant disturbance in sleep, consisting of insomnia, daytime sleepiness, parasomnia, or mixed, thought to be due to caffeine use

Expert Interview
Continued from page 1

addiction clinics embedded within other practices. Practitioners can also gain recognition as experts in a growing subspecialty and assume leadership positions as administrators, educators, and policy consultants. All of this can open up earning potential.

CATR: There continues to be a tremendous need, and having that certification increases the chances of finding employment in any setting.

Dr. Weaver: Absolutely, and now that addiction medicine is recognized as a subspecialty by the American Board of Medical Specialties (ABMS), it is gaining more credence among medical practitioners (https://www.abms.org). And, of course, addiction psychiatry has been an ABMS subspecialty for quite a while.

CATR: This leads us to an issue that is confusing for many practitioners. Could you tell us about the difference between board certification in addiction psychiatry and addiction medicine?

Dr. Weaver: These are two separate boards. To get certified in addiction psychiatry, you have to be board-certified in psychiatry and complete a 1-year addiction psychiatry fellowship. Addiction medicine is newer and more inclusive—you can come from any specialty, not just psychiatry, and there is no requirement for a fellowship, at least until 2021. Instead, there is a practice pathway, so psychiatrists who have been treating addiction but didn't do a fellowship may have the opportunity to get board certification by virtue of their clinical practice.

CATR: Are there any differences in focus between addiction psychiatry and addiction medicine?

Dr. Weaver: The differences are pretty minor. Philosophically, addiction medicine may be a little bit broader in terms of addressing more potential medical complications, and may include more aspects of pain management or considerations related to obstetrics. So it may be a little bit more broad-based, but then anyone who has been doing addiction psychiatry for a while probably has encountered some of that in the course of their practice. Addiction psychiatry, on the other hand, has more of a focus on co-occurring psychiatric disorders.

"Philosophically, addiction medicine may be a little bit broader than addiction psychiatry in terms of addressing more potential medical complications, and may include more aspects of pain management or considerations related to obstetrics. Addiction psychiatry, on the other hand, has more of a focus on co-occurring psychiatric disorders."

Michael Weaver, MD, FASAM

CATR: Makes sense. Let's talk about the process of board certification in addiction medicine—can you break it down?

Dr. Weaver: Sure. There are a couple of ways to do it, but across all those different pathways to certification in addiction medicine, you need to have certification in a primary board under ABMS. That can be psychiatry, internal medicine, pediatrics, obstetrics—any of those ABMS member boards.

CATR: And then you can do a fellowship or the practice pathway that you mentioned?

Dr. Weaver: Correct. So the fellowship pathway is pretty straightforward. You would do an addiction medicine fellowship. Those are in the process of being accredited by the Accreditation Council for Graduate Medical Education (ACGME), and there are 14 programs currently accredited (https://www.acgme.org). You can also complete one that has been accredited by the Addiction Medicine Foundation, formerly known as the American Board of Addiction Medicine and soon to be known as the American College of Academic Addiction Medicine (https://www.addictionmedicinefoundation.org). There are around 50 of those programs, and they also will count, because they basically followed the same guidelines that the ACGME is using.

CATR: Are these 1-year fellowships?

Dr. Weaver: Most of them are. Some institutions have either a requirement or an option for a research-focused 2-year fellowship, so you can do either, but you must do the full fellowship and complete it successfully in order to apply for certification. So if you do a 2-year fellowship, you've got to do both years before you apply. If you don't complete the fellowship, you can count that toward the time in practice, but that would fall under the practice pathway.

CATR: Can you walk us through what the practice pathway is about?

Dr. Weaver: Sure. For the practice pathway, you need to have 1,920 hours of subspecialty-level addiction medicine–specific practice. And those 1,920 hours are basically the equivalent of 1 year's full-time practice. However, that doesn't have to be done over 1 year; it can be spread out over the 5 years prior to the time in which you apply for certification. Plus, it requires a minimum of 24 months in practice, so if you did 1 year full-time you wouldn't meet the requirements; however, if you did 2 years half-time or full-time, then that would meet them. Also, these cannot be hours earned in residency training.

CATR: Do you need to primarily or exclusively treat addiction during these required hours?

Dr. Weaver: Well, you have to be able to describe the kind of addiction-specific practice that you are doing. You can count up to 25% of those 1,920 hours as addiction-specific practice within another primary specialty. For example, if you are doing family medicine and you're addressing smoking cessation, or you are seeing people and doing motivational interviewing for alcohol use disorder, you can count up to 480 hours if you describe what you are doing consistently in a general practice.

CATR: What about the remaining 75% of the hours?

Dr. Weaver: The other 1,440 hours need to be in addiction medicine–specific practice, but this can include research or teaching. It's just that 480 of those hours have to be hands-on patient care, so you can't be doing all academics or all lab. At least 25% has to be hands-on patient care in addiction medicine.

Continued on page 5

Expert Interview
Continued from page 4

CATR: Could you give us some examples of an addiction-specific practice?
Dr. Weaver: It can take a variety of forms. The simplest example a lot of people think of is prescribing buprenorphine and describing the number of patients and amount of time you spend doing that with patients, and what you do in addition to prescribing in terms of counseling, prevention, and addressing other comorbidities. It could also be spent part-time in a formal treatment facility, such as working as a staff physician or medical director for a residential program doing evaluations for current patients.
CATR: So this would need to be documented in the application. Is there any verification process?
Dr. Weaver: Yes. All of that would need to be verified by someone who is familiar with the individual's practice—ideally, the direct supervisor, department chair, or chief of staff. But it could also be, for example, another physician in the community who has direct experience through cross-referral of patients, or collegial interactions through medical societies and professional meetings, or someone who works with the applicant who is not under the applicant's direct supervision.
CATR: So if I were a clinician in private practice who screens every patient for addiction, treats comorbidities, and then treats some addiction directly, would that meet the requirement?
Dr. Weaver: That would count for up to 25% of the 1,920 hours. For the other 1,440 hours, you need to devote time specifically to doing addiction medicine activities separate from that, which could be all those things that I gave examples of earlier. Or you could work in a hospital detox unit or a dual-diagnosis unit, for example.
CATR: So those additional hours would have to be in an addiction specialty setting?
Dr. Weaver: In general, yes. If you're saying, "Well, I just screen everybody and counsel everybody in my own general practice," that's really hard to justify.
CATR: What if I were doing, say, full-time buprenorphine practice in private practice? Would that qualify?
Dr. Weaver: You could say, "Well, here's the time I set aside for doing that and here's how many patients I see, and here's what I do for them." There's not a set template for how people are doing these things—obviously there's some latitude—so it depends on how well people describe what it is that they are doing.
CATR: OK. Let's say I meet the criteria for the practice pathway and apply for certification. What happens next?
Dr. Weaver: That allows you to sit for the certification exam. The exam is offered at Prometric test centers with the National Board of Medical Examiners (https://www.nbme.org). There are about 300 centers in the US, so it's similar to many other medical certification exams in that respect. It's a computer-administered secure exam for the initial certification.
CATR: Can you give us some tips on how to prepare for the exam?
Dr. Weaver: If you've met the requirements, then you're at least doing some addiction practice on a daily or weekly basis, so that in itself would help you just by virtue of having clinical experience. Folks interested in that will likely have sought out CME credits, which is a good way to gain additional knowledge in areas that maybe you don't see in your individual practice all the time. And because this is a fairly broad specialty, there will be questions about medical as well as psychiatric complications. Being able to consider the breadth of the field is important, and there are a variety of educational opportunities through the American Academy of Addiction Psychiatry (AAAP), the American Society of Addiction Medicine (ASAM), and

Continued on page 6

Addiction Medicine Resources

Resource	Website	Description/Notes
American Academy of Addiction Psychiatry (AAAP)	https://www.aaap.org	Membership society for psychiatrists, trainees, and associated professionals. Offers educational materials and continuing education. Holds an annual meeting. Publishes a bimonthly journal, *The American Journal of Addictions*.
American Society of Addiction Medicine (ASAM)	https://www.asam.org	Membership society for physicians, trainees, and associated professionals. Offers educational materials and continuing education. Holds an annual meeting. Publishes a bimonthly journal, *Journal of Addiction Medicine*.
National Institute on Alcohol Abuse and Alcoholism (NIAAA)	https://www.niaaa.nih.gov	Part of the National Institutes of Health (NIH). Conducts and funds research on the impact of alcohol use. Provides free resources on alcohol consumption and alcohol-related problems for clinicians, patients, and families.
National Institute on Drug Abuse (NIDA)	https://www.drugabuse.gov	Part of the NIH and the U.S. Department of Health and Human Services. Funds research on drug use and addiction. Provides free resources on drug use and addiction for clinicians, patients, and families.
Providers Clinical Support System (PCSS)	https://pcssnow.org	Funded by SAMHSA (see below). Trains providers in the prevention and treatment of substance use disorders, with a focus on opioid use disorders. Offers a wide range of training materials and educational resources. Has an active listserv: https://pcssnow.org/mentoring/discussion-forum
Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov	Agency within the U.S. Department of Health and Human Services. Works to advance behavioral health priorities, which includes reducing the impact of substance misuse. Provides free publications on treatment, prevention, and recovery, including the popular TIP book series.

Research Updates

OPIOIDS

More Evidence of Lives Saved by Medications for Opioid Use Disorder

REVIEW OF: Larochelle MR et al, *Ann Intern Med* 2018;169(3):137–145

We are in the middle of an opioid crisis in the US, with many lives lost daily to opioid-related deaths. Pharmacotherapy with methadone, buprenorphine, or naltrexone represents an important tool for clinicians during this crisis. But just how good are these medications in saving lives? A recent retrospective cohort study evaluated the effects of methadone, buprenorphine, and naltrexone on all-cause and opioid-related mortality in the 12 months after an opioid overdose.

This analysis used data from Massachusetts government and hospital records from 2012 to 2014 to identify adults who survived an opioid overdose, then looked at the 12 months after that overdose. If an individual had multiple overdoses during that period, the first overdose was used for the data collection. A total of 17,568 cases were identified. In the 12 months after the index overdose, 11% (2,040) were on methadone for a median of 5 months, 17% (3,022) were on buprenorphine for a median of 4 months, and 6% (1,099) were on naltrexone for a median of 1 month.

All-cause mortality over 12 months was significantly reduced in those receiving methadone (adjusted hazard ratio [AHR] 0.47 [CI 0.32–0.71]) and buprenorphine (AHR 0.63 [CI 0.46–0.87]), but not those on naltrexone (AHR 1.44 [CI 0.84–2.46]). Similarly, opioid-related mortality was significantly decreased for patients on methadone (AHR 0.41 [CI 0.24–0.70]) and buprenorphine (AHR 0.62 [CI 0.41–0.92]), but not those on naltrexone (AHR 1.42 [CI 0.73–2.79]).

CATR'S TAKE

This study represents real-world population data linking treatment with methadone or buprenorphine after an opioid overdose to a decrease in all-cause and opioid-related mortality in the following year. Remember, these results were tallied over a 1-year period even though most patients discontinued treatment within 6 months. Naltrexone failed to show a significant difference in mortality, perhaps because most people stopped it after 1 month, or because the researchers could not distinguish between the oral and extended release injectable formulations (unlike oral naltrexone, extended release naltrexone has shown treatment efficacy). Another takeaway from this article is that only about a third of those who had an opioid overdose were ever prescribed any form of opioid use disorder pharmacotherapy. Much work remains to be done to provide better access to life-saving treatment for opioid use disorder.

—*Thomas Jordan, MD, MPH.* Dr. Jordan has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Expert Interview
Continued from page 5

the Addiction Medicine Foundation. Those last two also have mock self-test programs available that people can utilize in order to get some practice.

CATR: How up-to-date would I have to be on recent advances in the field?

Dr. Weaver: Anything that's brand-new is probably not going to be tested because the exam covers things that are accepted and practiced in the field. Also, if it's pretty controversial, it's probably not going to be tested. The exam covers the basic principles, mainly in the form of clinical scenarios and vignettes that test application of knowledge.

CATR: How often is the exam offered?

Dr. Weaver: Every year. The application period runs from April 1 to June 30, and then the exam itself is in October into November of that year. Applicants are notified of their results in late January of the following year, and that's when they become board-certified for the standard 10 years.

CATR: Great. Let's say I took the exam and passed. What does the maintenance of certification (MOC) process look like?

Dr. Weaver: We are still in the process of building it out, but it has the same components that other medical specialties require. So part 1 is just maintaining licensure. Part 2 is lifelong learning—basically CME credits, and ABPM is pretty inclusive in terms of CMEs. So if you are boarded in another primary specialty, then you can have a lot of CMEs counted toward addiction medicine MOC. Part 3 we are working on. Typically, it's been another high-stakes certification examination. It depends on what ABMS does to change MOC, but it may move like other boards have to more of a longitudinal assessment. And then part 4 is practice improvement modules, and again that's going to depend on what ABMS does with MOC. We are still in the process of setting that up.

CATR: So folks that have just been certified can start working on parts 1 and 2, and parts 3 and 4 are still in the works.

Dr. Weaver: Yes, for parts 3 and 4 they've got a number of years before those become imperative. Another point to add is that for MOC, you are not required to maintain your primary board certification. Board certification in a primary ABMS board is required to apply for initial certification in addiction medicine, but then it is not required to maintain certification in addiction medicine.

CATR: That's an interesting point. So as a psychiatrist who is board-certified in addiction medicine, I can continue to be certified even if I don't maintain my psychiatric boards?

Dr. Weaver: Yes, that's correct. And this works for folks who are not doing general psychiatry anymore. It wouldn't make sense for them to recertify in general psychiatry if all they are doing is addiction medicine.

Continued on page 7

CE/CME Post-Test

This CME test is only available to active subscribers. Tests must be completed within a year from each issue's publication date. If your subscription expires before that date, you will not have access to the test until your subscription is renewed. To earn CME or CE credit, you must read the articles and then take the post-test at www.TheCarlatReport.com. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. As a subscriber to *CATR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. What are the two primary outcomes of the Community Reinforcement and Family Training (CRAFT) approach? (LO #1)
   a. Getting patients to see their own disease clearly and getting them into addiction treatment
   b. Promoting well-being for patients and increasing the well-being of their concerned significant others
   c. Getting patients into addiction treatment and increasing the well-being of their concerned significant others
   d. Getting patients to see their own disease clearly and promoting their well-being

2. There is currently no fellowship requirement to become board-certified in addiction medicine, while board certification in addiction psychiatry requires a 1-year addiction psychiatry fellowship. (LO #2)
   a. True
   b. False

3. According to a 2018 study evaluating the effectiveness of opioid treatment medication on mortality after an opioid overdose, opioid-related mortality over 12 months was significantly reduced in patients receiving which of the following medications? (LO #3)
   a. Methadone and naltrexone
   b. Methadone and buprenorphine
   c. Naltrexone and buprenorphine
   d. Methadone, buprenorphine, and naltrexone

4. Certified CRAFT therapists are easily accessible both in the U.S. and internationally. (LO #1)
   a. True
   b. False

5. The ____________________ is the administrative board that governs addiction medicine certification. (LO #2)
   a. American Board of Addiction Medicine (ABAM)
   b. American Society of Addiction Medicine (ASAM)
   c. American Academy of Addiction Psychiatry (AAAP)
   d. American Board of Preventive Medicine (ABPM)

Expert Interview
Continued from page 6

CATR: Finally, there is some confusion about the process that the addiction medicine board underwent. It used to be a board administered through ASAM, but now it's separate?

Dr. Weaver: Right, it used to be an independent board that was not a part of ABMS. Now addiction medicine is under the American Board of Preventive Medicine. That's the administrating board that said, "We'll take responsibility for certifying the physicians in the subspecialty of addiction medicine," but of course, anyone from any other board can apply. Additional details about the board and certification process are on the website at www.theabpm.org. ***(Editor's note:** For further addiction medicine resources, see the table on page 5.)*

CATR: Thank you for your time, Dr. Weaver.

Coffee: Healthy Study Aid or the Addiction We Hate to Acknowledge?
Continued from page 3

individuals. Low (40 mg) to moderate (300 mg) amounts improve cognition in a dose-dependent manner. Caffeine also improves attention, vigilance, and reaction times, but doses above 400 mg are more likely to cause anxiety and could actually impede performance.

Caffeine's most reliable impact is on vigilance: sustaining performance on long, boring, or monotonous tasks. Amounts in the 200 mg range improve functioning for several hours. This same effect, with 200–300 mg, is seen in sleep-deprived individuals. Otherwise, studies show caffeine has little impact on complex judgment, risky decision-making, and possibly short-term memory (McLellan TM et al, *Neurosci Biobehav Rev* 2016;71:294–312).

A cup or two of coffee a day may keep the doctors away; more than four cups may call them back. For the majority of our patients (and us), the benefits of coffee will likely outweigh the risks, but for a small subset, it can have a negative impact.

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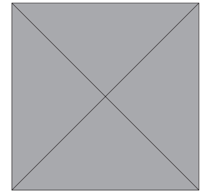

This Month's Focus:
Board Certification in Addiction Medicine

Next issue in *The Carlat Addiction Treatment Report:* Traumatic Brain Injury and Addiction

Introducing CRAFT: A Non-Confrontational Intervention
Continued from page 2

listed. However, there are good self-directed resources available. One of these is a book called *Get Your Loved One Sober: Alternatives to Nagging, Pleading, and Threatening* (Meyers R and Wolfe B. Center City, MN: Hazelden Publishing; 2003). A 2012 study compared CRAFT group therapy to self-directed therapy with this book and found that 40% in the self-directed group got their loved one into treatment, compared to 60% in the group therapy arm (Manuel JK et al, *J Subst Abuse Treat* 2012;43(1):129–136). Families can also use online CRAFT courses, available from sites like https://alliesinrecovery.net or www.cadenceonline.com.

Final thoughts

When a family member or friend of a person struggling with addiction comes to you for answers, it's hard to know how to help. CRAFT interventions have proven effective for families struggling with addiction—both for the caregiver and for the loved one. CRAFT offers a practical, skills-based approach for significant others to implement, with the goal of improving family dynamics and getting their loved one into addiction treatment. Not everyone will have access to weekly in-person therapy sessions, but linking them with either self-directed CRAFT literature or online CRAFT therapy resources is a step in the right direction.

CATR VERDICT: CRAFT-style interventions are an effective way for family members to both help themselves and get help for their loved ones struggling with addiction.

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