Title	Position Statement - Medication Assisted Treatment Guidelines for Substance Use Disorders
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Medication Assisted Treatment Guidelines for Substance Use Disorders

Treatment of Substance Use Disorders (SUD) has been plagued by high dropout rates, relapse rates and readmission rates. A range of care with a tailored comprehensive treatment program and follow up options can be crucial to success. Treatment should include both medical and mental health timely services as needed. Effective prevention and treatment strategies exist for alcohol and opioid misuse and addiction but are highly underutilized across the United States.

Medications used primarily to treat ***intoxication and withdrawal states*** will require consistent use of standardized withdrawal measuring scales (CIWA-AR, CIWA–B, COWS) to evaluate severity of withdrawal signs and symptoms and determine appropriate taper of substitution meds:

Opioid overdose:

- naloxone

Opioid Detox Protocols

a. Using opioid substitution:

  - Buprenorphine
  - Methadone
  - Other opioids

b. Using clonidine

Alcohol Detox Protocols:

a. Using benzodiazepine substitution
b. Using phenobarbital substitution
c. Using anticonvulsants meds (gabapentin, carbamazepine)

B vitamins, especially B12, folate, thiamine and PRN comfort meds addressing peripheral symptoms of withdrawal should be used as needed.

Sedative-Hypnotics Detox Protocols:

a. Using phenobarbital substitution
b. Using clonazepam substitution
c. Using other benzodiazepine substitution.
B vitamins, especially B12, folate, thiamine and PRN comfort meds addressing peripheral symptoms of withdrawal should be used as needed.

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retaining rates in the recovery path. These best practices recommended by National Institute of Drug Abuse (NIDA) and American Society of Addiction Medicine (ASAM) regarding Medication Assisted Treatment implementation include:

- Medication to decrease urges or cravings for:
    - Alcohol
        - Acamprosate: 666mg TID; this should be offered as an integral part of the SUD treatment recommendation to all alcoholic patients reporting cravings >3/10 as soon as they have completed Detox and throughout their SUD treatment stages for as long as they experience cravings.

- Medications to decrease the reinforcing effects of:
    - Alcohol
        - Naltrexone: usual daily dose is 50mg; this should be offered as an integral part of the SUD treatment recommendation to all alcoholic patients reporting ongoing cravings and showing early recovery impaired coping skills, living and/ or working in triggering settings and longing for the "alcohol high."
        - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered as part of the integral treatment plan recommendations to the same patients as noted above after they have shown good tolerance to Naltrexone PO and continue to be considered at high risk for relapse.
    - Opiates
        - Naltrexone: patients must be opioid free 5-7 days; this should be offered as an integral part of the SUD treatment recommendation to all opioid use disorder patients reporting ongoing cravings and showing early recovery impaired coping skills, living and or working in triggering settings and longing for the "opioid high."
        - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered as an integral part of the treatment planning to the same patients as noted above after they have shown good tolerance to Naltrexone PO and

continue to be considered at high risk for relapse.

- Agonist or mixed agonist/ antagonist maintenance therapies for:
    - Opiates: these should be offered as part of the treatment planning options to opioid use disorder patients who have repeatedly failed to sustain abstinence despite prior completion of rehabilitation treatment.
        - Methadone: 40mg/day – 60mg/day (sometimes less) of methadone is usually sufficient to block opioid withdrawal symptoms. Higher doses (80-120mg/ day) have been shown to curb dramatically additional use of opioids.
        - Buprenorphine used in implant (Probuphine) or long acting injectable (Sublocade or Brixadi) formulation for long term maintenance.
        - Buprenorphine/naloxone combination (ranging between 4mg/0.5mg – 32mg/8mg per day, sublingual in divided doses). Doses used more frequently in the outpatient ambulatory setting include 16mg/4mg per day sublingual or less and typically require monthly visits for renewal as well as continued participation in SUD treatment or recovery community support systems.
- Abstinence-promoting and relapse prevention therapies for:
    - Alcohol
        - Disulfiram: usual dose 250mg/day, rarely: 125mg/day – 500mg/day (potentially aversive if used with alcohol). This medication can be helpful in those patients who have a track record consistent with frequent relapse and inability to maintain abstinence for an extended period. Breathalyzer testing to assure compliance and continued abstinence and liver function tests should be checked periodically. This treatment should be withdrawn in patients who consistently demonstrate a failure to remain abstinent from alcohol despite the aversive effects.

Overcoming the misunderstandings and other barriers that prevent wider adoption of these treatments is crucial for tackling the problem of alcohol and opioid addiction and the epidemic of opioid overdose in the United States.

Within the context of the opioid epidemic, in California, Legislation AB 2760 may require prescribers to offer Naloxone to patients when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.
(C) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

Consistent with the existing standard of care, physicians must provide education to patients receiving a prescription under this law on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression. This education must also be offered to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

Resources:

NIDA: https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

California legislation AB 2760: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB2760

SAMHSA:

https://www.samhsa.gov/medications-substance-use-disordershttps://www.samhsa.gov/medications-substance-use-disorders/provider-support-services/recommendations-curricular-elements-substance-use-disorders-training

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