DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

HMA HEALTH MANAGEMENT ASSOCIATES

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness A System of Care and Recovery

MEDICATIONS FOR ADDICTION TREATMENT (MAT)

This handout is intended for treatment providers.

Medications for Addiction Treatment (MAT) describes the use of medications for the treatment of substance use disorders.

The Food and Drug Administration (FDA) has approved the following medications –

- For **Alcohol Use Disorder (AUD)**:
  - *acamprosate*
  - *disulfiram*
  - *naltrexone*

- For **Opioid Use Disorder (OUD)**:
  - *buprenorphine*
  - *methadone*
  - *naltrexone*

Benefits of MAT:

- Improves treatment retention
- Decreases withdrawal symptoms
- Improves birth outcomes
- Decreases substance use
- Improves functioning
- Decreases cravings
- Increases employment
- Decreases overdose
- Restores healthy brain function
- Decreases criminal behavior
- Helps people feel stable
- Decreases intravenous drug use (IVDU) and complications
- Decreases risk of death

Considerations

- Immediate access to MAT should be built into every medical and behavioral health care site.
- Ancillary supports (counseling, care coordination, case management, etc.) should be offered in conjunction with MAT but participation in these services should not be a requirement to access this life-saving medication.
- MAT has shown to be safe and can be used by pregnant and breastfeeding persons as well as by teenagers. It is much safer than illicit opioid use.
- Length of time for treatment is based on the needs of the individual. For some, it may be indefinite.
- MAT helps people restore functionality, improve quality of life, and reintegrate into their families/communities.

REFERENCES

- American Society of Addiction Medicine. (2019). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder. In American Society of Addiction Medicine. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- SAMHSA. (2023, October 3). Medications for Substance Use Disorders. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medications-substance-use-disorders

MEDICATIONS FOR OPIOID USE DISORDER (MOUD): PATIENT OVERVIEW

METHADONE

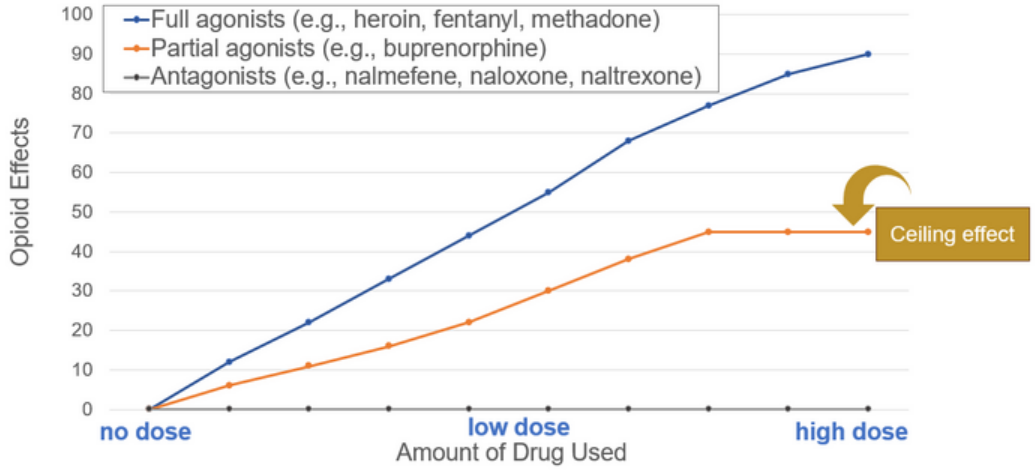
is a full agonist at the opioid receptor. This means it fully turns on the receptor and with higher doses of methadone, you get increasing effects (see **blue** line below). For this reason, some patients will benefit from methadone, compared to buprenorphine. You can only get it from a special clinic called an opioid treatment program (OTP)/narcotic treatment program (NTP).

BUPRENORPHINE

is a partial opioid agonist. This means it only partially turns on the opioid receptor (see **orange** line below). It has a ceiling effect, which means that you don't get more of an effect even with higher doses. This makes it safer than methadone if taken in excess. Buprenorphine can be prescribed without going to an OTP or NTP.

NALTREXONE

is an opioid antagonist. This means it blocks the opioid receptor but does not turn it on (see **gray** line below). Naltrexone can be prescribed without going to an OTP or NTP.



- MOUD is ***safe***.
  - MOUD can be used by pregnant and breastfeeding persons.
  - MOUD can be used by teenagers.
  - MOUD is <u>much</u> safer than illicit opioid use.
- MOUD is ***effective***.
  - MOUD can decrease withdrawal symptoms, use, and cravings.

.

- MOUD ***saves lives***.
  - MOUD helps people restore functionality, improve quality of life, and reintegrate into their families/communities.

- "The chronic nature of addiction means that some people return to relapse or drug use after an attempt to start. Relapse rates to drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse." (NIDA, 2020).
- Length of time for MOUD treatment is based on the needs of the individual. For some, it may be indefinite.

Benefit	Methadone	Buprenorphine	Naltrexone
Decreases withdrawal symptoms	+	+	
Decreases cravings	+	+	+
Decreases opioid use	+	+	+
Decreases transmission of infectious diseases (HIV, Hepatitis C)	+	+	
Decreases criminal activity	+	+	
Decreases overdoses	+	+	
Decreases risk of death	+	+	
Improves treatment retention	+	+	+
Improves birth outcomes	+	+	
Increases employment	+	+	+

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness A System of Care and Recovery
HMA HEALTH MANAGEMENT ASSOCIATES

MEDICAMENTOS PARA EL TRASTORNO POR CONSUMO DE OPIOIDES (MOUD): VISIÓN GENERAL DEL PACIENTE

METADONA

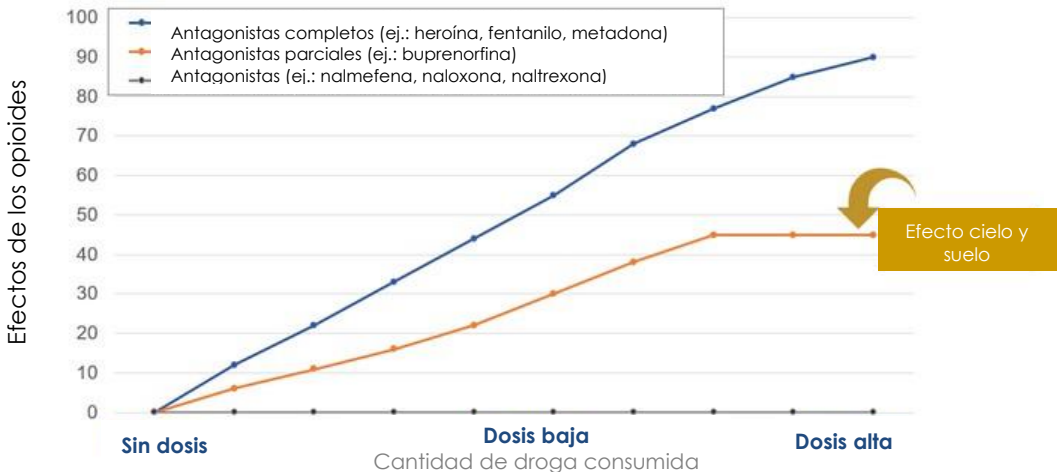
es un agonista completo en el receptor opioide. Esto significa que enciende completamente el receptor y, con dosis más altas de metadona, se obtienen efectos crecientes (ver línea **azul** más abajo). Por esta razón, algunos pacientes se beneficiarán de la metadona, en comparación con la buprenorfina. Solo puede obtenerlo de una clínica especial llamada programa de tratamiento de opioides (OTP)/programa de tratamiento de narcóticos (NTP).

BUPRENORFINA

es un agonista opioide parcial. Esto significa que solo enciende parcialmente el receptor opioide (ver línea **naranja** abajo). Tiene un efecto cielo y suelo, lo que significa que no se obtiene más de un efecto incluso con dosis más altas. Esto hace que sea más seguro que la metadona si se toma en exceso. La buprenorfina se puede recetar sin ir a un OTP o NTP.

NALTREXONA

es un antagonista opioide. Esto significa que bloquea el receptor opioide pero no lo enciende (ver línea **gris** abajo). La naltrexona se puede prescribir sin necesidad de ir a un OTP o NTP.



- MOUD es ***seguro***.
  - MOUD puede ser utilizado por las personas embarazadas y lactantes.
  - MOUD puede destinarse a adolescentes.
  - MOUD es mucho más seguro que el uso ilícito de opioides.
- MOUD es ***efectivo***.
  - MOUD puede disminuir los síntomas de abstinencia, el consumo y los antojos.
- MOUD ***salva vidas***.
  - MOUD ayuda a las personas a restaurar la funcionalidad, mejorar la calidad de vida y reintegrarse en sus familias/comunidades.

- "La naturaleza crónica de la adicción significa que algunas personas vuelven a la recaída o al consumo de drogas después de un intento de comenzar. Las tasas de recaída al consumo de drogas son similares a las tasas de otras enfermedades médicas crónicas. Si las personas dejan de seguir su plan de tratamiento médico, es probable que recaigan". (NIDA, 2020).
- La duración del tratamiento MOUD se basa en las necesidades del individuo. Para algunos, puede ser indefinido.

Beneficio	Metadona	Buprenorfina	Naltrexona
Reducir los síntomas de la abstinencia	+	+	
Reducir los antojos	+	+	+
Reducir el consumo de opioids	+	+	+
Reducir la transmission de enfermedades infecciosas (VIH, Hepatitis C)	+	+	
Reducir la actividad delictiva	+	+	
Reducir las sobredosis	+	+	
Reducir el riesgo de vida	+	+	
Mejorar la retención en el tratamiento	+	+	+
Mejorar los resultados del nacimiento	+	+	
Aumentar el empleo	+	+	+

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness A System of Care and Recovery
HMA HEALTH MANAGEMENT ASSOCIATES

REFERENCIAS

1. Amato, L., Davoli, M., Minozzi, S., Ferroni, E., Ali, R., & Ferri, M. (2013). Methadone at tapered doses for the management of opioid withdrawal. *The Cochrane database of systematic reviews*, 2013(2), CD003409. https://doi.org/10.1002/14651858.CD003409.pub4
2. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. (2017). *Obstetrics and gynecology*, 130(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235
3. Evans, E. A., Zhu, Y., Yoo, C., Huang, D., & Hser, Y. I. (2019). Criminal justice outcomes over 5 years after randomization to buprenorphine-naloxone or methadone treatment for opioid use disorder. *Addiction (Abingdon, England)*, 114(8), 1396–1404. https://doi.org/10.1111/add.14620
4. Gowing, L., Farrell, M. F., Bornemann, R., Sullivan, L. E., & Ali, R. (2011). Oral substitution treatment of injecting opioid users for prevention of HIV infection. *The Cochrane database of systematic reviews*, (8), CD004145. https://doi.org/10.1002/14651858.CD004145.pub4
5. Hagan, H., Pouget, E. R., & Des Jarlais, D. C. (2011). A systematic review and meta-analysis of interventions to prevent hepatitis C virus infection in people who inject drugs. *The Journal of infectious diseases*, 204(1), 74–83. https://doi.org/10.1093/infdis/jir196
6. Jakubowski, A., & Fox, A. (2020). Defining Low-threshold Buprenorphine Treatment. *Journal of addiction medicine*, 14(2), 95–98. https://doi.org/10.1097/ADM.0000000000000555
7. Kandall, S. R., Albin, S., Gartner, L. M., Lee, K. S., Eidelman, A., & Lowinson, J. (1977). The narcotic-dependent mother: fetal and neonatal consequences. *Early human development*, 1(2), 159–169. https://doi.org/10.1016/0378-3782(77)90017-2
8. Krans, E. E., Kim, J. Y., Chen, Q., Rothenberger, S. D., James, A. E., 3rd, Kelley, D., & Jarlenski, M. P. (2021). Outcomes associated with the use of medications for opioid use disorder during pregnancy. *Addiction (Abingdon, England)*, 116(12), 3504–3514. https://doi.org/10.1111/add.15582
9. Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., Bagley, S. M., Liebschutz, J. M., & Walley, A. Y. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Annals of internal medicine*, 169(3), 137–145. https://doi.org/10.7326/M17-3107
10. Lobmaier, P., Kornør, H., Kunøe, N., & Bjørndal, A. (2008). Sustained-release naltrexone for opioid dependence. *The Cochrane database of systematic reviews*, (2), CD006140. https://doi.org/10.1002/14651858.CD006140.pub2
11. Low, A. J., Mburu, G., Welton, N. J., May, M. T., Davies, C. F., French, C., Turner, K. M., Looker, K. J., Christensen, H., McLean, S., Rhodes, T., Platt, L., Hickman, M., Guise, A., & Vickerman, P. (2016). Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*, 63(8), 1094–1104. https://doi.org/10.1093/cid/ciw416
12. National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310
13. NCCHC Foundation. (2021). From the General Public to America's Jails: MAT Saves Lives. In *National Commission on Correctional Health Care*. https://www.ncchc.org/wp-content/uploads/From the General Public to Americas Jails - MAT Saves Lives- Indivior.pdf
14. NIDA. (2020). Drugs, Brains, and Behavior: The Science of Addiction. https://nida.nih.gov/research-topics/addiction-science/drugs-brain-behavior-science-of-addiction
15. Pearce, L. A., Min, J. E., Piske, M., Zhou, H., Homayra, F., Slaunwhite, A., Irvine, M., McGowan, G., & Nosyk, B. (2020). Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study. *BMJ (Clinical research ed.)*, 368, m772. https://doi.org/10.1136/bmj.m772
16. Santo, T., Jr, Clark, B., Hickman, M., Grebely, J., Campbell, G., Sordo, L., Chen, A., Tran, L. T., Bharat, C., Padmanathan, P., Cousins, G., Dupouy, J., Kelty, E., Muga, R., Nosyk, B., Min, J., Pavarin, R., Farrell, M., & Degenhardt, L. (2021). Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA psychiatry*, 78(9), 979–993. https://doi.org/10.1001/jamapsychiatry.2021.0976
17. Saxon, A. J., Akerman, S. C., Liu, C. C., Sullivan, M. A., Silverman, B. L., & Vocci, F. J. (2018). Extended-release naltrexone (XR-NTX) for opioid use disorder in clinical practice: Vivitrol's Cost and Treatment Outcomes Registry. Addiction (Abingdon, England), 113(8), 1477–1487. https://doi.org/10.1111/add.14199
18. Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., Wilson, M. E., & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and alcohol dependence*, *103*(3), 148–154. https://doi.org/10.1016/j.drugalcdep.2009.03.007
19. Shulman, M., Wai, J. M., & Nunes, E. V. (2019). Buprenorphine Treatment for Opioid Use Disorder: An Overview. *CNS drugs*, 33(6), 567–580. https://doi.org/10.1007/s40263-019-00637-z
20. Skeie, I., Clausen, T., Hjemsæter, A. J., Landheim, A. S., Monsbakken, B., Thoresen, M., & Waal, H. (2022). Mortality, Causes of Death, and Predictors of Death among Patients On and Off Opioid Agonist Treatment: Results from a 19-Year Cohort Study. *European addiction research*, 28(5), 358–367. https://doi.org/10.1159/000525694
21. Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ (Clinical research ed.)*, 357, j1550. https://doi.org/10.1136/bmj.j1550
22. Substance Abuse and Mental Health Services Administration. (2023). *Medications for Substance Use Disorders*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medications-substance-use-disorders
23. Tsui, J. I., Evans, J. L., Lum, P. J., Hahn, J. A., & Page, K. (2014). Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA internal medicine*, *174*(12), 1974–1981. https://doi.org/10.1001/jamainternmed.2014.5416

REFERENCES

1. Amato, L., Davoli, M., Minozzi, S., Ferroni, E., Ali, R., & Ferri, M. (2013). Methadone at tapered doses for the management of opioid withdrawal. *The Cochrane database of systematic reviews*, 2013(2), CD003409. https://doi.org/10.1002/14651858.CD003409.pub4
2. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. (2017). *Obstetrics and gynecology*, 130(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235
3. Evans, E. A., Zhu, Y., Yoo, C., Huang, D., & Hser, Y. I. (2019). Criminal justice outcomes over 5 years after randomization to buprenorphine-naloxone or methadone treatment for opioid use disorder. *Addiction (Abingdon, England)*, 114(8), 1396–1404. https://doi.org/10.1111/add.14620
4. Gowing, L., Farrell, M. F., Bornemann, R., Sullivan, L. E., & Ali, R. (2011). Oral substitution treatment of injecting opioid users for prevention of HIV infection. *The Cochrane database of systematic reviews*, (8), CD004145. https://doi.org/10.1002/14651858.CD004145.pub4
5. Hagan, H., Pouget, E. R., & Des Jarlais, D. C. (2011). A systematic review and meta-analysis of interventions to prevent hepatitis C virus infection in people who inject drugs. *The Journal of infectious diseases*, 204(1), 74–83. https://doi.org/10.1093/infdis/jir196
6. Jakubowski, A., & Fox, A. (2020). Defining Low-threshold Buprenorphine Treatment. *Journal of addiction medicine*, 14(2), 95–98. https://doi.org/10.1097/ADM.0000000000000555
7. Kandall, S. R., Albin, S., Gartner, L. M., Lee, K. S., Eidelman, A., & Lowinson, J. (1977). The narcotic-dependent mother: fetal and neonatal consequences. *Early human development*, 1(2), 159–169. https://doi.org/10.1016/0378-3782(77)90017-2
8. Krans, E. E., Kim, J. Y., Chen, Q., Rothenberger, S. D., James, A. E., 3rd, Kelley, D., & Jarlenski, M. P. (2021). Outcomes associated with the use of medications for opioid use disorder during pregnancy. *Addiction (Abingdon, England)*, 116(12), 3504–3514. https://doi.org/10.1111/add.15582
9. Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., Bagley, S. M., Liebschutz, J. M., & Walley, A. Y. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Annals of internal medicine*, 169(3), 137–145. https://doi.org/10.7326/M17-3107
10. Lobmaier, P., Kornør, H., Kunøe, N., & Bjørndal, A. (2008). Sustained-release naltrexone for opioid dependence. *The Cochrane database of systematic reviews*, (2), CD006140. https://doi.org/10.1002/14651858.CD006140.pub2
11. Low, A. J., Mburu, G., Welton, N. J., May, M. T., Davies, C. F., French, C., Turner, K. M., Looker, K. J., Christensen, H., McLean, S., Rhodes, T., Platt, L., Hickman, M., Guise, A., & Vickerman, P. (2016). Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*, 63(8), 1094–1104. https://doi.org/10.1093/cid/ciw416
12. National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310
13. NCCHC Foundation. (2021). From the General Public to America's Jails: MAT Saves Lives. In *National Commission on Correctional Health Care*. https://www.ncchc.org/wp-content/uploads/From_the_General_Public_to_Americas_Jails_-_MAT_Saves_Lives-_Indivior.pdf
14. NIDA. (2020). Drugs, Brains, and Behavior: The Science of Addiction. https://nida.nih.gov/research-topics/addiction-science/drugs-brain-behavior-science-of-addiction
15. Pearce, L. A., Min, J. E., Piske, M., Zhou, H., Homayra, F., Slaunwhite, A., Irvine, M., McGowan, G., & Nosyk, B. (2020). Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study. *BMJ (Clinical research ed.)*, 368, m772. https://doi.org/10.1136/bmj.m772
16. Santo, T., Jr, Clark, B., Hickman, M., Grebely, J., Campbell, G., Sordo, L., Chen, A., Tran, L. T., Bharat, C., Padmanathan, P., Cousins, G., Dupouy, J., Kelty, E., Muga, R., Nosyk, B., Min, J., Pavarin, R., Farrell, M., & Degenhardt, L. (2021). Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA psychiatry*, 78(9), 979–993. https://doi.org/10.1001/jamapsychiatry.2021.0976
17. Saxon, A. J., Akerman, S. C., Liu, C. C., Sullivan, M. A., Silverman, B. L., & Vocci, F. J. (2018). Extended-release naltrexone (XR-NTX) for opioid use disorder in clinical practice: Vivitrol's Cost and Treatment Outcomes Registry. Addiction (Abingdon, England), 113(8), 1477–1487. https://doi.org/10.1111/add.14199
18. Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., Wilson, M. E., & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and alcohol dependence, 103*(3), 148–154. https://doi.org/10.1016/j.drugalcdep.2009.03.007
19. Shulman, M., Wai, J. M., & Nunes, E. V. (2019). Buprenorphine Treatment for Opioid Use Disorder: An Overview. *CNS drugs*, 33(6), 567–580. https://doi.org/10.1007/s40263-019-00637-z
20. Skeie, I., Clausen, T., Hjemsæter, A. J., Landheim, A. S., Monsbakken, B., Thoresen, M., & Waal, H. (2022). Mortality, Causes of Death, and Predictors of Death among Patients On and Off Opioid Agonist Treatment: Results from a 19-Year Cohort Study. *European addiction research*, 28(5), 358–367. https://doi.org/10.1159/000525694
21. Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ (Clinical research ed.)*, 357, j1550. https://doi.org/10.1136/bmj.j1550
22. Substance Abuse and Mental Health Services Administration. (2023). *Medications for Substance Use Disorders*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medications-substance-use-disorders
23. Tsui, J. I., Evans, J. L., Lum, P. J., Hahn, J. A., & Page, K. (2014). Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA internal medicine, 174*(12), 1974–1981. https://doi.org/10.1001/jamainternmed.2014.5416

HOW TO TALK ABOUT MEDICATIONS FOR ADDICTION TREATMENT (MAT)

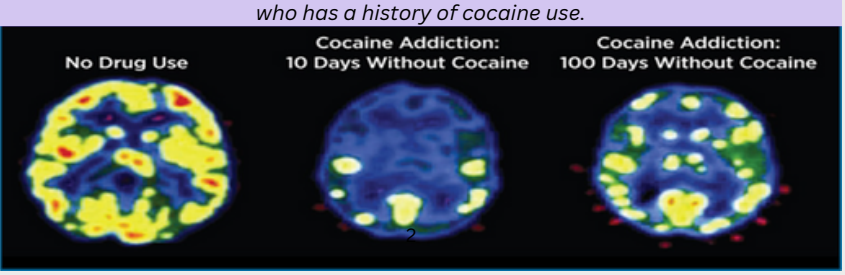
Background[5]

- Changes that occur in the brain from opioid use disorder (OUD) make it unlikely that a person can stop using without a medication intervention, increasing risk of death.
  - Compared to those not receiving MAT, opioid **overdose deaths decreased** by 59 percent for those receiving methadone and 38 percent for those receiving buprenorphine.
- The craving for the substance is up to 1,000 times stronger than the craving for survival needs like food or water.
  - This craving persists for more than a year after discontinuing use.
- Dopamine, which is needed to help us have the motivation for basic tasks like getting out of bed, is hijacked during substance use.
  - Substances cause our brain to produce up to 10x the amount of dopamine we have on our best day.
  - Our brain stops producing dopamine like it used to because it depends on the substance to trigger dopamine production.
    - This often leads to severe depression and lack of motivation for those in early recovery.
- SUD has the same medication compliance rates as other chronic diseases like hypertension and diabetes.

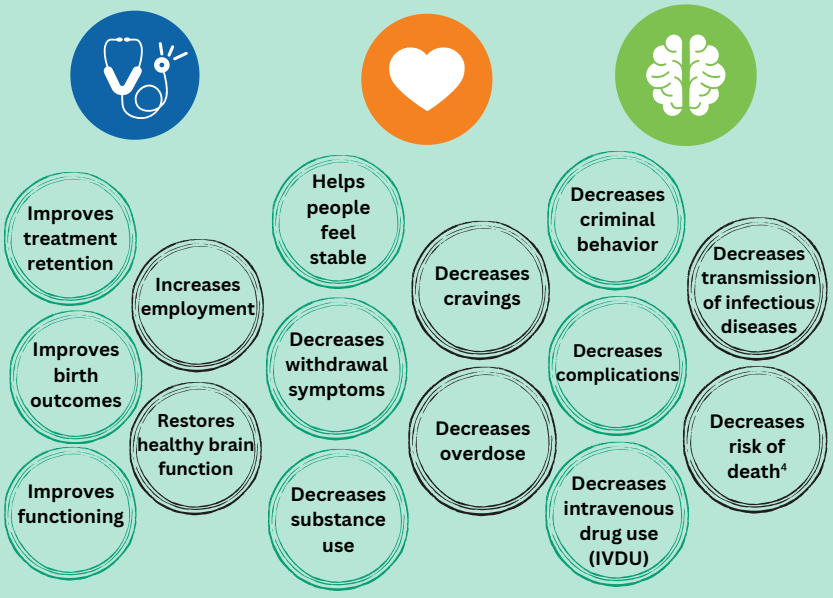
Effects of Substance Use on the Brain

Note: The brain still needs a lot of healing after active withdrawal ends. It takes more than a year for our brains to heal after a person stops using substances of abuse. For many, it takes even longer.[3]

The diagram below displays the brain glucose metabolism in a person who has a history of cocaine use.



MAT Benefits



Using MAT

- MAT may be used for months, years, or for life.
- MAT should be expected to be used until the client expresses interest in exploring discontinuation, without any encouragement to taper and/or discontinue from the provider.
  - Clients should be educated on risks of discontinuation.
- Discontinuation of MAT is shown to increase return to use and overdose.[7]
- MAT should not be discontinued if other substances are being used. The risk of death is higher than the risk from co-occurring use.
- While counseling can be beneficial, it should not be required to initiate/continue MAT.

MAT Access

- There continues to be significant disparities in terms of who is referred to MAT.
- African-American Communities are half as likely to receive treatment.
- Communities of color are less likely to have access to all approved forms of MAT.[2]
- Individual providers and agencies should have a plan to review data to ensure equitable access to MAT.
- Teens should be offered access to MAT at a comparable rate to adults.[6]

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness A System of Care and Recovery

HMA Health Management Associates

REFERENCES

1. Dong H, Stringfellow EJ, Russell WA, Jalali MS. Racial and Ethnic Disparities in Buprenorphine Treatment Duration in the US. JAMA Psychiatry. 2023;80(1):93–95. doi:10.1001/jamapsychiatry.2022.3673.
2. Lynch, S., Katkhuda, F., Klepacz, L., Towey, E., & Ferrando, S. J. (2023). Racial disparities in opioid use disorder and its treatment: a review and commentary on the literature. J Ment Health Clin Psychol, 7(1), 13-18.
3. National Institute on Drug Abuse. (2018). Bringing the Power of Science to Bear on Drug Abuse and Addiction. https://archives.nida.nih.gov/publications/teaching-addiction-science/bringing-power-science-to-bear-drug-abuse-addiction
4. National Institutes of Health. (2018). Methadone and buprenorphine reduce risk of death after opioid overdose. https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose
5. NIDA. (2020). Drugs, Brains, and Behavior: The Science of Addiction. https://nida.nih.gov/research-topics/addiction-science/drugs-brain-behavior-science-of-addiction
6. Pilarinos, A., Bromberg, D. J., & Karamouzian, M. (2022). Access to Medications for Opioid Use Disorder and Associated Factors Among Adolescents and Young Adults: A Systematic Review. *JAMA pediatrics*, 176(3), 304–311. https://doi.org/10.1001/jamapediatrics.2021.4606
7. Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., & Sanghavi, D. M. (2020). Comparative effectiveness of different treatment pathways for opioid use disorder. JAMA network open, 3(2), e1920622-e1920622.

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness A System of Care and Recovery

HMA Health Management Associates

CULTURAL CONSIDERATIONS IN MEDICATIONS FOR ADDICTION TREATMENT (MAT)

Cultural considerations impact every aspect of prescribing Medications for Addiction Treatment (MAT).

Race, ethnicity, gender identity, sexual orientation, disability, and other cultural factors influence the level of understanding and openness to MAT experienced by the client and family.

Ensuring cultural responsiveness promotes equitable prescribing of MAT which decreases disparities.

DISPARITIES:

- Racial and ethnic minority patients are more likely to discontinue buprenorphine treatment earlier than white patients. This is thought to be linked to lack of appropriate supports and resources.[3]
- Asian-Americans and Pacific Islanders with opioid use disorder had the lowest rate of opioid-specific treatment at 1.2%.[5]
- Only one in twelve Black people who died of an opioid-related overdose had engaged in treatment. This is half the rate of the white population.[5]
- Black and Brown communities were found to have limited access to all approved forms of Medications for Addiction Treatment (MAT).[5]
- Teens often do not have equitable access to MAT.[7]

DEFINITIONS:

• **Cultural competence** is the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.[1]

• **Cultural responsiveness means** understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued.[4]

• **Cultural humility is** a lifelong personal examination of one's own beliefs and cultural identities to better understand the beliefs and cultural identities of others.[1]

TIPS FOR CULTURALLY RESPONSIVE PRESCRIBING:

- Policies and procedures should establish access to training, supervision, and congruent policies that enable staff to respond in a culturally appropriate manner to clients' psychological, linguistic, and physical needs.
- Use data to monitor programs, outcomes, and disparities.
  - Examine demographics of people served vs. local population.
    - Who is under-represented?
  - Monitor clinical outcomes for disparities and create a strategy to proactively address needs in this area
- Ensure that you have high-quality interpretation and translation services available (language, ASL, braille)
  - Interpretation services should be provided by a certified interpreter (not a family member).
  - Hire staff who are culturally diverse including: bilingual, and of various, races, gender identity, sexual orientations, ages, and abilities.
- Promote culturally, linguistically, and ability-related accessible education to patients and their families, as appropriate.
- Ensure your screening tools are indicated for the cultures you serve or are culturally neutral.
  - See SAMHSA's TIP 59 (link on reverse page)[2] for a list.
- Complete cultural competency assessments for staff and agency at least once per year to determine areas of strength and need.
  - See SAMHSA's TIP 59 (link on reverse page)[2] for a list.

See reverse page for references

REFERENCES

1. Betancourt, J., Green, A., & Carrillo, J. (2002). *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_oct_cultural_competence_in_health_care__emerging_frameworks_and_practical_approaches_betancourt_culturalcompetence_576_pdf.pdf
2. Center for Substance Abuse Treatment (US). (2014). *Improving Cultural Competence*. Substance Abuse and Mental Health Services Administration (US). https://store.samhsa.gov/sites/default/files/sma14-4849.pdf
3. Dong, H., Stringfellow, E. J., Russell, W. A., & Jalali, M. S. (2023). Racial and Ethnic Disparities in Buprenorphine Treatment Duration in the US. *JAMA psychiatry*, 80(1), 93–95. https://doi.org/10.1001/jamapsychiatry.2022.3673
4. Hopf, S. C., Crowe, K., Verdon, S., Blake, H. L., & McLeod, S. (2021). Advancing workplace diversity through the culturally responsive teamwork framework. *American Journal of Speech-Language Pathology, 30*(5), 1949–1961. https://doi.org/10.1044/2021_AJSLP-20-00380
5. Lynch, S., Katkhuda, F., Klepacz, L., Towey, E., & J. Ferrando, S. (2023). Racial disparities in opioid use disorder and its treatment: A review and commentary on the literature. *Journal of Mental Health & Clinical Psychology*, 7(1), 13–18. https://doi.org/10.29245/2578-2959/2023/1.1263
6. Photo by Nataliya Vaitkevich from Pexels
7. Pilarinos, A., Bromberg, D. J., & Karamouzian, M. (2022). Access to Medications for Opioid Use Disorder and Associated Factors Among Adolescents and Young Adults: A Systematic Review. *JAMA pediatrics*, 176(3), 304–311. https://doi.org/10.1001/jamapediatrics.2021.4606
8. Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

BUPRENORPHINE OUTPATIENT PRESCRIBER GUIDE

Buprenorphine is a high-affinity, partial opioid agonist with a ceiling effect.
It is safe & highly effective for treating opioid use disorder (OUD).

Buprenorphine can be prescribed by anyone with an unrestricted DEA license.
There are no requirements for a special license and there are no limits to the number of patients that can be treated.[1]

This handout is intended for prescribers of transmucosal buprenorphine.
Long-acting injectable buprenorphine is not addressed in this handout.

This document 'Buprenorphine Outpatient Prescriber Guide' IS NOT A CLINICAL RECOMMENDATION, but represents evidence-based clinical treatment and standards of care.

BEFORE YOU START TRANSMUCOSAL BUPRENORPHINE

1. **Take patient history.**
   a. This can be a problem-focused history and exam
2. **The only absolute contraindication to buprenorphine is allergy.**
   a. Do not withhold medication because of other medical/psychiatric diagnoses or substance use (other than allergy to buprenorphine)
   b. Have a risk, benefits, and alternatives discussion with patient
3. **Order LFTs, hepatitis panel, HIV, urine toxicology, and urine HCG in females.**
   a. These results do NOT have to be available to start medication
4. **Refer to substance use treatment and mutual support groups.**
   a. Do not withhold treatment from someone who refuses SUD treatment or mutual support

Buprenorphine is almost always given as buprenorphine/naloxone and comes in films or sublingual (SL) tablet.

TREATMENT DURATION

- **As long as benefits outweigh the risks, treatment can be continued.**
- **Current recommendations are to discontinue treatment, only in those who want to discontinue treatment and have reached treatment goals.**
- **Taper over months and stop taper (and increase to prior dose) if cravings or use occur.[2]**

MONITORING PATIENTS

1. **How is the patient doing?**
   a. Side effects?
   b. Drug or alcohol use?
   c. Cravings?
   d. Attendance at SUD treatment and/or mutual support?
2. **Check urine toxicology.**
   a. More frequently at the beginning of treatment
   b. Monthly for the remainder of the first year of remission
   c. After the first year of remission, every two months
3. **Check liver functions if signs or symptoms of liver disease present & annually.**

If patient is doing well, then continue current treatment plan and see patient back regularly.

Arrange **follow up** 1-2 days after initiation, weekly for 4-6 weeks, then schedule visits biweekly, followed by monthly for first 6-12 months of remission; can extend beyond monthly with extended remission.

If patient is not doing well, then check the following:

1. **Is their dose of buprenorphine therapeutic?**
   a. Treatment works better at ≥16 mg/day than lower doses.
   b. Are they taking medication correctly (SL not PO)?
   c. Are they pregnant and need higher or more frequent dosing?
   d. Are they a hyper metabolizer or have drug interactions and need a higher or more frequent dose?
2. **Does the patient have co-occurring disorders that need addressing?**
3. **Are they better served by a higher level of addiction treatment?**
   a. What level of SUD treatment are they getting?
   b. What mutual support are they attending?
   c. Would they be better served getting daily observed buprenorphine dosing from a narcotic treatment program?
4. **Do NOT stop buprenorphine for inconsistent toxicology test or lack of psychosocial treatment/mutual support; adjust the treatment plan.**

DON'T FORGET

1. **Ensure diagnosis of OUD is documented in electronic medical records.**
2. **Prescription Drug Monitoring Program (PDMP) should be checked and documented.**
3. **Document Informed Consent**
   a. In the State of California, patients 16 years or older can consent to treatment with buprenorphine.
4. **Prescribe an adequate amount of medication until next visit.**
5. **Prescribe or provide access to overdose reversal agent of your choice.**
6. **Discontinue other opioids.**
7. **Provide Patient Guide to Starting Buprenorphine at home.**
   a. For patients who *are undergoing or will soon undergo withdrawal*, review the Patient Guide to Starting Buprenorphine at Home:
      i. Prescribe 8mg tabs or films, enough to take up to 16-32mg/day until next appointment.
      ii. Less than 5% will experience precipitated withdrawal using standard or high dose initiation.[3] For these patients, use low dose buprenorphine initiation[4] as described in ASAM Clinical Considerations.[5]
   b. For those who *have already completed withdrawal*, yet remain at risk of return to opioid use review Patient Guide to Starting Buprenorphine at Home:
      i. Start 2-4mg every day (lower dose due to loss of tolerance) & adjust dose as stated in Patient Guide.
      ii. Prescribe 8mg tabs or films, enough to take 16mg/day until next appointment.
8. **Arrange follow-up.**

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

HMA HEALTH MANAGEMENT ASSOCIATES

RESOURCES

1. **Addiction Free CA**: https://addictionfreeca.org
2. **American Society of Addiction Medicine**: https://www.asam.org
3. **CA Bridge Program**: https://bridgetotreatment.org/addiction-treatment/ca-bridge
4. **Grayken Center for Addiction**: https://www.bmc.org/addiction
5. **Providers Clinical Support System (PCSS)**: https://www.samhsa.gov/providers-clinical-support-system-pcss
6. **University of California, San Francisco (UCSF)'s Substance Use Management Support**, a free clinical consultation hotline for non-California healthcare providers. The hotline, which operates Monday-Friday from 9am to 8pm ET, can be accessed by calling **(855) 300-3595**. More information can be found at: https://nccc.ucsf.edu/clinician-consultation/substance-use-management.
7. **University of California, San Francisco (UCSF)'s California Substance Use Line**, a free clinical consultation hotline specifically for California healthcare providers. The hotline, which operates 24 hours a day/7 days a week, can be accessed by calling **(844) 326-2626**. More information can be found at: https://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line.

REFERENCES

1. SAMHSA. (2023, January 10). Waiver Elimination (MAT Act). www.samhsa.gov. https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act
2. American Society of Addiction Medicine. (2019). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder. In American Society of Addiction Medicine. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
3. D'Onofrio, G., Hawk, K., Perrone, J., Walsh, S., Lofwall, M. R., Fiellin, D. A., & Herring, A. A. (2023). Incidence of Precipitated Withdrawal During a Multisite Emergency Department–Initiated Buprenorphine Clinical Trial in the Era of Fentanyl. JAMA Network Open, 6(3), e236108–e236108. https://doi.org/10.1001/jamanetworkopen.2023.6108
4. Snyder, H., Chau, B., Kalmin, M. M., Speener, M., Campbell, A., Moulin, A., & Herring, A. A. (2023). High-Dose Buprenorphine Initiation in the Emergency Department Among Patients Using Fentanyl and Other Opioids. JAMA Network Open, 6(3), e231572. https://doi.org/10.1001/jamanetworkopen.2023.1572
5. Weimer, M., Herring, A. A., Kawasaki S, Meyer, M., Kleykamp, B. A., & Ramsey, K. S. (2023). ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids. Journal of Addiction Medicine, 00(00). https://doi.org/10.1097/adm.0000000000001202

CLINICAL SUPERVISION IN MEDICATIONS FOR ADDICTION TREATMENT

Clinical supervision is a process in which an approved supervisor provides formal observation, instruction, mentorship, and guidance for treatment professionals.
It promotes:

- **Improved client care**
- **Improved job performance**
- **Enhanced proficiency in knowledge, skills, and attitudes essential for effective job performance**
- **Decreased risk for clients and agency**

This handout is intended to be a guide for treatment providers.

IMPORTANT TOPICS TO INCORPORATE:

- **Expedient access to MAT:**
  - **Although comprehensive diagnostic history and assessment of substance use disorders (SUD) is ideal for treatment planning, medications can be initiated following focused history and exam.**
- **Ongoing education:**
  - **For those who are appropriate for MAT and not receiving it, initial and ongoing client education regarding the potential benefits of MAT is critical.**
- **Comprehensive review of ancillary supports:**
  - **These include: individual, group, and family counseling; peer support; care coordination; employment services; transportation; and spiritual supports.**
- **Cultural considerations and supports:**
  - **Culture, race, language, ethnicity, and ethics impact all aspects of clinical care. It is important to ensure clinicians are aware of disparities and are comfortable exploring how a client's identity impacts their clinical care.**
- **"Golden Thread" in treatment and discharge planning:**
  - **Treatment and discharge planning should clearly outline how each of the client's identified goals are connected to the current and ongoing planned services.**
- **Evaluation of medication efficacy and side effects.**
- **Discharge planning:**
  - **Starts at the beginning of treatment and ensures that the client has aftercare for all identified needs. Barriers such as transportation, housing, and childcare are addressed.**
- **Identification of any educational or training needs that may improve efficacy of MAT care delivery.**

Structured clinical supervision specific to treatment of substance use disorders ensures clients are consistently being screened for:

- **MAT service needs**
- **Effectiveness of medication**
- **Appropriate level of care**

Clinical supervision should be documented on an approved form. It is recommended that the supervisee complete the supervision form prior to the meeting so that the discussion is focused and intentional. Additionally, this will help track themes in supervision.

Discussions regarding culture, race, language, ethnicity, and ethics should be included in all supervisory interactions.

REFERENCES

- Center for Substance Abuse Treatment. *Clinical Supervision and Professional Development of the Substance Abuse Counselor*. Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. (SMA) 144435. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
- Photos by Nataliya Vaitkevich from Pexels