

## Aspirus Practice Guideline

**Topic:** Treatment of Patients With Substance Use Disorders

**Date:** Initial Guideline Adoption: September 17<sup>th</sup>, 2020  
Last QIACC Review/Approval: September 27<sup>th</sup>, 2022

**Primary Source:** American Psychiatric Association

**Link to Guideline:**

[http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/substanceuse.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf)

The Practice Guideline for the Treatment of Patients with Substance Use Disorders was adopted as the Aspirus Clinical Practice Guideline with the following modifications:

**Aspirus Comments/Modifications of Guideline:**

Aspirus adopted the American Society of Addiction Medicine (ASAM) clinical practice guideline for the treatment of Opioid Use Disorders. We recommend using that guideline for Opioid Use Disorder guidance.

The Substance Abuse Guideline is not based on high quality evidence (e.g. randomized controlled studies). Rather, like many behavioral health treatment guidelines, it is based on expert consensus. Some of the references are old, (e.g. information on “brief treatment” from 1977). There is very little information on screening and brief intervention.

The Guideline underscores that the foundation of substance use treatment is psychiatric management:

1. Motivating change
2. Establishing and maintaining a therapeutic framework and alliance
3. Assessing safety and clinical status
4. Managing intoxication
5. Managing withdrawal
6. Reducing the morbidity and sequelae of substance use disorders
7. Facilitating adherence to a treatment plan and preventing relapse
8. Providing education about substance use disorders and their treatment
9. Facilitating access to services and coordinating resources among mental health, general medical, and other service systems

The section on “Commonly available treatment and setting” is of interest to managed care organizations. The guideline highlights important considerations (e.g. the quality of the recovery supportive environment, the person’s level of motivation, and documented history of failure to engage in, or not benefiting from, outpatient treatment) to admit patients to the rehab level of care. Residential/rehab treatment provides high levels of psychosocial and community support,

as well as temporary stress relief. Another key point made is that internal motivation is not a

prerequisite for success; certain populations do relatively well despite being coerced into treatment.

The following sections were adequately covered:

- Legal and confidentiality issues
- Gay/lesbian/bisexual/transgender issues
- Racial, ethnic, and cultural factors
- The need for providers to promote smoking cessation
- Comorbid general medical disorders
  - o This section underscored the importance of managing drug-related risk behaviors, such as injection use (not always “intravenous”). It mentioned the sharing of “needles” but not the sharing of, “works”, or “cottons” or other paraphernalia related to injection drug use.
  - o HCV is now a leading cause of premature death in drug using populations; the guideline is still focused on HIV, which has taken a back seat to HCV. The guideline has not caught up with the prevalence and devastation of HCV.

In summary, the guideline, although not strongly evidence-based, provides a clear and relevant, knowledge-based map for psychiatrists and other providers treating people with substance use disorders.