Care Principles for treatment of opioid use disorder for Youth

SUDs are chronic, relapsing conditions and youth with OUD may need to engage in multiple approaches of varying intensities along the care continuum.

The continuum of care for OUD should be understood as inclusive and supportive of youth achieving long-term recovery, with an understanding that recovery looks different for each person.

Early intervention should be emphasized in providing care for youth using illicit (illegal and non-medical) opioids.

The full range of available treatments should be considered for youth with OUD, including OAT and other pharmacological and non-pharmacological treatments, with buprenorphine/naloxone recommended as first-line treatment for moderate/severe OUD.

Treatment approaches should be tailored individually to each patient.

Psychosocial treatment interventions and supports should be routinely offered to all youth with OUD but should not be a barrier to accessing care.

Youth SUD treatment should ensure continuity of care, prevent "aging out", and support transitions between care settings and levels of care.

All youth with OUD should be assessed (and, when necessary, offered treatment), for co-occurring disorders.

Education and referral to take-home naloxone programs and other harm reduction services should be routinely offered as part of standard care for OUD.

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Summary of Clinical Recommendations

1. The full range of available treatments should be considered for youth with OUD, including OAT, other pharmacological treatments, non-pharmacological interventions, and recovery-oriented services, with buprenorphine/naloxone recommended as first line treatment for moderate/severe OUD.
2. Treatment approaches/plans for youth with OUD should be developmentally-appropriate, youth-centered, trauma-informed, culturally appropriate, confidential, promote recovery, and include family involvement when appropriate.
3. When pharmacological treatment is indicated, buprenorphine/naloxone is recommended as first line treatment due to safety advantages and improved flexibility (e.g., take-home doses).
4. Transitioning to methadone should be considered in youth who do not respond to adequately dosed buprenorphine/naloxone.
5. Withdrawal management alone is not recommended, as this approach has been associated with elevated rates of relapse, HIV infection and overdose death. If it is the chosen course of action, a discharge plan should be in place for referral to ongoing addiction treatment (i.e., intensive outpatient treatment, residential treatment, access to long-term OAT, or antagonist treatment).
6. Psychosocial treatment interventions and support should be routinely offered to all youth with OUD but should not be a barrier into accessing care.
7. All youth should be screened for substance use disorders, including co-occurring mental health disorders.
8. Information and referral to take-home naloxone programs and other harm reduction services should be routinely offered to patients and, when appropriate, friends and family members as part of standard care for OUD.
9. Prescribers should consult the Rapid Access to Consultative Expertise (RACE) line and/or refer to addiction physicians with experience treating youth with OUD and refer to specialty care targeted at youth as available and appropriate.

Read the full guidelines at www.bccsu.ca/oud-youth