DBH Policy Expectations for the Use of Medications for OUD
“10 Do’s and Don’ts of Medical Treatment for OUD”

1. Do not initiate a taper or discontinuation of buprenorphine or methadone in response to any client “infraction” (e.g., missing therapy sessions).

2. (Other side of #1) Do not mandate participation in individual or group counseling as a requirement for continued medical treatment. See #10.


4. Do not encourage ‘rapid’ buprenorphine taper protocols with the goal of transitioning to antagonist medications or no medications at all.

5. Do not discharge a client based on positive drug test results for illicit substances.

6. Do not discharge a client from a residential setting without enough medication to supply them to their first outpatient physician visit.

7. Do not withhold medical treatment if the treatment provider does not have staffing capacity to provide psychosocial services at the time the client presents.

8. Do not switch a client from Vivitrol to oral naltrexone solely for cost saving purposes.

9. Do individualize dose decisions based on individual client factors, particularly craving intensity and environmental support (i.e., be wary of underdosing – most 7 clients do best when stabilized between 16mg-24mg of buprenorphine per day).

10. Do increase client accountability measures (e.g., drug testing, frequency of medication/dosing visits) -- if and when adherence to treatment protocols becomes disrupted by client behaviors described above -- without discontinuing the needed medications. Use motivational interviewing and make clear the rationale for the recommendation of individualized psychosocial supports. Peer support services can also be effective in helping a consumer engage in needed services.