Core Competencies for Use of Collaborative Care in the Treatment of Substance Use Disorders

A Psychiatrist's Guide

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Opioid Response Network

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Overview

The Collaborative Care Model (CoCM) is an evidence-based approach to deliver behavioral healthcare in primary care settings. This model has been adapted to address substance use disorders in primary medical settings. CoCM requires a team of providers; trained primary care providers (PCP) work with embedded behavioral health care managers (BHCM) to provide a range of effective treatment, including evidence-based medication and/or psychosocial treatments. The PCP and BHCM are supported by a psychiatric consultant who engages with the team primarily through indirect care through regular case consultation and treatment adjustment for patients who are not improving as expected. Ideally, a counselor/psychotherapist will be available (internally or externally) to receive referrals when indicated.

CoCM Evidence Base

The Collaborative Care Model has a strong evidence base with over 90 randomized controlled trials (RCTs) showing that this team-based approach can improve outcomes for a range of behavioral health conditions. A 2010 Cochrane review included 79 RCTs and 24,308 participants and reported that patients with depression and anxiety treated with the CoCM demonstrated significantly greater improvement in mental health outcomes. The largest trial of CoCM to date is the IMPACT trial, (Unützer J, et al. 2002) which included 1,801 patients and showed that CoCM more than doubled the effectiveness of depression treatment, was well received by patients and providers and was equally effective in black and Latino patients (Arean P, et al. 2005).

More recent studies have explored the effectiveness of CoCM to treat patients with substance use disorders. A recent systematic review of integrated care models for patients with alcohol use disorder in primary care concluded that across studies, integrated care models can increase treatment uptake, and that alcohol-related outcomes in studies varied (Rombouts SA, Conigrave JH, Saitz R et al. 2020). The SUMMIT trial (Watkins KE, Ober AJ, Lamp K et al. 2017) reported that treatment with collaborative care resulted in a significantly greater proportion of individuals receiving higher quality of care and reporting abstinences from opioids or alcohol at 6 months. This trial also examined the cost-effectiveness of this care. Findings suggest that the costs of a CoCM program are likely to be offset by savings of 25% if patients with OUD receive treatment in a panel size of about 85, while achieving better patient outcomes (Lee CM, Scheuter C, Rochlin D, et al. 2019).

In summary, there is a strong and expanding evidence-base for using CoCM to provide access to behavioral health services for a variety of conditions in primary medical settings.

Principles of Collaborative Care Model

Across the various trials of collaborative care, five key principles have been identified as core elements of effective care. These principles, along with core components and tasks, were developed in consultation with a group of national experts in integrated behavioral health care in 2011 with support from The John A. Hartford Foundation, the Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California Health Care Foundation.

Patient-Centered Team Care: This approach requires the collaboration of both primary care and behavioral health providers. The three core roles include: a primary care provider who continues to serve as the primary provider and prescriber for the patient, a behavioral health care manager who provides both care coordination and brief psychosocial treatment and a psychiatric consultant who leverages expertise through routine indirect systematic case review.
Population-Based Care: In CoCM, a defined group of patients with active symptoms are identified to be in need of care. These patients are tracked in a registry to allow for proactive care, including efforts to engage patients who are not

engaging in care and to adjust treatment of patients who are not improving. The use of a registry is considered a core component of care.

Measurement-Based Treatment to Target: Patient progress on personal goals and clinical outcomes is monitored in CoCM through routine use of behavioral health measures. Measures should be used at each contact where there is the opportunity to intensify treatment if needed. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

Evidence-Based Care: In CoCM, sites should offer patients the opportunity to engage in a full range of effective treatments, typically including both medications and psychosocial treatments.

Accountable Care: Strong CoCM teams routinely monitor both processes and outcomes of care and engage in continuous quality improvement to optimize the work of the CoCM team.

Legal Implications

Delivering care as a team, especially the indirect care provided by the psychiatric consultant, may be a new scope of practice. It is important to note that CoCM is not meant to be a substitute for direct psychiatric care if that is needed. However, in many practice settings, CoCM may allow patients more access to care and improved behavioral health outcomes when access to direct psychiatric care is limited. The American Psychiatric Association (APA) has created a source document that provides guidance about best practice management approaches to delivering this type of care, including obtaining malpractice coverage if consultation is being provided outside of the organization where the psychiatrist is employed.

Implementation Considerations

Delivering CoCM takes considerable practice change, and a more structured approach to implementation can facilitate the delivery of high-quality integrated SUD care. An overview of the implementation process can be found on the Advancing Integrated Mental Health Solutions (AIMS) Center website: http://aims.uw.edu/collaborative-care/implementation-guide, and additional resources to support this process are available from the APA: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement.

An overview of the implementation process and key considerations for delivering CoCM for SUD are outlined below. Even if the practice has been delivering integrated care for common mental health conditions, practices and providers may have a wide range of experiences with delivering SUD care and making sure each step in the implementation process is considered as a practice expands care to include SUDs and can support a more successful effort.

- **Lay the Foundation (Exploration)**: This phase of implementation prepares the practice to make the commitment to practice change needed to deliver CoCM. This step identifies gaps between care as it is now and the future vision for access to SUD care.
  - Develop understanding of CoCM for SUD: It may be helpful to assess the experiences of all team members related to engaging and treating patients with SUD. This should include anyone that will be part of the success of the program, including providers, clinical leadership, and support staff, such as the front-desk staff and medical assistants.
  - Enhance advocacy and commitment in practice for SUD care: This may require education for the whole team. For example, many providers may have had limited experience with newer effective SUD treatment approaches, such as harm reduction.
  - Create a vision for SUD care delivery: Gathering input from all practice partners about their goals for successful

SUD care can help identify three to five priorities. For example, it may be helpful to determine if specific disorders will be targeted and how the practice will measure success. An actual written vision and measures are strategic to shape the rest of the implementation process.

- **Plan for Clinical Practice Change (Preparation):** Successful delivery of SUD care will require the whole team to work in new ways. This phase allows the team to consider the workflows and training needed.
  - Consider the best approach to identifying patients in need of SUD care: Patients with SUD may present less frequently than patients with depression or anxiety. Teams will need to consider the best screening and referral approach for the population served.
  - Build registry capacity for SUD care: The team will need a way to track all the patients who have been identified as needing care. Additionally, the team will need to identify measures that can be used to track response to treatment.
  - Create SUD care clinical workflows and protocols: This will require consideration of all the steps in an episode of care for a patient. In this process, the team may identify the need for additional provider training in any SUD treatment approaches that have not been offered previously.
  - Consider SUD quality metrics: Using the goals identified during the visioning process can inform the development of quality measures. It can be helpful to identify both process measures (for example completed intakes for patients with SUD, regular follow up for SUD care) and outcome measures (for example patients stable on medication for opioid use disorder [MOUD]). Once measures are identified, planning to be able to regularly measure and report data on these quality measures will set up your program to optimize and sustain care.
  - Develop funding strategy for SUD CoCM: It may be helpful to consider sources of reimbursement and billing for SUD care as they may inform workflow and clinical provider selection. For example, Medicare has CoCM codes that are general for CoCM, and there are additional specific codes for OUD care. Each of these billing approaches have specific requirements that need to be tracked.

- **Build Clinical Skills (Preparation):** All members of the clinical and administrative team may need education and training to deliver CoCM for SUD. Clinics must clearly define team member roles, create a workflow, and identify how to track SUD treatment and outcomes.
  - Consider SUD training needs: Include all members of the team, including front desk staff, medical assistants, nursing, management, clinical team. Team members will likely have variable experience and comfort delivering SUD care.
  - Describe SUD care key tasks: These may include patient identification and engagement, treatment initiation, outcome tracking, treatment adjustment and relapse prevention as potential training topics.
  - Utilize the many available resources: Trainings from national organizations are available for both SUD and CoCM. Please see the list of resources.
  - Plan to practice key skills as a team before launching SUD clinical care: For example, consider a walk-through of the care team approach to supporting a home induction for buprenorphine.

- **Launch Care (Implementation):** Once the workflows have been developed and team members have been trained to offer integrated SUD care, your team is ready to deliver care.
  - Start delivering SUD care: It can be helpful to pick a start date to start offering care. Consider how best to engage the whole care setting in supporting the identification and engagement of patients in need of SUD care. Provider and staff meeting reminders can help remind people that care is now available.

- Celebrate early wins in SUD care: As a team is learning to deliver SUD care, celebrating progress toward integrated SUD care goals can help sustain motivation during the hard process of change. Consider both quantitative and qualitative results to share.
- Prepare to adjust SUD workflows: No matter how much planning goes into preparing to deliver care, all teams will need to adjust workflows and supports to optimize care. It may be helpful to remember that SUD care may be new to some team members, and additional training and support needs may be identified during the early weeks and months of offering care.

- **Nurture Care (Sustainment):** Once care is being delivered, the team can shift to monitoring integrated SUD processes and outcomes of care as part of the routine clinical processes of continuous quality improvement of the organization.
  - Monitor progress toward SUD care goals: Monitor the quality measures identified in the early phases of implementation. As your team accomplishes goals, you can consider updating vision and setting additional goals for SUD care.
  - Engage in continuous quality improvement for SUD CoCM: As areas of improvement are identified, it may be helpful to consider each of the implementation phases: Are changes needed in vision, new training needs or new workflows?
  - Share SUD care progress widely: Delivering integrated care is challenging and for clinics expanding access to SUD care there will be challenges. Taking time to celebrate progress toward goals can help the whole organization sustain their commitments and motivation.

Clinical Considerations:

Psychiatric Consultant / BHCM Interface

In delivering collaborative care, a key role of the psychiatric consultant is to meet regularly with the BHCM for case review. CoCM teams should determine the frequency of these meetings based on their needs, but systematic case review meetings typically occur weekly and typically last for 30-60 minutes (depending on the number and complexity of patients to be reviewed). During systematic case review, some patients may be identified as doing well and so only discussed briefly, while others may need more detailed discussion (Bauer AM et al. 2019). As described below, various activities occur in the regular systematic case review meetings.

Setting Expectations: It is helpful for the psychiatric consultant to identify how frequently the BHCM will meet with patients; the frequency will be based on the individual patient's current condition and needs. The psychiatric consultant should also identify which topics the BHCM will discuss with the patient. These topics can include queries about side effects, medication adherence, current symptoms, reminders of upcoming appointments, identifying social determinants of health, etc. When the BHCM meets with patients, measurement based care tools will be used to gain information for use by team in treatment planning.

Use of a Patient Registry: Tracking progress to inform treatment plan changes is a central feature of CoCM. This tracking occurs via a registry that includes all patients assigned to the BHCM. It allows the BHCM and the psychiatric consultant to easily view important information about the patient, such as the dates of their last visits with the PCP, substance use counselor/psychotherapist (if engaged in psychological care) and BHCM, as well as measurement-based treatment to target (sometimes referred to as measurement-based care, or MBC) scores, current medications, and notes made by the BHCM to prompt review at the next case review meeting. Patient registries can range in

complexity (based on the organization's needs and resources) from a clinic-generated spreadsheet to an EHR-interoperable tool. The University of Washington AIMS Center has created two registries that are available for licensing with discount pricing options for non-profit safety net organizations.

Determining Appropriate Measurement Based Care Tools: In collaborative care, measurement-based care tools are typically used each time a BHCM meets with a patient. The information gained by these tools provides the team with information for treatment planning and allows for monitoring of change over time. MBC tools are selected based on the target population. Some validated MBC tools to consider are the PHQ9 (depression), GAD7 (generalized anxiety), PCL5 (PTSD), Brief Addiction Monitor, and the Alcohol Symptom Checklist.

Motivational Interviewing: Training in this modality is available from various sources online and basic skills are useful in the BHCM's interactions with patients. The psychiatric consultant plays an important role as a coach in developing the BHCM's motivational interviewing skills.

Reviewing Scope of Practice: While meeting with patients, BHCMs may offer recommendations on topics such as sleep hygiene, tips for medication adherence, etc. At times, BHCMs may relay recommendations from PCP to patients on topics such as specifics of medication treatment. Care should be taken that the BHCM relays the PCP's medication instructions verbatim. The psychiatric consultant offers important guidance in this discussion of practice scope.

Identifying Resources: The BHCM and psychiatric consultant will work to identify the most important resources needed to optimize their patients' care. These include internal resources such as the medical assistant and scheduler/clerk associated with each PCP, case managers, and specialists such as behavioral health clinicians/counselors and staff/providers involved with MOUD teams. Important external resources may include local programs that offer medically supervised withdrawal, residential treatment programs, intensive outpatient programs, opioid treatment programs that provide methadone and therapy referral options.

Guidance for BHCM Communications to PCP: Considering the typical PCP's rapid clinical schedule and large volume of inbox messages, the psychiatric consultant offers valuable guidance to the BHCM regarding messaging. This guidance may include determining whether to message the PCP or their medical assistant, how to craft a succinct message, and the appropriate frequency of messages.

Handling Patient Crisis Situations: Clinics typically have a procedure in place for the management of crisis situations, such as a patient experiencing suicidal thinking. The psychiatric consultant and BHCM should be aware of the clinic's procedure and have the necessary contact information, which may include the schedule and means of reaching the charge nurse or 'doc of the day.' Having this information on hand is important because most psychiatric consultants may be off-site and unable to directly intervene in a crisis situation.

Approaches to Consider if Patient Engagement is a Challenge

Pursuing In-Person Meetings: As a means to develop rapport, face-to-face meetings between the BHCM and patient may be helpful. This could occur as a regularly scheduled meeting or as an informal check-in immediately before or after a PCP visit.

Use of Warm Handoffs: Meeting the patient at the time of referral is a helpful means of increasing engagement in CoCM. This can be achieved by the PCP's use of real time secure messaging to notify the on-site BHCM of a patient referral and that the patient is available to meet the BHCM before leaving the clinic.

Psychiatric Consultant / PCP Interface

Another role of the psychiatric consultant is to make treatment recommendations to the PCP, who will then implement those recommendations. This is typically performed via a message in the electronic health record or e-consult. In some cases, treatment recommendations may be relayed to the PCP by the BHCM. Including the following elements will help the PCP to understand the reasoning and intent of the psychiatric consultant.

Impression: Include the diagnosis or differential diagnosis, symptom severity, and MBC scores.
Indicate Recent Interventions: Recognizing the PCP's efforts thus far is helpful to demonstrate that the psychiatric consultant is aware of recent treatment and has incorporated that information in their recommendations. It is also helpful to build trust and deepen the team-oriented approach.

Treatment Recommendations: Indicate treatment recommendations with bullet points. Use wording to acknowledge that the PCP is the primary treater and will ultimately decide whether to utilize the consultant's recommendations. Offer stepwise recommendations that can be employed as the case continues to progress. Attempt to anticipate and offer guidance around common side effects.

Disclaimer Statement: It is important to include a statement indicating the limitations of remote psychiatric consultation. An example disclaimer statement has been generated by the UW AIMS center: https://aims.uw.edu/resource-library/example-disclaimer-psychiatric-consultants

The following are considered standard treatments for substance use disorders. These interventions are outlined for the purpose of guiding general psychiatrists seeking to expand their expertise in the treatment of substance use disorders.

Treatments for Opioid Use Disorder (OUD)

Substance use disorder (SUD) counseling is an important part of treatment for patients experiencing OUD. The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a document that outlines SUD counseling. It is useful for the BHCM and psychiatric consultant to be aware of counselors with SUD expertise who can accept referrals.

Buprenorphine induction is the process of transitioning a patient from use of another opioid to treatment with buprenorphine. The induction process is often the first step in treatment of opioid use disorder. SAMHSA created Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings that includes dosing recommendations and guidance for the induction process.

Co-prescribing of naloxone (Narcan®) is a potentially lifesaving treatment and an important component to the treatment plan for those experiencing OUD. Education of patients and supportive persons to ensure proper use is necessary when prescribing naloxone.

Complex Induction Strategies to Manage Precipitated Withdrawal: Successful induction of buprenorphine treatment necessitates the presence of early withdrawal symptoms. In some situations, such as the use of synthetic opioids (fentanyl and methadone) with unique pharmacokinetics, induction can be challenging and require more complex induction strategies. Controlled trials to inform about atypical induction strategies, such as buprenorphine micro dosing, are lacking. However, case studies are available to offer some guidance in these situations (Joao P. et al. 2021, Ahmed S, et al. 2021, Antoine D, et al. 2021, D'Onofrio et al. 2023, Cunningham CO et al., 2013, Silverstein SM et al. 2019).

Harm Reduction (Syringe Exchange, Supervised Use Areas, Test Dosing, Safe Storage, HepC/HIV Screening, Education): local departments of health typically have harm reduction programs, and many areas have harm reduction programs run by not-for-profit organizations.

Sample Treatment Recommendations Note:

THIS CASE WAS DISCUSSED IN CARE COORDINATION MEETING: The treatment considerations and suggestions are based on consultations with the patient's behavioral health care manager and a review of information available in the care management tracking system. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.

Impression:

Opioid Use Disorder
currently taking buprenorphine 16mg daily
- reporting ongoing cravings and some continued use of fentanyl
- denies access to naloxone currently

Major Depressive Disorder
- currently taking fluoxetine 20mg daily
- reports some benefit but depression symptoms continue
- most recent PHQ9 score is 19/27 (moderate symptoms)
- denied thoughts of harming self.
- past treatment has included paroxetine, which caused weight gain and treatment discontinuation.

Anxiety Disorder vs. Trauma-Related Disorder (PTSD)
symptoms reported as distressing
symptoms include frequent nightmares
- trauma history is present

Plan / Recommendations to Primary Care Provider:
1) Consider advancing buprenorphine dose to 24mg daily to address continued cravings and opioid use.
2) Recommend renewing prescription for naloxone.
3) Consider advancing fluoxetine dose to 30mg daily.
   Dose may be further advanced to 40mg after 6-8 weeks if symptoms remain distressing.
   Continue to inquire about thoughts of self-harm at each visit.
   Continue to monitor for common fluoxetine side effects (nausea, weight gain, sexual side effects).
4) BHCM will administer PCL5 at next visit to inform about possible PTSD diagnosis. If PCL5 score is higher than 33 (suggestive of PTSD), then consider initiating treatment with Prazosin 1mg QHS to address nightmares.
   Dose can be advanced by 1mg increments weekly if tolerated. Max dose = 25mg.
   Counsel about risk of blood pressure decrease and the importance of rising slowly to standing position for the first few days after starting this medication and after each dose increase.
5) Consider making referral for counseling if patient is agreeable at next visit.
6) Behavioral health care manager (Mr. X) will continue weekly contact with patient.
7) Please contact me via EHR messaging if you have questions about these recommendations.

Dr. A.
Psychiatry and Addiction Medicine Consultant

Relationship of OUD and Chronic Pain: Pain is an antecedent to development of OUD in 60% of cases (Hser YI et al. 2017). It is common for a reduction in pain to occur during treatment for OUD (Ferguson E et al. 2022). For various reasons, including a better safety profile compared to full agonist opioids, buprenorphine is increasingly used by pain specialists in the treatment of chronic pain (Kaski S et al. 2021, Pergolizzi J et al 2019). Non-opioid treatment strategies can be combined with buprenorphine to optimize pain management.

Buprenorphine Products: Buprenorphine is available in several different formulations (buprenorphine/naloxone, buprenorphine mono product, weekly or monthly subcutaneous buprenorphine).(Poliwoda S et al. 2022) The determination of which product to use is dependent on patient-specific considerations. Buprenorphine has a favorable safety profile and can be prescribed directly from a healthcare provider's office. In the past, a special waiver (DATA 2000, or "X" wavier) was required from the DEA to prescribe buprenorphine for OUD. In January of 2023 legislation was approved allowing for buprenorphine's prescription without a waiver. However, the legislation requires that practitioners applying for new or renewed DEA registration will need to attest to having completed at least 8 hours of training on opioid or other SUDs.

Methadone (Hser Y et al. 2013) as a treatment for OUD has been available since the 1960s and remains an important treatment option today. Methadone may have some advantages over buprenorphine related to retention in treatment. Methadone is similar to other full-agonist opioids in that it can cause overdose when not taken properly or when taken in conjunction with other central nervous system depressants. Methadone for the treatment of OUD cannot be prescribed from a practitioner's office. For the indication of OUD, methadone can only be dispensed from a DEA-registered opioid treatment program (OTP).

Long-acting Injectable naltrexone (Kjome KL et al. 2011) is a treatment option for patients who are no longer physiologically dependent on opioids but wish to use a treatment that can offer protection against return to use. Long-acting injectable naltrexone is a once-monthly intramuscular injection that is FDA-approved for OUD.
Clonidine is a non-FDA-approved medication that can be helpful—when used adjunctively with buprenorphine—to reduce opioid cravings that are related to stress.

Buprenorphine in Combination with Benzodiazepines: The relative safety of buprenorphine when prescribed to patients with OUD who also take benzodiazepines (Xu K et al. 2021) was demonstrated in a recent study showing the addition of buprenorphine led to a reduction in poisoning events. This evidence is consistent with 2017 recommendations from the FDA urging caution when withholding OUD treatment medications from patients currently taking benzodiazepines.

Treatments for Alcohol Use Disorder (AUD)

Withdrawal Management Strategies: Alcohol withdrawal can result from the abrupt cessation of alcohol after a period of physiologic dependency. Alcohol withdrawal is a potentially life-threatening condition that requires in-person evaluation to determine the appropriate level of care. Some patients experiencing alcohol withdrawal can be managed in the outpatient setting. Other patients require ICU-level care. The American Society of Addiction Medicine has prepared a practice guideline for the management of alcohol withdrawal. The document includes guides to determine the severity of withdrawal, the risk factors in a particular case, level of care determination, and specific treatment recommendations such as pharmacotherapy.

Motivational interviewing (MI), and the closelyrelated motivational enhancement therapy (MET), are psychotherapeutic approaches to management of AUD. These approaches seek to identify the individual's values, then use various methods to invoke inwardly motivated change, so the individual's behavior more closely aligns with those values. SAMSHA has generated a summary guide to the use of MI in SUD treatment. It is useful for the BHCM and psychiatric consultant to

have skills in this treatment modality and to be aware of counselors with MI expertise who can accept referrals.
SUD counseling is an important treatment for patients experiencing AUD. SAMHSA offers a document that outlines SUD counseling. It is useful for the BHCM and psychiatric consultant to be aware of counselors with SUD expertise who can accept referrals.

Mutual support programs such as Alcoholics Anonymous (AA) have shown mixed results (Kaskutas LA et al. 2009) in studies. Reduction in healthcare costs (Kelly J et al. 2020) have been demonstrated with AA. Anecdotal evidence suggests that individuals may visit several groups before finding the right fit for them. Many patients report benefits from the support of an Alcoholics Anonymous sponsor.

Naltrexone / Long-Acting Injectable Naltrexone: Naltrexone is FDA-approved for the treatment of AUD and is the most commonly prescribed medication for this indication. It is also the most commonly prescribed medication for AUD during pregnancy. Research has shown that treatment with naltrexone can lead to benefits (Anton R et al. 2006, Rosner S et al. 2010) including a reduction in return to heavy drinking and reduction in return to any drinking. Naltrexone containing products should not be used to treat patients with AUD who are currently dependent on opioids, as this approach would lead to precipitated opioid withdrawal. However, for patients with both AUD and OUD, who are no longer physically dependent on opioids, naltrexone containing products are a viable treatment option for both conditions.

Acamprosate is FDA-approved for AUD. Acamprosate has shown conflicting results (Anton R et al. 2006, Rosner S et al. 2010) in research but remains an important treatment option for AUD. Positive studies have shown a reduction in risk of any drinking.

Disulfiram is an FDA-approved but a less-commonly used medication for AUD. Disulfiram differs from other medications used to treat AUD in that it utilizes the principle of operant conditioning to help patients remain free of alcohol use. When treated with disulfiram, patients who consume alcohol experience unpleasant effects such as dizziness, nausea, vomiting, flushing and headache. Research has demonstrated that disulfiram is effective in reducing heavy drinking days, reducing average weekly consumption, and increasing number of abstinent days Laaksonen E et al. 2008). Evidence shows that the effectiveness of disulfiram is limited unless taken under supervised settings (Garbutt JC et al. 1999).

Gabapentin is a non-FDA-approved medication with evidence to support its use in the treatment of AUD. The treatment effect of gabapentin is in the increase in abstinence rate compared to placebo (Garbutt JC et al. 1999). One study demonstrated that gabapentin combined with naltrexone for AUD is more effective than either treatment alone at decreasing heavy drinking days and delaying return to heavy drinking (Anton R et al. 2011). Gabapentin is listed as a controlled medication in some areas of the United States. Some abuse potential, as well as overdose risk when combined with opioid medications, is associated with gabapentin.

Topiramate is a non-FDA-approved medication with evidence support its use in the treatment of AUD. Topiramate has been shown to reduce alcohol consumption and cravings (Blodgett JC et al. 2014, Jonas DE et al. 2014). It has also been shown to reduce PTSD symptom severity (Batki SL et al. 2014). In spite of not being FDA-approved, topiramate has been recommended as a first line AUD treatment by the Veteran's Administration/Department of Defense.

Treatments for Stimulant Use Disorder

Contingency management is an evidence-supported behavioral intervention for the treatment of stimulant use disorder. Contingency management has been shown to reduce the number of days of stimulant use and reduce stimulant cravings. It has also been shown to reduce stimulant use among patients with co-occurring serious mental illness (McDonnell M et al. 2013). SAMSHA offers a guide to the use of contingency management and other psychotherapeutic interventions for stimulant use disorder.

Cognitive-Behavioral therapy is a psychotherapy in which negative patterns of thought about the self and the world are challenged and skills to cope with high-risk situations are developed to alter unwanted behavior patterns and treat SUDs and psychiatric disorders. Training is required for therapists to deliver this treatment with fidelity.

Community reinforcement approach is a comprehensive behavioral therapy based on operant conditioning theory. Clinicians work closely with patients to adjust aspects of their lives that interfere with a healthy lifestyle, seeking to build a new way of living without substances that is more rewarding than their life with substance use. The community reinforcement approach requires resources and training that would typically fall beyond the capacity to deliver in a primary care setting.

The Matrix Model of addiction treatment is a structured, multicomponent behavioral therapy that delivers individual counseling; cognitive-behavioral therapy, family education, and social support groups; and encouragement for mutual support group participation over 16 weeks. requires resources and training that would also typically fall beyond the capacity to deliver in a primary care setting.

Mirtazapine is a non-FDA-approved medication for the indication of methamphetamine use disorder. Is has been shown in two studies to increase the likelihood of refraining from methamphetamine use and reduce the likelihood of associated high-risk sexual behavior in the MSM (men who have sex with men) population (Colfax et al. 2011, Coffin P et al. 2020).

Bupropion is a non-FDA-approved medication for the indication of methamphetamine use disorder. It has been shown in two studies (Elkashef AM et al. 2008, Shoptaw S et al. 2008) to increase the likelihood of a methamphetamine-free weeks among lighter users, defined as those who use half of days or less. Bupropion did not demonstrate a treatment effect for patients who used more heavily. Bupropion also has some evidence of efficacy in reducing cocaine use.

Bupropion and long-acting injectable naltrexone is a non-FDA-approved combination of medications for the indication of methamphetamine use disorder. This combination was demonstrated to reduce methamphetamine use compared to placebo (Trivedi MH et al. 2021).

Topiramate is another non-FDA approved medication for stimulant use disorder that has shown very modest efficacy compared to placebo in reducing methamphetamine use and better efficacy in reducing cocaine use. Topiramate requires a gradual titration over several weeks to reach a therapeutic dosage.

Modafinil also non-FDA approved for stimulant use disorder has shown evidence of efficacy for reduction of cocaine use in patients who have cocaine use disorder but not do have alcohol use disorder.

Schedule II controlled psychostimulant medications such as methylphenidate or mixed amphetamine salts are sometimes used off-label to treat stimulant use disorders. However, it is generally recommended, because of the potential risk of using these medications, that they be used for this purpose only by physicians with training in addiction medicine or addiction psychiatry (AAAP, ASAM. 2023).

Management of Cannabis Use Disorder

Successful treatment of cannabis use disorder involves **identifying/treating** underlying conditions to reduce reliance on cannabis and developing alternative coping skills.

SUD counseling is an important consideration in the care of patients experiencing cannabis use disorder.

Recognizing Cannabis Hyperemesis (Allen JH et al. 2004, Collins AB et al. 2023): Nausea and cyclical vomiting is a potential side effect of cannabis products. The severity of cannabis hyperemesis can range from mild to severe and life threatening. Treatment of this syndrome requires reduction or cessation of cannabis use.

Resources

Training:
American Psychiatric Association: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained
Providers Clinical Support System - Medications for Opioid Use Disorders: www.PCSS-MOUD.org
PCSS-MOUD SUD 101 Core Curriculum: https://pcssnow.org/education-training/sud-core-curriculum/

Implementation:
American Psychiatric Association:
Implement: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement
Get Paid: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid
AMNet: https://www.psychiatry.org/psychiatrists/registry/amnet

AIMS Center:
Implementation Guide: Implementation Guide | University of Washington AIMS Center (uw.edu)
Financing: Billing & Financing | University of Washington AIMS Center (uw.edu)
Office Hours: Office Hours | University of Washington AIMS Center (uw.edu)

Clinical Care:
PCSS-MOUD Resources: www.PCSS-MOUD.org
The AAAP/ASAM Clinical Practice Guideline on the Management of Stimulant Use Disorder: https://www.aaap.org/education/management-of-stimulant-use-disorder-guideline/

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