



Alcohol Use Disorder Care Pathway:

Assessment	1) Assess for risk factors for complicated withdrawal (ASAM): Co-occurring medical, behavioral, and other substance use History of delirium tremens, seizures History of prolonged cognitive impairment.
Treatment	2) The initial goals of treatment of alcohol use disorder be agreed on between the patient and clinician. 3) Use withdrawal assessment scale-triggered dosing rather than fixed schedule dosing, and longer half-life medications when possible. (ASAM) 4) Care plan includes education, recommendations for medication for AUD, initiating medication for alcohol use disorder (MAUD) at the current level of care if possible and coordinating continuity of care. (American Psychiatric Association)
Support	5) Identify and list how the treatment team is addressing the needs of special populations such as (Surgeon General's Report): ▪ Adolescents ▪ Patients with medical comorbidities ▪ Pregnant women ▪ Geriatric patients
Recovery	6) Throughout treatment, identify and address social determinants of health (SDOH) impacting, or potentially impacting, recovery (National Alliance for the Mentally Ill Circle of Care).

Assessment:

Assess for risk factors for complicated withdrawal (ASAM):

Assessment should include:

- **Comprehensive Evaluation:** includes validated risk scales, history, physical exam, collateral information from family/friends, and laboratory tests (metabolic panels, liver function, pregnancy test when applicable)
- **Risk Factors for Severe/Complicated Withdrawal:** Include history of alcohol withdrawal seizures or delirium, multiple prior withdrawal episodes, comorbid medical illness (e.g. traumatic brain injury), age > 65, signs of autonomic hyperactivity, physiological dependence on GABAergic agents
- **Concurrent Conditions:** Screen and assess for polysubstance use, psychiatric disorders, and pregnancy status
- **Mental Health:** Evaluate for suicide risk and mental health disorders; consult specialists as indicated

Background Information:

For patients who have signs and symptoms suggestive of alcohol withdrawal, assess the quantity, frequency, and time of day when alcohol was last consumed to determine whether the patient is experiencing or is at risk for developing alcohol withdrawal. For this assessment, it may be helpful to (ASAM):

- Use a scale that screens for unhealthy alcohol use (e.g., Alcohol Use Disorders Identification Test-Piccinelli Consumption [AUDIT-PC])
- Use information from collateral sources (i.e., family and friends)
- Conduct a laboratory test that provides some measure of liver function (ALT, AST, ...), and pregnancy test for all woman of childbearing age
- Conduct and document History and Physical examination
- Assess depression and suicidality (PHQ-9)

Assess for the following factors associated with increased patient risk for complicated withdrawal or complications of withdrawal (ASAM):

- History of alcohol withdrawal delirium or alcohol withdrawal seizure
- Numerous prior withdrawal episodes in the patient's lifetime
- Comorbid medical or surgical illness (especially traumatic brain injury)
- Increased age (>65)
- Long duration of heavy and regular alcohol consumption
- Seizure(s) during the current withdrawal episode
- Marked autonomic hyperactivity (unstable or fluctuating vital signs)
- Physiological dependence on GABAergic agents such as benzodiazepines or barbiturates

The following individual factors may increase a patient's risk for complications of withdrawal (ASAM):

- Concomitant use of other addictive substances
- Positive blood alcohol concentration in the presence of signs and symptoms of withdrawal
- Signs or symptoms of a co-occurring psychiatric disorder are active and reflect a moderate level of severity

The clinician needs to ask about other drug use and potentially obtain information from the state Prescription Drug Monitoring program (SAMHSA).

Treatment:

1. **The initial goals of treatment of alcohol use disorder (e.g., abstinence from alcohol use, reduction or moderation of alcohol use, other elements of harm reduction) be agreed on between the patient and clinician and that this agreement be documented in the medical record.**

Background:

Clinicians should collaborate with patients to identify specific treatment goals regarding their alcohol use. With the patient's permission, involvement of family members in developing treatment goals can be helpful. Options for treatment goals might include abstinence, reduction in alcohol use, or eliminating drinking in particularly high-risk situations (e.g., at work, before driving, when responsible for caring for children). Data have shown that having explicit drinking goals at baseline may be associated with improved AUD treatment outcomes.

Abstinence as a pretreatment goal has been associated with greater rates of abstinence or moderation, but all groups with an explicit pretreatment goal showed some reduction in alcohol use. Abstinent and non-abstinent drinking goals can include controlled or occasional use, abstinence with the recognition that slips may occur, or total abstinence on a short- or long-term basis. Motivational interviewing (MI) is one model for having discussions about goals with patients (APA).

As part of a person-centered treatment plan, it is important to consider both non-pharmacological and pharmacological treatment approaches.

APA recommends that naltrexone or acamprosate be offered to patients with moderate to severe alcohol use disorder who:

- have a goal of reducing alcohol consumption or achieving abstinence,
- prefer pharmacotherapy or have not responded to nonpharmacological treatments alone, and
- have no contraindications to the use of these medications.

2. Withdrawal management medications should be given when triggered by scores from a validated assessment-scale, rather than based on a fixed dosing schedule. Use longer half-life medications when possible. (ASAM)

Background Information:

A validated scale should be used to assess alcohol withdrawal severity. Assess the risk for scores on an alcohol withdrawal severity assessment scale to be confounded by causes other than alcohol withdrawal. If risk factors are present, interpret the results of scales with caution (ASAM).

Use a scale that relies more on objective signs of withdrawal (autonomic activity) if a patient has difficulty communicating about their symptoms. A validated withdrawal severity assessment scale can be used as part of risk assessment. A high initial score can indicate risk of developing severe or complicated withdrawal, although scores should not be the only information used to predict patient risk.

The CIWA-AR (The Clinical Institute Withdrawal Assessment Alcohol Scale, Revised) is the most widely used scale, but other valid and reliable scales can be used. Regardless of the instrument used, there is a wide variety in the literature and in practice as to which scores best delineate mild, moderate, and severe withdrawal. Classification of withdrawal severity is ultimately up to the judgment of clinicians and the choice of reference range may be based on their patient population or capabilities.

TABLE 1. Alcohol Withdrawal Severity should be assessed using a standardized tool

TABLE 1. Alcohol Withdrawal Severity.		
Severity Category	Associated CIWA-Ar Range	Symptom Description
Mild	CIWA Ar < 10	Mild or moderate anxiety, sweating and insomnia, but no tremor
Moderate	CIWA Ar 10 to 18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA Ar > 19	Severe anxiety and moderate to severe tremor, but not confusion, hallucinations, or seizure
Complicated	CIWA Ar > 19	Seizure or signs and symptoms indicative of delirium, such as an inability to fully comprehend instructions, clouding of the sensorium or confusion, or new onset of hallucinations

The CIWA can be found at: <https://www.ci2i.research.va.gov/paws/pdfs/ciwa-ar.pdf>.

A front loading regime is recommended for patients at high risk of withdrawal, and at least a single dose for patients with lower risk with medical comorbidities: history of severe complicated withdrawal, an acute medical, surgical or medical illness, severe coronary artery disease or heart failure, and those with symptoms of withdrawal despite positive blood alcohol content

Withdrawal Scale-triggered dosing and benzodiazepines with longer half-lives are diazepam (Valium) and chlordiazepoxide (Librium) are preferred over fixed scheduled dosing or short acting benzodiazepines. Lorazepam (Ativan) is often used for patients with liver impairment as this benzodiazepine is not metabolized by the liver, unlike other benzodiazepines.

3. Care plan includes education, recommendations for medication for AUD, initiating medication for alcohol use disorder (MAUD) at the current level of care if possible and coordinating continuity of care. (American Psychiatric Association)

Background Information:

Clinicians should ensure the patient has been informed about the potential health and other consequences of untreated alcohol use disorder and inform the patient about both nonpharmacologic and pharmacologic interventions. Nonpharmacologic and pharmacologic interventions are complementary and not exclusive of one another. This informed consent should be documented. (APA)

There are several evidence-based options for non-pharmacological treatment that have minimal harm:

- Motivational Enhancement Therapy (MET): manualized psychotherapy based on the principles of motivational interviewing; shown to have a small to medium effect size on achieving abstinence
- Cognitive Behavioral Therapy (CBT): focusing on the relationships between thoughts, feelings, and behaviors; help manage urges and triggers
- Medical Management (MM): manualized treatment that provides education and strategies to support recovery and promote medication adherence
- Community based peer support groups such as Alcoholics Anonymous (AA) and other 12-step programs: helpful in achieving long-term remission but not for replacing formal medical treatment.

Pharmacologic interventions consist of the following FDA approved medications: Naltrexone (Revia or Vivitrol), Acamprosate (Campral) and Disulfiram (Antabuse).

A review by the Agency for Healthcare Research and Quality (AHRQ) found no evidence for superiority of one of the medications over the other. Evidence on the combined use of naltrexone and acamprosate is not sufficient to make any recommendation. Specific recommendations are focused on treatment of moderate to severe AUD because individuals with mild AUD are less likely to be included in clinical trials of pharmacotherapies. Selection of a medication should be based on factors such as ease of administration, side effects or potential risks, co-occurring conditions, patient history and preferences, etc.

Naltrexone or Acamprosate should be considered if the patient:

- has the goal of reducing alcohol consumption or achieving abstinence;
- prefers pharmacotherapy or has not responded to nonpharmacological treatments alone, and
- has no contraindications to the use of these medications

Disulfiram should be considered if the patient:

- has the goal of achieving abstinence;
- prefers disulfiram or is intolerant to or has not responded to naltrexone and acamprosate,
- is capable of understanding the risks of alcohol consumption while taking disulfiram, and has no contraindications to the use of this medication. (APA)

Support:

4. Identify and list how the treatment team is addressing the needs of special populations such as (Surgeon General’s Report):

- [Adolescents](#)
- [Patients with medical comorbidities](#)
- [Pregnant women](#)
- [Geriatric patients](#)

Background Information:

Detailed information about considerations for each of the special populations above is available in the Appendix. Select the link above to go to detailed information about treatment considerations for each of the identified special populations.

Recovery:

5. Throughout treatment, identify and address social determinants of health (SDOH) impacting, or potentially impacting, recovery (National Alliance for the Mentally Ill Circle of Care).

Background Information:

Decent, safe, affordable housing lays a foundation for recovery, yet without financial assistance, independent housing is out of reach for many people on a fixed income. Although there are advantages to living with an extended family, the situation can also be stressful. National Alliance of Recovery Residences (NARR) are not covered by most insurances but offer safe, sober, supportive housing and can be subsidized with work placements. NARRonline.org

There are many advertised sober homes that are dangerous. Only recommend sober homes that are NARR certified.

Appendix: Special Populations

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	<u>Pharmacotherapy</u>, when used in conjunction with psychosocial substance treatment interventions, may improve outcomes compared to psychosocial treatment alone. 1. Compared to ample research in adults, relatively few randomized controlled medication trials have been conducted in adolescents with SUD. 2. Some preliminary studies suggest that naltrexone, disulfiram, ondansetron, and topiramate may be relatively safe, well-tolerated medications that show some promise as adjunctive treatment for adolescents with AUDs. However, larger randomized controlled trials are warranted. When to consider pharmacotherapy for SUDs in adolescents ▪ Moderate to severe SUD ▪ Comorbid/Co-occurring psychiatric disorders[±] ▪ Youth has failed psychosocial interventions ▪ Youth is engaged in psychosocial interventions but is not improving (no change in substance use, no functional improvement) ▪ High-risk for morbidity and mortality (intravenous drug use, drunk or drugged driving, unprotected sexual intercourse, accidents) ▪ Family or parents/guardians are engaged in treatment planning and willing to monitor medication What factors should be considered in choosing a medication ▪ Patient's experience with SUD recovery enhancing medications ▪ Patient and family's opinions and beliefs ▪ Family and parent/guardian involvement in treatment plan (for monitoring) ▪ Level of motivation for treatment goals: harm reduction versus abstinence ▪ Health Status (medical and psychiatric history, and allergies) ▪ Contraindications for medications ▪ Safety profile of medication and drug-to-drug interactions between medication and substance of abuse ▪ History of medication compliance [±] For patients with comorbid substance use and psychiatric disorders, pharmacotherapy should be initially directed at treating the co-occurring psychiatric symptoms and disorders

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 there 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 (<i>American Psychological Association 2016 Standard 10:01; American Psychiatric Association 2015 Standard 3:2:4</i>) 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 the 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. (<i>American Psychological Association 2016 Standard 4:01-4:07; American Psychiatric Association 2015 Standard 3:2:4</i>).
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 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 family history of use/abuse, developmental disability, mental

	illness, poor or no family support, parental hostility, peer rejection, peer drinking, 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 substance use. It is important to recognize the impact of trauma on substance 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) plays 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 alcohol use such as sexual activity, interpersonal violence, cigarette smoking or vaping, a history of impulsive behavior, history of distractibility, history of ADHD, anxiety disorder and having a peer social network engaging in high-risk drinking and substance use..
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 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 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 alcohol use from parents and older siblings can set the stage for future use. Parents who warn children about the impact of alcoholism may decrease use. A school that the teen attends can have an impact on use. If there are other teens drinking that 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 the feeling of hopelessness. Feeling hopeless can increase the risk of drinking 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.

PATIENTS WITH MEDICAL COMORBIDITIES

Impacts of medical condition on SUD & Treatment	Impacts of physical health conditions on Mental Health and Substance Use: Individuals with medical conditions such as diabetes or high blood pressure may have corresponding anxiety or depression related to their medical condition. Often these individuals will self-medicate their anxiety and depression with use of alcohol. Alcohol use may in turn exacerbate their medical conditions. 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. In addition to the use of alcohol, the use of opioids or benzodiazepines (prescribed or non-prescribed), marijuana (“medical” and “non-medical”), and other problematic substances like Kratom needs to be assessed and addressed with the health care provider and member. 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, alcohol and illicit substances 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 in general should be avoided when possible. When the list of medications is long, including both scheduled and as needed (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. Also, consider any medication-supplement interactions if patient is taking any over the counter or prescribed supplements.

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 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 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 a 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. Alcohol use may increase the severity of their medical conditions, and these conditions may not be treated regularly or appropriately.

PREGNANT WOMEN

Impacts of pregnancy on SUD & Treatment	Alcohol use during pregnancy can cause birth defects and developmental disabilities collectively known as fetal alcohol spectrum disorders (FASDs). It can also cause other pregnancy problems, such as miscarriage, stillbirth, and prematurity. (CDC.gov) Women with a SUD are likely to cut back or stop use of alcohol 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 sustained heavy alcohol consumption during pregnancy, treatment of alcohol use disorder in pregnant women is a very important clinical need. Usually, abstinence after previous detoxification in an inpatient setting can be considered as first-choice in the treatment of alcohol dependent patients or women with high alcohol consumption. However, in individual cases, when total abstinence is an unrealistic therapeutic goal, a reduction in the amount of alcohol consumption and number of heavy drinking days may also be considered a possible treatment goal. In either case, a close collaboration with an obstetrician is of high importance to monitor the risk to the fetus. 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 alcohol 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 alcohol 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, and relationships, and promote a safe and caring treatment environment. ▪ Consideration for using Peer Support Specialist and/or Doulas to engage and retain pregnant mothers with AUD/SUD in treatment. ▪ 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	The American Psychiatric Association guidelines for the pharmacologic treatment of patients with alcohol use disorder, state that for pregnant or breastfeeding women with alcohol use disorder, pharmacologic treatments should not be used unless treating acute alcohol withdrawal or a co-occurring disorder. The treatment of pregnant women with substance use disorder should be managed by clinicians with specialized expertise in this area. Psychosocial treatments are prioritized as there is a paucity of data on the safety of pharmacologic therapies for alcohol use disorder in pregnant individuals. If abstinence is not achieved without the use of medications, the risks of continued heavy drinking likely outweigh the possible adverse effects of medication. In weighing risks and benefits of prospective treatment, one should consider potentially harmful effects of alcohol to the mother and to the developing fetus, with alcohol a known teratogen and the most common cause of congenital anomaly in the United States. Pregnant patients must be advised against stopping drinking "cold turkey". During inpatient detoxification the use of pharmacological therapy should be considered even earlier than in patients who are not pregnant since withdrawal and the associated elevated stress levels may represent a much higher risk to the fetus than the use of safe pharmacological agents. In the case of alcohol dependence, detoxification with benzodiazepines, combined with intensive psychosocial support, should be the treatment of first choice. The use of pharmaceutical agents cannot be recommended for relapse prevention in pregnant women because of the limited knowledge of possible toxic or teratogenic effects. Medications: Key Points Low doses of BZDs (Recommendation D) may be used, if necessary, at the lowest dose and for the shortest duration, to prevent alcohol withdrawal symptoms when chronic and high alcohol intake is stopped Due to the low level of evidence or to their low benefit/risk ratio, pharmacological treatment for maintenance of abstinence should not be used during pregnancy. Furthermore, carbamazepine, and especially valproic acid, are contraindicated during pregnancy. Caution is required if baclofen is used during pregnancy and disulfiram should be avoided.

	Benzodiazepines: There is some evidence suggesting negative effects particularly during the first trimester as well as during the last weeks of pregnancy. Benzodiazepine use in the first trimester has been associated with an elevated risk of oral clefts and other malformations, but these results are controversial. In addition, the use of benzodiazepines in the last weeks of pregnancy carries the risk of postnatal withdrawal syndrome as well as perinatal problems like floppy-infant syndrome. These potential risk factors have to be taken into account, although they can be well managed in the majority of patients. Chlordiazepoxide and diazepam (with caution) should be considered first-line BZDs when needed in early pregnancy. Some caution is given with clonazepam and lorazepam due to higher malformation risks. Other medications: Anticonvulsants: (such as carbamazepine, valproate, lamotrigine, topiramate) are not recommended for prevention and treatment of alcohol withdrawal during pregnancy. An increased risk for congenital malformations was observed for nearly all first-generation anticonvulsants in infants exposed to anticonvulsants in early pregnancy. The teratogenic effect of many anticonvulsants precludes their use during pregnancy, especially for valproic acid and carbamazepine, which must be avoided. 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 alcohol use, employment, supportive family environment (no drinking or smoking).

	Risk: Risk Factors are situations that increase the risk of addiction. Risk factors include partner violence, being unmarried, major depression, loss of income, smoking, access to insurance, living with families that drink alcohol, a family history of use/abuse, developmental disability, mental illness, poor or no family support, spouse or partner hostility, peer rejection, peer drinking, poor self-esteem, exposure in the environment. 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 alcohol use to manage the experience of violence. Women in domestic violence situations may join their abuser in use of alcohol to mitigate the violence. In some cases, alcohol 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 to AUDs. 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 caregiver 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 alcohol use in pregnant women should be promoted in all perinatal caregivers.

	Pregnant women tend to under declare alcohol consumption, and perinatal caregivers are in an ideal position to screen pregnant women for alcohol use and to advise women on the importance of avoiding alcohol. They can use behavioral interventions or refer them to specialized treatment units if necessary (depending on the level of risk of AUDs). 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 issues such as fetal alcohol syndrome. Teen pregnant women may not have the social supports in their environment and may not be aware of the need to stop alcohol 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.

GERIATRIC PATIENTS

Impacts of age on SUD & Treatment

[Aging](#) can lead to social and physical changes that may increase vulnerability to substance misuse. Older adults may also be more likely to experience physical health problems, mental health problems, loneliness and cognitive changes.

Substances can worsen these conditions and exacerbate the negative health consequences of substance use. The effects of alcohol, 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.

Suicide rates in older adults continue to increase. Alcohol /drug use increases suicide and other co-occurring risks including severe anxiety, severe depression, domiciled alone, panic attacks, bereavement (more so in men), physical pain, and previous suicide attempt(s).

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

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 alcohol use, stable income, spouse or partner living, supportive family environment (no drinking or smoking). Risk: Risk Factors are situations that increase the risk of addiction. Examples include a family history of use/abuse, developmental disability, mental illness, poor or no family support, spouse or partner hostility, grief/loss, isolation. - 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 drink alcohol to cope with the grief and loss.
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 for 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 alcohol may need 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 alcohol 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.
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