Guideposts for the Treatment of Opioid Use Disorder

Optum is committed to assuring our members are receiving the highest quality evidence based and person-centered care available. Optum recognizes the time demand on staff and providers and offers this resource to give rapid access to evidence based strategies and guidance from professional organizations. These key components from several best practice guidelines will serve as a common language among Optum, providers and members that allows us to all work together in a member-centric manner. We want to partner to provide the highest quality care to our members.

1. **Opioid withdrawal management (i.e., detoxification) without ongoing psychotherapy for opioid use disorder is not recommended.** (The National Practice Guideline for the Treatment of Opioid Use Disorder, American Society of Addiction Medicine (ASAM))

2. **The use of methadone or buprenorphine for opioid withdrawal management is recommended over abrupt cessation of opioids. Abrupt cessation of opioids may lead to strong cravings, and/or acute withdrawal syndrome which can put the patient at risk for relapse, overdose, and overdose death. (ASAM)**

3. **Patients who discontinue buprenorphine treatment should be made aware of the risks associated with opioid overdose, and especially the increased risk of death if they return to illicit opioid use. (ASAM)**

4. **Patients' psychosocial needs should be assessed, and assistance with psychosocial issues should be offered based on individual need. A decision to decline assistance, or the absence of available assistance should not preclude or delay appropriate medication management (ASAM)**

5. **The unique needs of special populations** (e.g., Adolescents, Aging patients, Patients with medical comorbidities/pain management issues, Pregnant women) **should be identified and documented in the patient's treatment plan.** (Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health; Office of the Surgeon General (US) Washington (DC): US Department of Health and Human Services; 2016 Nov. (Surgeon General's Report))

6. **Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating OUD. Treatment alternatives including methadone and naltrexone, as well as opioid overdose prevention with naloxone should be discussed with any patient choosing to discontinue treatment (ASAM)**

7. **Initial and ongoing treatment planning should include collaboration with behavioral healthcare providers to determine the optimal type and intensity of psychosocial treatment and for reevaluation of the treatment plan when patients do not adhere to agreed-upon plans. (ASAM)**

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8. **Family therapy can effectively address OUD and related family problems** (e.g., family conflict, unemployment, conduct disorders). **Specific forms of family therapy are useful with adolescents and can be used to address family members' biases about use of medication for OUD.** (Federal Guidelines for Opioid Treatment Programs, SAMHSA, HHS Publication No. (SMA) PEP15-FEDGUIDEOTP First Printed 2015 (SAMHSA))

9. **Patient preferences, treatment history, current state of illness** (including suicide risk), **and treatment setting should be considered when offering and deciding between the use of methadone, buprenorphine, and naltrexone. (SAMHSA)**

10. **Assertive community treatment (ACT) should be considered for patients with co-occurring schizophrenia and opioid use disorder who have a recent history of, or are at risk of, repeated hospitalization and/or homelessness. (ASAM)**

Guideposts Details

1. **Opioid withdrawal management (i.e., detoxification) without ongoing psychotherapy for opioid use disorder is not recommended. (ASAM**).

   Background Information:
   Opioid withdrawal management on its own is not a treatment method. Withdrawal management is physiological treatment for withdrawal symptoms solely and does not address the whole person approach that is needed to understand the many factors that may be impacting the member's substance use.

   Clinicians should assess the psychosocial needs of patients and should be offering or referring to psychosocial treatments, based on their specific needs

   Maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorders.

2. **The use of methadone or buprenorphine for opioid withdrawal management is recommended over abrupt cessation of opioids. Abrupt cessation of opioids may lead to strong cravings, and/or acute withdrawal syndrome which can put the patient at risk for relapse, overdose, and overdose death. (ASAM)**

   Background Information:
   Opiate withdrawal is the strongest factor relating to relapse, but it is rarely life threatening. The goal of withdrawal management is to suppress the withdrawal symptoms. Withdrawal occurs after tolerance has developed and the regular supply of opioid is stopped abruptly. Additionally, a severe withdrawal reaction can be triggered by introducing an opioid antagonist (naloxone or naltrexone) or a partial agonist (buprenorphine) while there is still opioid in the system. This type of withdrawal can be severe enough to lead to medical hospitalizations.

Medications for the withdrawal management of opioids include methadone, buprenorphine, and alpha-2 adrenergic agonists (lofexidine and the off-label use of clonidine.) The use of buprenorphine or methadone is aimed at *suppressing the withdrawal symptoms*. This means the COWS should be coming down rapidly. Buprenorphine treatment generally begins at 2-4 mg and is increased until symptoms are suppressed. Methadone cannot be given in doses greater than 30 mg on the first day to avoid overdose and death.

Buprenorphine must be used only after withdrawal symptoms have begun or it may precipitate a severe withdrawal reaction. Providing methadone for withdrawal management while still intoxicated can lead to stupor, coma, and death by opioid overdose.

There are multiple settings where withdrawal management can occur: acute care, ASAM level 4 WM, ASAM level 3.7 WM, ASAM level 2 and ASAM Level 1 (including OTP). Stabilizing withdrawal symptoms and initiating maintenance is the standard of care.

3. **Patients who discontinue buprenorphine treatment should be made aware of the risks associated with opioid overdose, and especially the increased risk of death if they return to illicit opioid use. (ASAM)**

Background Information:

Maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorders. There is no recommended time limit for pharmacological treatment with buprenorphine.

Patients who discontinue buprenorphine treatment should be made aware of the risks associated with opioid overdose, and especially the increased risk of death if they return to illicit opioid use. Treatment alternatives including methadone and naltrexone, as well as opioid overdose prevention with naloxone should be discussed with any patient choosing to discontinue treatment. Buprenorphine taper and discontinuation should be a slow process with close monitoring. Maintenance buprenorphine tapering is generally accomplished over several months. Patients should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.

4. **Patients' psychosocial needs should be assessed, and assistance with psychosocial issues should be offered based on individual need. A decision to decline assistance, or the absence of available assistance should not preclude or delay appropriate medication management (ASAM).**

Background Information:

Psychosocial treatment can help patients manage cravings, reduce the likelihood of relapse, and assist them in coping with the emotional and social challenges that often accompany substance use disorders. Psychosocial treatment is available in a variety of outpatient and inpatient settings, but most studies have focused on outpatient treatment. Psychosocial treatment is provided using a variety of approaches in various milieus, including social skills training; individual, group, and couples counseling; cognitive behavioral therapy; motivational interviewing; and family therapy. Determining level of need and best approach to psychosocial treatment should be individualized to each patient. Mutual help and other recovery support services complement professional treatment, but do not substitute for professional treatment.

Psychosocial treatment should be considered in conjunction with all pharmacological treatments for opioid use disorder. However, because of the potential harm associated with untreated opioid use disorder, a patient's decision to decline psychosocial treatment or the

absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder with appropriate medication management. Motivational interviewing or motivational enhancement therapy can be used to encourage patients to engage in psychosocial treatment or support services appropriate for addressing their individual needs. In the absence of added psychosocial treatment, clinicians may need to further individualize treatment plans to address the potential for issues related to adherence and diversion.

5. **The unique needs of special populations (e.g., Adolescents, Aging patients, Patients with medical comorbidities/pain management issues, Pregnant women) should be identified and documented in the patient's treatment plan. (Surgeon General's Report)**

   Background Information:
   Identify and list how the treatment team is addressing the needs of special populations such as (Surgeon General's Report). Click below links for specific information:
   - Adolescents
   - Geriatric patients
   - Patients with medical comorbidities
   - Pregnant women

6. **Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating OUD. Treatment alternatives including methadone and naltrexone, as well as opioid overdose prevention with naloxone should be discussed with any patient choosing to discontinue treatment (ASAM).**

   Background Information:
   Abrupt withdrawal from Opioids or detoxing with medications is not an effective treatment for OUD. Without ongoing maintenance medication, the risk for overdose and death is *higher* than having no treatment at all. This is because after detox, all tolerance is gone and a return to usual doses increases the chance of overdose and death significantly. This means that detox without maintenance medication can be more dangerous than no treatment at all.

   There are several reasons that a person would not want maintenance medications. They might want to decrease or eliminate their tolerance to be able to get a better high, or because without the tolerance, the amount of drug needed to get high will cost less. Or they might not believe or be interested in being on a medication feeling that abstinence is the only way to go. For whatever reason, not being on maintenance medication leads to increased mortality. It is vital that the treating provider discuss all of this with the member, emphasizing the increased risk of OD or death and to try to determine the reason for the refusal of the treatment. "Failure" to achieve success with past episodes of buprenorphine or methadone are not reasons to avoid its use. We always recommend ongoing maintenance medication with psychosocial treatments.

7. **Initial and ongoing treatment planning should include collaboration with behavioral healthcare providers to determine the optimal type and intensity of psychosocial treatment and for reevaluation of the treatment plan when patients do not adhere to agreed upon plans. (ASAM)**

   Background Information:
   In addition to pharmacologic treatments, i.e., MAT, psychosocial treatments are beneficial to help manage relapse prevention. There are various modalities and treatment settings available, and it is best to individually match the treatments to the specific needs of the

member. Even so, the potential harm of having untreated opioid use disorder is so great, that pharmacotherapy should begin immediately even if the member refuses psychosocial interventions. This underscores the need to be very specific in the options offered to the member to best assure acceptance of the psychosocial treatments presented. In addition to community-based services, self-help programs, social needs assistance and other interventions, we might want to utilize individual or group counseling and/or additional psychosocial assessments. Accordingly engaging the entire treatment team will lead to the most chance of success. All providers, especially behavioral healthcare providers are best suited for this work.

8. **Family therapy can effectively address OUD and related family problems (e.g., family conflict, unemployment, conduct disorders). Specific forms of family therapy are useful with adolescents and can be used to address family members' biases about use of medication for OUD (Federal Guidelines for Opioid Treatment Programs, SAMHSA, HHS Publication No. (SMA) PEP15-FEDGUIDEOTP First Printed 2015 (SAMHSA)).**

   Background Information:
   Programs develop and implement policies to ensure that adolescents are provided with developmentally appropriate treatment and evidence-based psychosocial support, such as family involvement, for that treatment. Screenings and assessments tailored to adolescents ensure that medication-assisted treatment is the most appropriate treatment for these patients.

   The involvement of family members contributes to positive treatment outcomes while also providing benefits to the family members. It is useful to expand the concept of family to include the patient's social network; significant others; persons in recovery, such as a sponsor; and resources from the community including the outpatient provider and others at the patient's request. An Opioid Treatment Program (OTP) provides opportunities for family and significant others to become involved in therapy. Some OTPs use short-term groups to educate the family on medication-assisted treatment, substance use disorders and their effects on the family, and other family issues. Family counseling allows more participants to address their concerns with the patient. When appropriate, referrals for family treatment should be made and follow-up to the referrals confirmed. If needed, identification of the ongoing need for collaboration should occur with the informed consent of the patient and a valid release of information. Consistent with best practices for developmentally appropriate treatment, family involvement is an expectation of treatment for young adults (18-24 years). Onsite education and training for all patients who are parents should be available. Children of patients in medication-assisted treatment may have special mental health and cognitive needs, especially if there has been physical or sexual abuse or neglect. Children should be permitted inside the treatment program under parental supervision. When appropriate, program staff should refer patients who are parents to resources and services in parenting skills and childcare as well as parent support groups. OTPs also should provide reproductive health education for all patients and, when needed, make appropriate referrals for contraceptive services.

9. **Patient preferences, treatment history, current state of illness (including suicide risk), and treatment setting should be considered when offering and deciding between the use of methadone, buprenorphine, and naltrexone. (SAMHSA).**

   Background Information:
   Assessment for psychiatric disorders should occur at the onset of agonist or antagonist treatment. Patients with suicidal or homicidal ideation should be referred immediately for

treatment and possibly hospitalization. Clinicians should be aware of potential interactions between medications used to treat co-occurring psychiatric conditions and opioid use disorder.

Office Based Opioid Treatment (OBOT) provides buprenorphine on a prescribed cadence in an outpatient setting per federal law (21 CFR 1306.07). Patients should be seen frequently at the beginning of their treatment, at least weekly, until patients are determined to be stable.

Opioid Treatment Program (OTP) offers daily supervised dosing of methadone (some offer buprenorphine). Methadone is recommended for patients who may benefit from daily dosing and supervision in an OTP.

Methadone should also be considered for patients for whom buprenorphine treatment for OUD has been unsuccessful in an OBOT setting.

Naltrexone can be prescribed in any setting by a clinician with prescriptive authority for any medication. Extended- release injectable naltrexone assists with medication adherence.

Switching from naltrexone (antagonist) to methadone (full agonist) or buprenorphine (partial agonist) is generally less complicated then switching from a full or partial agonist to an antagonist. This is because there is no physical dependence associated with the antagonist and thus no possibility of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used should be low. Patients should not be switched until a significant amount of naltrexone is no longer in their system.

When switching from buprenorphine to naltrexone 7 to 14 days should elapse between the last dose of buprenorphine and the start of naltrexone. This is to ensure that the patient is not physically dependent on opioids prior to starting naltrexone. If not, enough time has lapsed the patient will experience precipitated withdrawal.

When switching from buprenorphine to methadone, there is no required time delay.

When a patient is seeking transfer from methadone to buprenorphine, it is advisable to determine if the request is based on realistic expectations. It is advised that most patient's taper their dose of methadone prior to transferring to buprenorphine. Patients switching from methadone to buprenorphine in the treatment for OUD should be on low doses of methadone (usually 30 mg day or less) prior to switching medications. As with any buprenorphine induction, patient should be agonist free, from 48 to 72 hours.

Unfortunately, for some patients, the transfer process is associated with a period of discomfort, both from tapering methadone and starting buprenorphine. Individuals on moderate to high dosages of methadone, over 60 to 120, may not be able to taper without discomfort and a risk of relapse. As the methadone dose is lowered, if the patient begins to experience withdrawal that interferes with their functioning or leads to relapses, he or she can be advised that transfer later may be advisable.

If the buprenorphine practitioner is not associated with the patient's methadone clinic, it will be important to work with the methadone physician and treatment team to coordinate the taper and the timing of the transfer. One should work with the methadone clinic staff to ensure continuity of care and a smooth transition, and know that if the transfer fails, that the patient may return to methadone treatment.

10. **Assertive community treatment (ACT) should be considered for patients with co-occurring schizophrenia and opioid use disorder who have a recent history of, or are at risk of, repeated hospitalization and/or homelessness. (ASAM)**

Background Information:

Antipsychotic medication may be initiated with pharmacotherapy for opioid use disorder for patients with schizophrenia or other psychotic disorders. Coadministration of antipsychotic medications with opioid agonist pharmacotherapy or use of long-acting depot formulations of antipsychotic medications is an option to consider in patients with histories of medication nonadherence. All patients with schizophrenia should be asked about suicidal ideation and behavior. Patients with a history of suicidal ideation or attempts should have their medication use monitored regularly. This includes medications for the treatment of opioid use disorder and psychiatric medications. For patients with schizophrenia and co-occurring opioid use disorder who have a recent history of, or are at risk of repeated hospitalization or homelessness, assertive community treatment (ACT) should be considered. ACT is designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with severe psychiatric disorders, and whose needs have not been well met by more traditional psychiatric or psychosocial services. The efficacy of ACT has had mixed results on substance use disorder outcomes but has shown benefit in preventing homelessness. When ACT or other intensive case management programs are unavailable, traditional case management can be helpful to patients who are unable to manage necessary, basic tasks.

Appendix:
Unique Needs of Special Populations

I. ADOLESCENTS	
Collaborative Whole-Person Care Model	**Medical-Behavioral Integration:** The youth's treatment plan should include a multi-disciplinary collaboration between all care providers. This includes medical (primary care, pediatrics) and BH (psychiatry, SUD, counselors, therapists, etc.). Designing a treatment plan that is strength based can help promote a youth's engagement and progress in areas for further improvement. Adolescent substance use disorders (SUDs) are associated with elevated morbidity and mortality and represent a significant public health cost. While psychosocial interventions for adolescent SUDs have demonstrated short-term efficacy, many youth relapse after treatment.
Medications	The ASAM National Practice Guideline for Treatment for Opioid Use Disorder recommended "Clinicians should consider treating adolescents who have opioid use disorder using the full range of treatment options, including pharmacotherapy". Opioid agonists (Methadone and Buprenorphine) and antagonists (Naltrexone) may be considered for treatment of opioid use disorder in adolescents. Federal laws and FDA approvals should be considered when recommending pharmacotherapy for adolescent patients" (ASAM)
Regulations	**Informed Consent:** Different states have different ages for informed consent for teens. For Optum staff, state specific age of consent guidelines can be found here. Children under 18 who are married or are emancipated minors are able to consent independently from a parent/guardian. For all others under age 18 check to see if there is a documented verbal agreement or signed informed consent from the parent or guardian for treatment and referral to treatment. If not, ask for a verbal agreement and document the informed consent agreement for treatment and referral to treatment (*American Psychological Association 2016 Standard 10:01; American Psychiatric Association 2015 Standard 3:2:4)* **Privacy & Confidentiality:** Different states have different ages and qualifications for teens to access treatment without parent or guardian knowledge. Releases of information will need to be in place for treatment. A release of information is not the same as informed consent. Children under 18 who are married or are emancipated minors do not need parent/guardian approval on a release of information. In most cases a parent or guardian is involved in treatment. Teens in treatment may not want to share information about treatment with their parents or guardians. Please be aware that content of sessions may not be shared with parents or guardians unless there is a specific danger to self or others or current use that is endangering the teen. Providers may work on an agreement with parents and guardians to only reveal high risk behavior to help build trust with the teen in treatment. We need to respect the treatment process and be sensitive to what is shared with the parent. *(American Psychological Association 2016 Standard 4:01-4:07; American Psychiatric Association 2015 Standard 3:2:4).*
Developmental Age & Stage	Not all youth develop at the same rate. Their life experiences, neurological development, physical, mental, and emotional health all impact their strengths and developmental capacities, as well as areas of risk. The treatment plan should be appropriate for a young person's individual developmental stage and needs. **Developmental Disabilities:** Disabilities can impact the sharing of information or referral to treatment. Individuals who have a documented intellectual disability may have

	guardianship until age 21 and need parent or guardian approval for all treatment. Teens with a developmental disability may have more intensive needs in treatment or may need multiple providers involved.
Protective vs Risk Factors	**Protective**: Protective factors are conditions, skills, attributes or coping skills that help individuals manage stressful life situations more effectively. Examples of protective factors are good mental health, a supportive family system or strong social supports, positive attitude or belief about treatment, success at school, positive self-esteem, and friends who do not use substances. **Risk:** Risk Factors are situations that increase the risk of opioid addiction. Examples include a family history of use/abuse, poor parental monitoring, family rejection of gender identity, developmental disability, mental illness such as depression and anxiety, poor or no family support, parental hostility, peer rejection, peer substance use, poor self-esteem, exposure in the environment. **Risks of victimization/neglect:** A history of traumatic events (witnessing violence at home or in the community) and child abuse are risk factors for teen use. It is important to recognize the impact of trauma on teen use and include treatment that use Trauma-Informed Care. SAMHSA recommends that treatment providers understand the role that trauma and trauma triggers (news of violence, seeing more violence, situations similar to what was experienced during the violence) play in an individual's life and that the cycle of violence or experience of triggers may lead to relapse. **High risk behaviors:** There are several behaviors that can place a teen at a higher risk for substance use such as sexual activity, interpersonal violence, use of other substances such as cannabis or alcohol, cigarette smoking or vaping, a history of impulsive behavior, history of distractibility, history of depression, ADHD, and anxiety disorder.
Support System	**Family:** Determine whether or not a youth's family is a protective versus risk factor. Family involvement in treatment should be determined by the risks versus benefits of family involvement. Risks to keep in mind include history of trauma, domestic violence, or caregiver substance use and mental health conditions and supports. **Community Ecosystem:** Treatment and recovery plans should consider the youth's ancillary supports within the community and how they can be optimized to enhance the youth's recovery (school, primary care, connections to peer groups, mentors, faith-based or extracurricular supports).
Location & Access	Environment may impact the success of treatment. Individuals who are in a rural area may have limitations such as distance to treatment or limitations on available providers in their area. Consider situations such as ability to access transportation or afford transportation or ability to access or afford technology for telehealth.
Social Determinants of Health	Social determinants of health such as economic stability, education, health/health care, and social and community context play a role in use and continued use. Children with exposure to substance use including opioid abuse from parents and older siblings can set the stage for future use. A school that the teen attends can have an impact on use if there are other teens using substances, which may increase the chance of use. The economic and housing stability of the family can impact teen use. If the family is homeless or if the family income is not stable that may increase feeling hopeless. Feeling hopeless can increase the risk of opioid use to cope with the feelings. It is important to pay attention to the social determinants of health as they continue to impact risk of use and ability to successfully recover.

II. PATIENTS WITH MEDICAL COMORBIDITIES/ PAIN MANAGMENT	
Impacts of medical condition on SUD & Treatment	Impacts of physical health conditions on Mental Health and Substance Use: Chronic pain and medical conditions themselves and the demands of managing them can increase the likelihood of difficulty coping, depression, anxiety, and sleep disturbances. Individuals with chronic or acute pain may also be at an elevated risk of anxiety, depression and substance or medication misuse. The use of opioids or benzodiazepines (prescribed or non-prescribed), marijuana ("medical" and "non-medical") needs to be assessed and addressed with the health care provider and member. "For all patients with pain, it is important that the correct diagnosis is made and that the pain is addressed. For patients with pain who have an opioid use disorder but are not in treatment, Methadone or Buprenorphine should be considered. The patient's opioid use disorder and pain should be stabilized and managed concurrently." (ASAM National Practice Guideline for Treatment for Opioid Use Disorder) Alternative treatments including non-opioid medications with pain modulating properties, behavioral approaches, physical therapy, and procedural approaches (e.g., regional anesthesia) should be considered before prescribing opioid medications for pain. (ASAM) Healthcare system experience – severity and complexity of medical comorbidities impacts where, how, and how often an individual experiences/interacts with the health care system which can impact MH and SUD sequelae.
Collaborative Whole-Person Care Model	**Medical-Behavioral Integration:** Increased need for multidisciplinary, collaborative treatment model: It is important to be aware of the need to coordinate care with behavioral health and physical health providers. Conducting a thorough history and a physical exam is essential in developing a comprehensive clinical formulation that can shape treatment and care for both SUD and other physical health needs.
Medications	**Medications and Substance Use** In general, illicit substances, including opioids, should not be used with prescription medications. Risks increase with the combination of certain substances, such as opioids and benzodiazepines or alcohol. Combining these can increase the risk of respiratory depression. **Medication-Medication Interactions** Medications can interact and impact one another. This can include increasing the risk of negative outcomes, as well as impacting the efficacy and metabolism of a drug. It is important to ensure the treatment team is fully informed of all the medications a member was taking prior to admission. Abruptly stopping some medications can result in withdrawal or negative outcomes. The treatment team should also assess risk for current med-med interactions. Polypharmacy should be avoided when possible. When the list of medications is long, including both scheduled and prn, reassess the rationale and safety of the use of each medication for that patient. Some medications can be misused and therefore pose an elevated risk of adverse impact. These include but are not limited to benzodiazepines, opioids, stimulants, and gabapentin.
Protective vs Risk Factors	**Protective**: Protective factors are conditions, skills, attributes or coping skills that help individuals manage stressful life situations more effectively. Examples of protective factors are good mental health, a supportive family system or strong social supports, positive attitude or belief about treatment, success at school, positive self-esteem.

	Risk: Risk Factors are situations that increase the risk of addiction. Examples include: a younger age, past or current substance abuse, a history of multiple opioid prescriptions and/or opioids at high doses, a family history of use/abuse, developmental disability, mental illness, poor or no family support, family/partner hostility, exposure to substances in the environment. Physical health problems can also be a risk factor. This includes chronic pain, or other chronic health problems that can impact a person's ability to function, their quality of life, and the burden/demands of engaging with chronic treatment. Their response to treatment can also impact their psychological well-being which can impact the risks of substance use.
Support System	**Family:** Determine whether or not a patient's family is a protective versus risk factor. Family/Partner involvement in treatment should be determined by the risks versus benefits of family involvement. Risks to keep in mind include history of trauma, domestic violence, or family/partner substance use and mental health conditions **Community Ecosystem:** Treatment and recovery plans should consider the patient's ancillary supports within the community and how they can be optimized to enhance recovery (primary or specialty care providers, connections to peer groups, faith-based supports, a sponsor)
Location & Access	Environment may impact success of treatment. Individuals who are in a rural area may have limitations such as distance to treatment or limitations on available providers in their area. Consider situations such as ability to access transportation or afford transportation or ability to access or afford technology for telehealth.
Social Determinants of Health	Impact of SDOH- Social determinants of health such as economic stability, education, health/health care, and social and community context play a role in use and continued use for patients with medical comorbidities. Individuals who live in rural communities or who are homeless may have limited access to medical care. Abuse of opioids may increase the severity of their medical conditions and interfere with treatment.

III. PREGNANT WOMEN	
Impacts of pregnancy on SUD & Treatment	Opioid use during pregnancy can cause birth defects and developmental disabilities, increased risk of fetal growth restriction, abruptio placentae, fetal death, preterm labor, preeclampsia, and passage of meconium as a result of intrauterine distress (ACOG.org). Women with a SUD are likely to cut back or stop use of opioids during pregnancy, however they are also more likely to resume substance use after the pregnancy. Some women are motivated to address their SUD by entering and completing treatment because of their roles as mothers and caregivers. However, some women may fear the legal or social ramifications of engaging in treatment while pregnant (and parenting). Because of the severe consequences of opioid use during pregnancy, treatment for substance use in pregnant women is a very important clinical need. **"Treatment with Methadone or Buprenorphine is recommended and should be initiated as early as possible during pregnancy. Pregnant women who are physically dependent on opioids should receive treatment using Methadone or Buprenorphine rather than withdrawal management or psychosocial treatment alone."** (ASAM National Practice Guideline for Treatment for Opioid Use Disorder) Infants born to women who used opioids need to be monitored by a pediatric care provider for neonatal abstinence syndrome, which is a drug withdrawal syndrome that may occur in the infant after birth (ACOG.org).

	The patient should be offered an individualized care plan that takes into account individual's current physical health, trimester of pregnancy, current and past MH and SUD history (of symptoms and treatment response).
	There may be a stigma attached to discussing substance use while pregnant. Pregnant women with an existing mental illness may be at risk of increased symptoms of the mental illness due to the stress of the pregnancy or related hormone changes. This stress may also increase any current opioid use.
Collaborative Whole-Person Care Model	**Medical-Behavioral Integration:** Increased need for multidisciplinary, collaborative treatment model – It is important to be aware of the need to coordinate care with behavioral health and physical health providers (including OB/GYN to care for both the patient and unborn child). Treatment programs that integrate the whole person, including family and parenting responsibilities. Treatment should take into account the woman's entire health and psychosocial needs. Treatment and recovery planning should include: • Information and education about the impact of substance use in pregnancy and treatment options • Screening for other BH or Physical Health needs Behavioral interventions that are patient-centered, use CBT or motivational interviewing techniques are important to help the woman understand the risks of opioid use for her and the unborn child. Building recovery supports is essential to helping a woman engage in care (both SUD and OB/GYN) throughout and after pregnancy. Approaches to SUD treatment for women should include: • Relational approaches that take into consideration positive and negative familial and partner influences, relationships, and promote a safe and caring treatment environment. • Treatment programs that integrate the whole person, including family and parenting responsibilities. • Trauma-informed approaches that include screening and assessing women for trauma history. • A focus on identifying and addressing co-occurring substance use and mental disorders, such as mood, anxiety, and eating disorders. • Provider recognition of women's cultural expectations to help improve engagement and retention in treatment programs.
Medications/ Treatment	Methadone and buprenorphine are two types of medications which prevent withdrawal and control opioid cravings. Regarding medications such as: **disulfiram, naltrexone, acamprosate, baclofen, ondansetron**: • The data on teratogenic or toxic effects of these compounds during pregnancy is very limited. Hence no definitive recommendations can be given concerning these medications during pregnancy, and they should only be administered on a case-by-case basis and after careful evaluation. For example, according to the Food and Drug Administration (FDA) classification, ondansetron is in the pregnancy category B, while disulfiram, naltrexone, acamprosate and baclofen are in the pregnancy category C. Topiramate was reclassified from category C to category D, based on new data reporting an increased risk for cleft lip and/or cleft palate (oral clefts). **Medication-Medication Interactions** It is important to ensure the treatment team is fully informed of all the medications a member was taking prior to admission. Abruptly stopping some medications can result in withdrawal or negative outcomes. The treatment team should also assess risk for current med-med interactions. Polypharmacy in general should be avoided when possible. When the list of medications is long, including both scheduled and prn, reassess the rationale and safety of the use

	of each medication for that patient. Some medications can be misused and therefore pose an elevated risk of adverse impact. It is also important to consider the physical changes of pregnancy and how they may impact the metabolism of medications.
Protective vs Risk Factors	**Protective**: Protective factors for pregnant women include screening for opioid use, consistent prenatal health care, employment, good mental health, supportive family environment (no drinking or smoking). **Risk:** Risk Factors are situations that increase the risk of addiction. Risk factors include chronic pain, partner violence, being unmarried, major depression, loss of income, smoking, lack of access to insurance, living with families that use substances, a family history of use/abuse, developmental disability, mental illness, poor or no family support, spouse or partner hostility, peer rejection, peer drinking and substance use, poor self-esteem, exposure in the environment. (WFSBP and IAWMH Guidelines for the treatment of alcohol use disorders in pregnant women) Assessing and addressing risks of interpersonal violence or victimization: Pregnant women who are in situations where they are exposed to interpersonal violence may be at risk for opioid use to manage the experience of violence. Women in domestic violence situations may join their abuser in use of substances to mitigate the violence. In some cases, opioid use is associated with poly-consumption (including tobacco and illicit drugs), homelessness, comorbid psychiatric or somatic disorders, and domestic violence, which require specific psychosocial and/or medico-psychiatric care. The WHO published recommendations for first-line intervention regarding the identification and management of intimate partner violence often associated with OUD. Proper recording and referral should be encouraged.
Support System	**Family:** Determine whether or not a woman's family is a protective versus risk factor. Family involvement in treatment should be determined by the risks versus benefits of family involvement. Risks to keep in mind include history of trauma, domestic violence, or partner substance use and mental health conditions. **Community Ecosystem:** Treatment and recovery plans should consider the woman's ancillary supports within the community and how they can be optimized to enhance her recovery (school, primary care, OB/GYN providers, connections to parent/mother groups, peers, faith-based supports, and a sponsor).
Location & Access	Environment may impact success of treatment. Individuals who are in a rural area may have limitations such as distance to treatment or limitations on available providers in their area. Consider situations such as ability to access transportation or afford transportation or ability to access or afford technology for telehealth. A patient may be more inclined to engage in care with physical health providers for medical needs rather than BH. These are opportunities for screening, re-assessment of clinical needs, and engaging with BH services as indicated. Medical care providers may need access to BH consultation if BH resources are limited. In contrast, some women may be less inclined to access medical/prenatal care due to concerns about judgment, stigma, and legal ramifications. It is essential that the health care and community system support a pregnant woman in engaging in care and that the system provides her with stigma-free, high-quality evidence-based interventions. Education and training regarding screening and management of opioid use in pregnant women should be promoted in all perinatal caregivers. Pregnant women may under-report opioid use, and perinatal caregivers are in an ideal position to screen pregnant women for opioid use and to advise women on the importance of avoiding opioids. They can use behavioral interventions or refer

	them to specialized treatment units if necessary (depending on the level of risk of OUD). Networking and communication between health professionals during pregnancy and delivery as well as after birth should be improved.
Social Determinants of Health	Social determinants of health such as economic stability, education, health/health care, and social and community context play a role in use and continued use for pregnant women. Individuals who live in rural communities or who are homeless may have limited access to appropriate prenatal and postnatal care to monitor for potential issues. Teen pregnant women may not have the social supports in their environment and may not be aware of the need to stop opioid use while pregnant and attend pre and postnatal visits. SDOH can negatively impact a woman's engagement in prenatal and postnatal care, and therefore must be assessed and addressed in a holistic care and recovery plan.

IV. AGING PATIENTS	
Impacts of age on SUD & Treatment	Aging can lead to social and physical changes, including injuries and chronic pain, that may increase vulnerability to opioid misuse. Older adults may also be more likely to experience chronic physical health problems, mental health problems and cognitive changes. Substances can worsen these conditions and exacerbate the negative health consequences of substance use. The effects of opioids, illicit drugs and even prescribed medications can impair judgment, coordination, and reaction time. This increases the risks of accidents like falls and car accidents. These types of injuries can pose an even greater risk to health and require a longer recovery time. Medical conditions themselves and the demands of managing them can increase the likelihood of difficulty coping, depression, anxiety, and sleep disturbances. • Persistent pain may be more complicated in older adults experiencing other health conditions or substance use. The risks of using opioids or benzodiazepines (prescribed or non-prescribed), marijuana ("medical" and "non-medical") and alcohol need to be assessed and addressed with the health care provider and member. Geriatric patients can be at a greater risk of worse outcomes.
Collaborative Whole-Person Care Model	**Medical-Behavioral Integration:** Management of multiple chronic medical conditions: The gold standard is that all health care providers, both physical and behavioral health, collaborate with one another to share a holistic clinical formulation and understanding of the root causes of the patient's symptoms, their treatment needs, and the timeline for interventions (acute versus chronic). Treatment and recovery planning should include: • Information and education about the impact of substance use on health & safety, as well as treatment options (pharmacological and non-pharmacological) • Screening for other BH or Physical Health needs. **Since most geriatric patients engage with primary care before BH, it is essential that PCPs are equipped for screening and treating/referring to SUD care.**
Medications/Treatment	**Review of MAT treatment for geriatric population** It is good practice for the treatment team to review the data in the state's PDMP (Prescription drug monitoring program) to identify medications that the patient has been prescribed and may be taking. **Management of complex medication regimens:** As we age, our physiology can change. It is essential that all health care providers treating a geriatric patient collaborate with one another to ensure they are fully informed and in agreement with the safety of medications prescribed.

	The longer the list of polypharmacy, the greater the risks. Whenever the opportunity arises, it is important to reassess a patient's medications, the reason the medication is prescribed, the effects and the risks. Given the risks of memory impairment, it is also essential a geriatric patient has support in taking medications exactly as prescribed to avoid adverse outcomes. A patient's medical condition must be taken into consideration when selecting safe medications and doses to reduce the risks of negative outcomes. For example, if a patient has impaired liver, kidney or heart function, health care providers should ensure the member is not prescribed any medications that cannot be safely tolerated or metabolized. Geriatric patients often require smaller doses and carefully planned medication dosing schedules. Clinicians should avoid medications that increase the risk of falls.
Protective vs Risk Factors	**Protective**: Protective factors for geriatric patients include screening for opioid use, stable income, spouse or partner living, supportive family environment (no drinking or smoking), access to health care, access to transportation. **Risk:** Risk Factors are situations that increase the risk of addiction. Examples include history of injury and chronic pain, a family history of use/abuse, developmental disability, mental illness, poor or no family support, spouse or partner hostility, grief/loss, isolation, lack of access to insurance, lack of transportation access. • Assessing and addressing risks of interpersonal violence or victimization: Geriatric patients are a vulnerable population at risk of being victimized. This can come in many forms, not just physical violence. Some are neglected, taken advantage of financially, and left with minimal resources (scarcity of food, inability to pay for electricity, water, etc.). It is essential that treatment providers screen for any of these concerns. • Risk of grief, loss, bereavement, social isolation: those in late adulthood may be isolated after the death of a spouse and use substances to cope with the grief and loss. • Frequent falls or injury and chronic pain. Geriatric patients are at a higher risk for injury, repeated injury, and subsequent pain.
Support System	**Family:** • Including a patient's family and support system is also recommended if it is clinically and socially appropriate. It is important to assess a patient's autonomy and ability to consent to treatment, as some geriatric patients may have impaired capacity to make decisions. Some may have a legal guardian who needs to be included in their care planning. • Burdens of being a primary caregiver for a spouse with greater needs: The spouse of a disabled geriatric patient who is using opioids may need to be referred to counseling for themselves to help manage the stress. • Burdens of being a dependent of a caregiver/spouse: Disabled geriatric patients who are dependent on a caregiver may have increased stress related to being dependent and use opioids to cope. **Community Ecosystem:** Treatment and recovery plans should consider the patient's ancillary supports within the community and how they can be optimized to enhance recovery. Geriatric patients may be more at risk of social isolation without ongoing support after treatment.
Location & Access	Environment may impact success of treatment. Individuals who are in a rural area may have limitations such as distance to treatment or limitations on available providers in their area. Consider situations such as ability to access transportation or afford transportation or ability to access or afford technology for telehealth.

	A patient may be more inclined to engage in care with physical health providers for medical needs rather than BH. These are opportunities for screening, re-assessment of clinical needs, and engaging with BH services as indicated. Medical care providers may need access to BH consultation if BH resources are limited.
Social Determinants of Health	SDOH impacting health outcomes, utilization of health care system: Impact of SDOH access to services for all care needs: impact of SDOH- Social determinants of health such as economic stability, education, health/health care, and social and community context play a role in use and continued use for geriatric patients. Individuals may heavily rely on family supports for transportation to SUD treatment and medical care or rely on local public transportation. If transportation services are disrupted the individual may not be able to access treatment. Geriatric individuals may also be on Medicare and only have access to a limited provider network in their area. If they live in a rural area, they may not have access to an adequate provider network. Geriatric patients may also be dependent and/or live with their family and if the family is not supportive of cessation of alcohol use the individual may continue to use.