THE CARLAT REPORT
ADDICTION TREATMENT

A CE/CME Publication

CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Benjamin Oldfield, MD, MHS
Editor-in-Chief

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

1. Describe the benefits of using harm reduction to treat patients with substance use disorders.
2. Identify strategies for minimizing the risk of opioid overdose.
3. Summarize some of the findings in the literature regarding addiction treatment.

Harm Reduction Strategies—A Primer

As is frequently the case with chronic diseases, cure is often neither possible nor an appropriate goal in addiction treatment. That's where the concept of "harm reduction" comes in. Such strategies can help prevent death, serious injury, or other negative consequences of substance use in patients who are continuing to use drugs or struggle with addiction. In this article, we'll cover four practical harm reduction strategies that can be employed in many office settings: overdose education and naloxone distribution, syringe and needle exchange, fentanyl testing, and pre-exposure prophylaxis.

Overdose education and naloxone distribution
Overdose education and naloxone distribution (OEND) is a strategy emphasized by the Substance Abuse and Mental Health

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Highlights From This Issue

Overdose education with naloxone distribution, syringe exchange, fentanyl testing, and pre-exposure prophylaxis for HIV prevention are strategies that addiction providers can use in practice to reduce harm from substance use.

The CDC recommends naloxone prescriptions be offered to patients at risk for overdose, including those with opioid use disorder, those prescribed greater than 50 morphine milligram equivalents daily, and those concurrently prescribed benzodiazepines and opioids.

Clinicians can educate themselves about their states' Good Samaritan laws and syringe exchange laws in order to counsel patients about overdose risk.

Q&A With the Expert

The Clinician's Role: Reducing Harm Among People Who Use Drugs

Kimberly Sue, MD, PhD

Medical Director of the Harm Reduction Coalition (www.harmreduction.org). Attending physician at Rikers Island Correctional Health Services, NY.

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

CATR: You came out with a book last September called *Getting Wrecked: Women, Incarceration, and the American Opioid Crisis* (University of California Press). What lessons from your book might be relevant to the practicing clinician?
Dr. Sue: The book is based on my PhD work in sociocultural and medical anthropology. I spent a lot of time in Massachusetts at the local Boston jail, in the women's prison, and the state prison in Framingham, and then a local buprenorphine clinic at the state public health hospital. And I followed women through these different places who had opioid use disorder to understand what

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Harm Reduction Strategies—A Primer

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Services Administration in their practical recommendations to curb the epidemic of opioid-related deaths (SAMHSA Overdose Prevention Toolkit 2018, www.tinyurl.com/qq3hem2). Overdose education means teaching laypeople to recognize signs of an opioid overdose as well as factors involved in higher-risk drug use—mixing opioids with other sedatives, using alone, and using increasingly higher doses. Opioid overdose education may target people who use opioids; however, it's less likely that opioid users will curtail their drug use proactively and far more likely that peers and bystanders will intervene on the behalf of someone who is overdosing. With this in mind, overdose education is expanded to anyone likely to witness an overdose (Kerensky T and Walley AY, *Addict Sci Clin Pract* 2017;12(1):4). This includes family members or friends of people who use opioids, medical personnel, and emergency response technicians.

Naloxone strongly binds to and blocks opioid receptors, kicking off other opioids and reversing their effects. It should be used if someone is experiencing respiratory depression—struggling to breathe or not breathing at all. Naloxone for overdose reversal comes in intramuscular (IM), intravenous (IV), subcutaneous (SC), and intranasal (IN) formulations—though only certain IM/SC and IN versions are given for laypeople to use. By pairing overdose education with naloxone distribution, someone witnessing an overdose can not only recognize what is happening but also act to reverse it.

IM naloxone comes in a kit with a vial and needle used to draw up the 0.4 mg/1 mL solution. There is also an IM/SC auto-injector with audible prompts and a retractable needle. IN delivery is easier for laypersons since no needles are involved. There are two types of IN naloxone kits—one single-step kit with 4 mg/0.1 mL (Narcan) to be sprayed in one nostril and another multi-step kit with 2 mg/2 mL, spraying 1 mL in each nostril with the use of an atomizer device that the user must attach to the syringe. Each of the formulations comes with two doses of naloxone—the second dose is to be administered after 2 to 3 minutes if there is no response. When prescribing naloxone, it is sometimes helpful to discuss with your local pharmacy the formulations they carry and which ones are on the patient's insurance formulary.

The CDC's *Guideline for Prescribing Opioids for Chronic Pain,* published in 2016, recommended OEND to any patient or household member of a patient receiving opioids who has a history of overdose, is prescribed high doses of opioids (> 50 morphine mg equivalents per day), has a history of a substance use disorder, or is also taking benzodiazepines (Dowell D et al, *MMWR Recomm Rep* 2016;65(1):1–49). Any prescriber can prescribe naloxone, and states now have "standing orders" or "pharmacy access laws" allowing anyone to access naloxone without a prescription (and often covered by that person's prescription insurance plan). (For links to specific state laws, see: www.tinyurl.com/w8o936s.) It should be noted that some individuals, including health care providers, have been denied life insurance because of filling a naloxone prescription. This is an unfortunate barrier to expanding access to naloxone. Patients and health care providers filling prescriptions for naloxone may wish to contact life insurance providers to explain their reasoning for doing so.

Syringe and needle exchange

Another harm reduction strategy specifically for IV drug use is syringe and needle exchange. Exchange programs are designed to reduce the spread of infections from sharing needles, including hepatitis B and C, HIV, or soft-tissue infections such

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Welcoming Our New Editor-in-Chief

We're pleased to introduce Benjamin Oldfield, MD, MHS, as the new editor-in-chief of *The Carlat Addiction Treatment Report.* Dr. Oldfield is a clinical instructor at the Yale School of Medicine, and medical director of population health at Fair Haven Community Health Care where he provides addiction treatment to adults and adolescents. He attended Harvard Medical School and trained in medicine and pediatrics at Johns Hopkins Hospital. He then received advanced training in addiction and health services research at the Yale National Clinician Scholars Program. Dr. Oldfield's academic interests include addiction treatment among vulnerable populations, including youth and people with HIV.

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as abscesses. They safely dispose of used syringes and needles and provide sterile injection equipment to patients. These programs were first developed in the 1980s as the AIDS epidemic erupted; they have since become more widespread. As you might expect, syringe exchanges are more controversial than OEND programs because they directly provide drug paraphernalia. However, over the past three decades, syringe exchange programs have been associated with decreasing prevalence of viral infections. For example, New York's legalization of syringe exchange programs between 1990 and 2002 was associated with a decrease in HIV incidence in the drug-injecting population, with a strong inverse relationship between HIV incidence and the number of syringes distributed (Des Jarlais DC et al, *Am J Public Health* 2005;95(8):1439–1444).

Syringe exchange programs can also be entry points for patients into various forms of treatment, including viral infection testing, referrals to both infectious disease and addiction treatment, overdose education, naloxone distribution, and safer sex and injection counseling (Des Jarlais DC, *Harm Reduct J* 2017;14(1):51). The North American Syringe Exchange Network has a map to locate syringe exchanges in your state and other substance use resources: www.nasen.org/map. These programs are recorded by self-report only and are currently listed in 39 states. Some pharmacies may also dispense syringes. While some states require a prescription, many allow over-the-counter sales. For a good resource that lists specific policies in your state, see: www.tinyurl.com/tbtal7b.

Fentanyl testing

Fentanyl has been a major contributor to overdose deaths since 2013 and is now widely found in the North American heroin supply. In 2017, more than 28,000 deaths involving synthetic opioids like fentanyl occurred in the United States, more deaths than from any other type of opioid (Scholl L et al, *Morb Mortal Wkly Rep* 2019;67(5152):1419–1427). West Virginia, Ohio, and New Hampshire had the highest death rates from synthetic opioids. Fentanyl's deadliness lies in its higher potency and strong receptor affinity, which means that large doses of naloxone are required to reverse respiratory depression from a fentanyl overdose. Even a few grains of fentanyl contaminating a supply of heroin or other opioid can be lethal.

People who use opioids may be unaware that fentanyl has contaminated their drug supply. To empower people who use opioids with this information, fentanyl testing strategies are becoming more common. Fentanyl test strips can be applied to a small sample of heroin after mixing it with water—or to the rinse-water after a batch of heroin is cooked up—and within 1 minute a person can know if fentanyl is in the sample or not. When used in this way, the test strips have been found to be > 96% sensitive and > 90% specific for fentanyl (www.tinyurl.com/t8osks5). While test strip distribution to people who use opioids is still new, evidence supports inclusion of fentanyl testing in comprehensive harm reduction programs (Goldman JE et al, *Harm Reduct J* 2019;16(1):3). Inquire with your local harm reduction organization or syringe exchange program about the availability of fentanyl test strips.

Pre-exposure prophylaxis

Another harm reduction strategy for preventing the spread of HIV is offering pre-exposure prophylaxis (PrEP) for people who inject drugs. (PrEP is also indicated for patients otherwise at increased risk for HIV infection.) PrEP is the daily use of antiviral medication in order to prevent the spread of HIV (see *CATR* Nov/Dec 2019 for more detail); the medication used is typically either Truvada (emtricitabine and tenofovir disoproxil fumarate) or Descovy (emtricitabine and tenofovir alafenamide). Discuss PrEP with anyone who is sharing injection equipment or who is at increased sexual risk for HIV infection (US Preventive Services Task Force; Owens DK et al, *JAMA* 2019;321(22):2203–2213). In most clinical trials of PrEP in these populations, HIV infection rates were reduced by 50%–85%, depending on the adherence rate.

CATR VERDICT: Harm reduction strategies have been proven to reduce negative consequences of opioid use, can empower patients to make more informed choices about drug use, and can serve as entry points into other treatment services. The strategies outlined here—OEND, syringe exchange, fentanyl testing, and PrEP—not only reduce harm but save lives. Get to know local harm reduction policies and programs where you can refer your patients, or get involved yourself to offer some or all of these services.

A Patient-Centered Guide to Managing an Opioid Overdose	
STEP 1 Assessment	• Look for the classic triad of an opioid overdose: • Slow breathing • Not awakening • Very small pupils • If the person becomes unresponsive, vigorously rub your knuckles into the sternum (the breastbone in the middle of the chest) or pinch the ear lobes to "wake up" the person.
STEP 2 Call 911	• Opioid overdoses need immediate medical attention. • Regardless of whether the person arouses, 911 should be called right away.
STEP 3 Administer Naloxone	• If the person doesn't respond within 2 to 3 minutes after giving naloxone, give a second dose of naloxone. Some people will require additional doses while waiting for emergency services to arrive.
STEP 4 Support Breathing	• If the person doesn't have a pulse and isn't breathing, CPR will be needed. • If the person has a pulse but isn't breathing, perform rescue breathing by giving 1 breath every 5 seconds.
STEP 5 Monitor Response	• Because naloxone has a short duration, overdose symptoms may return. It is critical the person be transferred to the emergency department ASAP, even if there is a full revival after receiving naloxone. • It's also important to encourage the person overdosing not to use more opioids, even though the withdrawal introduced by the naloxone may be uncomfortable.

Expert Interview

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happens to them when they get incarcerated and how these systems make them feel. How do they make it? Who doesn't make it? How can we do better?

CATR: What drew you to this topic?

Dr. Sue: I was in medical school when I was doing most of this research, and I began to think about the limits of the clinic. There are basic needs that people leaving prison and jail and people with substance use disorders don't have met, and we need to figure out how we can fulfill those needs. For example, I brought someone with chaotic heroin use to the clinic for primary care after she'd had a bout of necrotizing fasciitis, and I was hoping for buprenorphine. The attending said, "Let's get all of these labs; let's do blood work." The person I was working with had just experienced someone overdosing and dying. She had come home from breakfast and he was dead. And the attending meant well, but he really wasn't able to meet the woman where she was at and prioritize what she needed. Securing blood work for someone who's got chaotic IV heroin use is painful, difficult, and sometimes impossible. Getting 6 to 10 tubes on the first visit was alienating—it led to lack of engagement.

CATR: Some say harm reduction is about "meeting people where they're at." Can you define harm reduction?

Dr. Sue: There's no one simple definition. At the Harm Reduction Coalition, we've been talking about harm reduction in a couple of ways. It is part of a broader movement based on political liberatory frameworks that shift power and resources to people vulnerable to structural violence (Farmer P et al, *PLoS Med* 2006;3(10):e449). And then we have "lowercase" harm reduction, which is a broad range of strategies that are practical in nature, aimed at reducing the negative consequences associated with drug use. Sometimes I meet people who are working out of one or both of those frameworks, and they are practicing harm reduction without knowing it. They just believe in meeting people where they are at and accepting people's use, not making judgments or moralizing, not trying to force people to do any one particular thing.

CATR: So harm reduction is an approach that can be used by different kinds of people and professionals.

Dr. Sue: Correct. You don't need any special training to practice harm reduction. A lot of people practice it within their own families: for example, having naloxone in the house and knowing how to use it if their son or daughter is struggling with substance use.

CATR: Some would say that harm reduction may increase risk-taking behavior. In your opinion, how should practicing clinicians weigh the benefits of harm reduction versus the potential risks?

Dr. Sue: I actually see the number of ways in which people start using more safely as a means into a steadier form of engagement and retention—whether that's in drug treatment or in primary care or just generally engaging with health care. So many people have walked into a syringe service program, accessed sterile supplies, and learned sterile injection techniques. When they are treated with respect and dignity, they feel like they are worthy, and they are then more willing and able to access treatment or additional care.

CATR: Let's unpack this a bit. How might this look for an individual patient?

Dr. Sue: Say a patient is a heroin user and is going to inject because of the onset of withdrawal symptoms upon waking up in the morning. That patient is going to use one way or another. It might happen locked away in a convenience store bathroom, where the patient has no light, is struggling to find a vein, and isn't following sterile practices. The patient might be using a previously used syringe, miss a vein, or accept the risk of an abscess. And it's chaotic. There's no space, time, or light. Contrast this with using in a place that is sterile and well lit; a place where there are people who have naloxone who could reverse an overdose if needed; a place where the patient has time and doesn't have to rush and cut corners.

CATR: How can clinicians begin to discuss harm reduction with patients?

Dr. Sue: First of all, I think it's critical to understand people's practices. If they are injecting, we can say, "Walk me through how you're injecting." If people are sharing equipment, are they using one syringe per injection, or are they reusing syringes? Are they sharing cookers and other paraphernalia? Are they using sterile water or are they injecting with water from puddles under the bridge? Obviously, the latter can lead to infection. There are other harm reduction strategies that involve choosing a safer way to use.

CATR: Can clinicians help patients identify ways of using drugs that may be safer than others?

Dr. Sue: Yes. Sniffing rather than injecting is one. Intranasal instead of intravenous use decreases a person's risk of HIV and hepatitis C. I'll give you a couple of examples for methamphetamine use, too. We encourage people who are using methamphetamine to set a time limit or dollar amount on their use (per day or per week). We try to keep people hydrated and make sure they have condoms, since we know that a lot of people use methamphetamine to enhance

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"There is some great information and booklets on the Harm Reduction Coalition website (www.harmreduction.org). We have a publication called *Getting Off Right* that goes through things that I never knew how to do—for example, how to do a safer injection. This is not something I'd learned how to counsel about in med school."

Kimberly Sue, MD, PhD

How to Talk to Patients About the Risk of Opioid Overdose

There were 47,600 deaths due to opioid-related overdoses in 2017. Put another way, in the time it'll take you to read this issue of *CATR*, almost 5 Americans will die from an opioid overdose (www.cdc.gov/drugoverdose/data/statedeaths.html). One important way to reduce risk is by empowering patients with the knowledge, skills, and tools to prevent and manage overdoses. This article will focus on how to talk to patients to do just that.

Preventing overdose

When addressing overdose risk, begin by having your patients tell you about how they use opioids. Your curiosity will help build an alliance with the patient; it'll also allow you to point out strategies to reduce harm. Be sure to mention specific factors that increase risk, such as concurrent benzodiazepine, gabapentinoid, or alcohol use; the possibility of fentanyl contamination; using alone; and changing dealers. Another high-risk situation is when people come out of incarceration, a hospital, or a residential program. If patients haven't used any opioids for even a few days and then start taking them again, they'll be at increased risk of overdose, especially if they go back to their previous amount, because they will have lost their former tolerance (this is called "tolerance shift"). See the table below for discussion points on reducing the risk of overdose. For additional information about how to discuss overdose risk with patients in various settings, see www.prescribetoprevent.org.

Next, talk to your patients about naloxone. In 2018, the US Surgeon General issued a recommendation that more people, including family, friends, and those at risk for opioid overdoses, keep naloxone (Narcan, Evzio) on hand. Ask your patients if they have naloxone at home, if the prescription has been renewed within the last year, if they know how to administer it, and if they've instructed others around them on how to use it. Many states have standing orders from medical directors that enable patients and family members to get prescriptions from a pharmacy without seeing a provider.

Assessing for overdose

Be sure to tell your patients to watch for the classic signs of an opioid overdose using language they'll understand (eg, "cold, clammy hands and bluish lips" instead of "poor perfusion and hypoxia"). If a patient experiences these symptoms, emergent action is required. See "Patient-Centered Guide to Managing an Opioid Overdose" on page 3. (*Ed note:* A great resource, published by SAMHSA, from which this section was drawn, is the Opioid Overdose Toolkit. It's available at www.store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742.)

Preventing an Opioid Overdose

Step	Notes
Know the risks of misusing opioids	Risks include developing an opioid use disorder, overdose, infection, and legal repercussions.
Know your tolerance	Tolerance will shift (decrease) after periods of abstinence or when transitioning from one opioid to another.
Know your supply	When supply changes, it can be helpful to do a "tester dose" (10% of a normal dose) to start.
Beware of the dangers of mixing drugs, especially sedatives with opioids	Sedatives include prescription and allergy medications, alcohol, or other recreational drugs.
Try not to use alone	If this does occur, it's best to make sure someone else is aware and can check in.
Make a safety plan	For an example, see www.tinyurl.com/ty9xest.
Use drug testing resources, like fentanyl strips	Encourage a "tester dose" (10% of the usual dose) if fentanyl is suspected. Local organizations may distribute fentanyl test strips to identify fentanyl in illicit products. These can keep patients from overdosing.
Have a naloxone kit accessible	Patients should educate family, friends, and those at risk for an opioid overdose on how to use a kit.

Good Samaritan laws

Patients engaged in illicit drug use may not want to get involved in a crisis due to fears of legal repercussions, such as arrest, loss of public housing, or loss of benefits. This means many lay responders don't call 911. As of July 2017, 40 states have passed Good Samaritan laws safeguarding individuals who report an overdose from certain criminal sanctions (Watson DP et al, *Harm Reduct J* 2018;15(1):18). However, these protections vary by state, and you should know your state's laws; begin by consulting www.tinyurl.com/wjbojlg.

Good Samaritan laws can include protection from arrest, charge, and prosecution for both controlled substance and paraphernalia possession. For example, New York law protects the individual who is overdosing AND the person who calls 911 from any prosecution for drug possession of alcohol (up to 8 oz; for underage drinkers) or marijuana (any amount), paraphernalia offenses, and sharing of drugs. The law may also provide protection for other crimes, such as probation or parole violations.

These regulations work. Persons with knowledge of Good Samaritan protections or those who have previously used naloxone are more likely to call 911 at the scene of an overdose (Watson, 2018). Furthermore, states with Good Samaritan laws have a lower incidence of opioid-overdose mortality than those without such laws (McClellan C et al, *Addict Behav* 2018;86:90–95).

CATR VERDICT: An important, patient-centered strategy for turning the tide of opioid-related overdose deaths is to talk to your patients about the risks of using opioids and what to do in an emergency. Use language they can understand and encourage patients to train those around them (friends, family, and peers) in the use of life-saving measures like naloxone.

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sexual activity. For each substance, you can go through different harm reduction strategies. And a lot of it entails having some compassion and curiosity and respect about how people actually use drugs and then doing some research about how people can use more safely.

CATR: How should clinicians educate themselves about what harm reduction modalities are available to them and their patients?

Dr. Sue: It's a varied landscape. I would recommend first familiarizing yourself with the laws. Are syringe exchanges or syringe access programs legal in your state? You can look that up in the LawAtlas (www.lawatlas.org). Sometimes they are legal but only for people that have a certain kind of card. Those people that have the card might still get arrested for having a syringe, or they might get arrested for having a cooker but not a syringe because only syringes are part of the legislation—even though we know that cookers transmit and hold HIV and hepatitis C for days as well.

CATR: Where does naloxone fit in?

Dr. Sue: In a primary care clinic in Massachusetts General Hospital Charlestown where I trained, we figured out ways of making harm reduction kits. These included naloxone and different sterile injection supplies. Being able to hand naloxone to people who are at incredibly high risk is so important, and it's vital that we lower the barriers to these life-saving harm reduction measures.

CATR: Why might this be better than simply writing a prescription for naloxone or referring to an outside organization?

Dr. Sue: Taking that approach can work sometimes, but it also involves enormous barriers for the patient. If you write a prescription for naloxone, have you gone to the pharmacy to see how that actually shakes out? What's the copay? Is the process stigmatizing? How are you treated? Unfortunately, these experiences can be logistically complicated, discriminatory, and shameful for patients—enough so that they might be driven away from care.

CATR: What are some emerging topics in harm reduction that clinicians might see in the future?

Dr. Sue: It's important to know about safe consumption spaces and the concept of a safe supply. Safe consumption spaces are important for all substances and routes of administration, not just opioids and not just intravenous use. It's important to think about people who smoke crack and/or meth. An argument in favor of safe consumption spaces is that they protect people from police. The criminalization of people who use drugs has terrible consequences. And if someone is using meth and is having a paranoid delusion, having a safe space where the delusion can pass without the patient possibly being persecuted, prosecuted, hurt, injured, or killed by police is a safer alternative.

CATR: Do safe consumption sites exist in the US?

Dr. Sue: There's an organization in Philadelphia called Safe House that is vying to be the first above-board legal site (Burris S et al, *N Engl J Med* 2020;382(1):4–5). It would be a place where people can bring and consume illicit substances that they've purchased, with the benefit of doing so in a facility that has harm reduction services and the ability to reverse overdoses. There are over a hundred of these sites around the world, and there have been no fatalities in them. So we do know that having places for people to use drugs more safely does not increase the risk of people using drugs.

CATR: You also mentioned safe supply.

Dr. Sue: Yes. There was a famous paper, the SALOME trial, that compared diacetylmorphine (heroin) to hydromorphone (Dilaudid) in the treatment of opioid use disorder and found that both had great retention and engagement (Oviedo-Joekes E et al, *JAMA Psychiatry* 2016;73(5):447–455). The idea of safe supply means access to IV diacetylmorphine; in this case it was made by the Canadian government—it was pharmaceutical grade. They also learned in that study that when they ran out of IV diacetylmorphine, they used IV hydromorphone for everyone, and generally people couldn't tell the difference. The idea now is that IV hydromorphone can be used for the treatment of opioid use disorder—at least in Vancouver and many other places. Medical use of diacetylmorphine is still illegal in the US.

CATR: In addition to reading your book, where can we learn more about harm reduction?

Dr. Sue: There is some great information and booklets on the Harm Reduction Coalition website (www.harmreduction.org). We have a publication called *Getting Off Right* that goes through things that I never knew how to do—for example, how to do a safer injection. This is not something I'd learned how to counsel about in medical school.

CATR: Anything else you'd like to add?

Dr. Sue: I feel strongly that practicing clinicians often disregard the dignity, autonomy, and well-being of people who use drugs—to the point that what clinicians say and do can actually increase harm and increase death. Whether you're a generalist or whether you're taking care of people with substance use, be nice to people who use drugs and understand that they come with long histories of trauma and disrespect at the hands of health care providers. That's something that I've learned being in the trenches with people who use drugs, who are cast into the shadows and the alleys. I don't think that you need to know all the answers, but I think that respecting patients as experts in their own bodies and in their own lives has really opened and changed my relationship with my patients. When you talk to people with respect and you stop trying to force a square peg into a round hole, your life as a provider changes. You change the dynamic between you and your patients so that it is much more level and comes from a place of mutual respect and mutual learning.

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

Research Update

TECHNOLOGY

A New Hope: CBT for Internet and Computer Game Addiction

REVIEW OF: Wölfling K et al, *JAMA Psychiatry* 2019;76(10):1018–1025

While many of us likely spend far too much time on our various devices—whether for fun or for work—between 0.3% and 1% of the general population might qualify for an internet gaming disorder (Przybylski AK et al, *Am J Psychiatry* 2017;174(3):230–236). Defined as excessive preoccupation with online gaming despite negative life consequences, internet gaming disorder was identified in the 2013 publication of the DSM-5 as a condition warranting more clinical research and experience before it might be considered for inclusion as a formal disorder. In a recent multicenter randomized clinical trial, researchers evaluated the effectiveness of short-term cognitive behavioral therapy (CBT) for internet addiction.

The study randomly assigned 143 patients with DSM-5-proposed research criteria for internet and computer game disorder to short-term CBT (n = 72) or wait-list control (n = 71) and followed them for 6 months. The mean age was 26.2 years, and most participants were single, high school educated, and unemployed. All were male, which was intentionally reflective of the preponderance of treatment seekers.

The treatment group underwent 15 weekly groups of manualized CBT and up to 8 individual sessions that conceptualized their disorder as resulting from an interaction of individual factors, features of online activity, dysfunctional coping strategies, and disorder-specific cognitive biases. The primary outcome was remission based on a self-report measure, the Assessment of Internet and Computer Game Addiction (AICA-S). Secondary outcomes included

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CE/CME Post-Test

To earn CME or CE credit, log on to www.TheCarlatReport.com with your username and password and take the post-test. You will be given 2 attempts to pass the test. You must answer at least 75% correct to pass. Tests must be completed within a year from each issue's publication date. The Carlat CME Institute is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Carlat CME Institute is also approved by the American Psychological Association to sponsor continuing education for psychologists. The Carlat CME Institute maintains responsibility for this program and its content. The Carlat CME Institute designates this enduring material educational activity for a maximum of one (1) *AMA PRA Category 1 Credit*™ or 1 CE for psychologists. Physicians or psychologists should claim credit commensurate only with the extent of their participation in the activity.

These questions are intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Learning objectives are listed on page 1.

1. Which formulations of naloxone are laypeople allowed to administer for opioid overdose reversal? (LO #2)
   [ ] a. Subcutaneous and intramuscular
   [ ] b. Intranasal and subcutaneous
   [ ] c. Intranasal, intramuscular, and subcutaneous
   [ ] d. None of the above

2. According to a 2019 study, subjects receiving short-term cognitive behavioral therapy (CBT) for internet and computer game disorder achieved a remission rate of _____. (LO #3)
   [ ] a. 39%
   [ ] b. 49%
   [ ] c. 59%
   [ ] d. 69%

3. Overdose education and naloxone distribution (OEND) is a harm reduction strategy targeted toward both the opioid-using and non-opioid-using population. (LO #1)
   [ ] a. True
   [ ] b. False

4. States with Good Samaritan laws, which provide safeguards to individuals who report an overdose, have a lower incidence of opioid-overdose mortality. Which of the following is true about Good Samaritan laws? (LO #2)
   [ ] a. People with a record of more than 2 naloxone uses on themselves are less likely to receive Good Samaritan protections for a future overdose
   [ ] b. As of 2018, all states in the continental US have passed Good Samaritan laws
   [ ] c. Persons with knowledge of Good Samaritan laws are more likely to call 911 at the scene of an overdose
   [ ] d. Good Samaritan laws cannot provide protection for other crimes, such as drug possession

5. Recent studies have shown that rapid fentanyl test strips, used to detect fentanyl in illegal drugs, are not an effective harm reduction strategy to reduce opioid overdose risk. (LO #1)
   [ ] a. True
   [ ] b. False

6. One of the limitations to a 2019 study of short-term CBT for internet and computer game disorder that affected the investigators' assessment of remission rates at 6 months included: (LO #3)
   [ ] a. High dropout rate
   [ ] b. Inaccurate sample size population
   [ ] c. Comorbidity of other addiction disorders
   [ ] d. Low effect size

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time spent gaming or online, psychosocial functioning, and depressive symptoms.

The researchers found 69.4% of patients in short-term CBT achieved remission compared with 23.9% of those wait-listed ($p < .001$). There was a greater likelihood of remission in short-term CBT vs wait-list after controlling for age, baseline severity, and comorbidity (adjusted odds ratio 10.10; 95% confidence interval 3.69–27.65). Both groups had improved depression ratings, which may have reflected repeat assessments and the prospect of future treatment for those wait-listed. At 6-month follow-up of half the patients in the short-term CBT group, 80.6% were in remission, but the authors claim this result is difficult to interpret owing to high rates of study dropout and the fact that follow-up data was not sought for the control group.

CATR'S TAKE

The results of this study offer hope for effective treatment of internet and computer game addiction. Still, more research is needed to better define these conditions, examine treatments among women, and compare short-term CBT with other treatments. When managing a patient struggling with problematic gaming and/or internet use, consider CBT as an option, especially as it is widely used for other addictive disorders.

—C. Jason Mallo, DO. Dr. Mallo has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.