


**BUPRENORPHINE
TREATMENT**

**Curriculum Infusion Package (CIP)
For Infusion into
Graduate Level Courses**


Using Buprenorphine in the Treatment of Opioid
Addiction

Developed by Mountain West ATTC



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● The O.A.S.I.S. Clinic developed and granted permission for inclusion of the video, "Put Your Smack Down! A Video about Buprenorphine."



Topics included in this Curriculum Infusion Package (CIP)

We will review the following:

- Prevalence of opioid use in the U.S.
- Identify groups of people who are using opioids
- Treatment of opioid addiction
- History of opioid treatment
- Drug Addiction Treatment Act 2000 (DATA)
- Opioid pharmacology
- Use of Buprenorphine in opioid treatment
- Understand how Buprenorphine will benefit the delivery of opioid treatment
- Role of multidisciplinary treatment team



Prevalence of Opioid Use and Abuse in the United States



Who Uses Heroin?

Individuals of all ages use heroin:

- More than 3 million US residents aged 12 and older have used heroin at least once in their lifetime.
- Heroin use among high school students is a particular problem. Nearly 2 percent of US high school seniors used the drug at least once in their lifetime, and nearly half of those injected the drug.

SOURCE: National Survey on Drug Use and Health; Monitoring the Future Survey.

Initiation of *Heroin* Use

- During the latter half of the 1990s, the annual number of heroin initiates rose to a level not reached since the late 1970s.
- In 1974, there were an estimated 246,000 heroin initiates.
- Between 1988 and 1994, the annual number of new users ranged from 28,000 to 80,000.
- Between 1995 and 2001, the number of new heroin users was consistently greater than 100,000.

SOURCE: SAMHSA, National Survey on Drug Use and Health, 2002.

Treatment Admissions for Opioid Addiction

Who Enters Treatment for *Heroin* Abuse?

- 90% of opioid admissions in 2000 were for heroin
- 67% male
- 47% White; 25% Hispanic; 24% African American
- 65% injected; 30% inhaled
- 81% used heroin daily

SOURCE: SAMHSA, Treatment Episode Data Set, 1992-2000.

Who Enters Treatment for Heroin Abuse?

- 78% had at least one prior treatment episode; 25% had 5+ prior episodes
- 40% had a treatment plan that included methadone
- 23% reported secondary alcohol use; 22% reported secondary powder cocaine use

SOURCE: SAMHSA, Treatment Episode Data Set, 1992-2000.

Who Enters Treatment for Other Opiate Abuse?

(Non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, opium, etc.)

- 51% male
- 86% White
- 76% administered opiates orally
- 28% used opiates other than heroin after age 30
- 19% had a treatment plan that included methadone
- 44% reported no secondary substance use; 24% reported secondary alcohol use

SOURCE: SAMHSA, Treatment Episode Data Set, 1992-2000.

A Brief History of Opioid Treatment

A Brief History of Opioid Treatment

- 1964: Methadone is approved.
- 1974: Narcotic Treatment Act limits methadone treatment to specifically licensed Opioid Treatment Programs (OTPs).
- 1984: Naltrexone is approved, but has continued to be rarely used (approved in 1994 for alcohol addiction).
- 1993: LAAM is approved (for non-pregnant patients only), but is underutilized.

A Brief History of Opioid Treatment, Continued

- 2000: Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication-assisted opioid treatment.
- 2002: Tablet formulations of buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) were approved by the Food and Drug Administration (FDA).
- 2004: Sale and distribution of ORLAAM® is discontinued.

Four Reasons for Not Entering Opioid Treatment

1. Limited treatment options
 - Methadone or Naltrexone
 - Drug-Free Programming
2. Stigma
 1. Many users don't want methadone
 - "It's like going from the frying pan into the fire"
 - Fearful of withdrawing from methadone
 2. Concerned about being stereotyped
3. Settings have been highly structured
4. Providers subscribe to abstinence-based model

A Need for Alternative Options

- Move outside traditional structure to:
 - Attract more patients into treatment
 - Expand access to treatment
 - Reduce stigma associated with treatment
- Buprenorphine is a potential vehicle to bring about these changes.

Understanding DATA 2000

Drug Addiction Treatment Act of 2000 (DATA 2000)

- Expands treatment options to include both the general health care system and opioid treatment programs.
 - Expands number of available treatment slots
 - Allows opioid treatment in office settings
 - Sets physician qualifications for prescribing the medication

DATA 2000: Physician Qualifications

Physicians must:

- Be licensed to practice by his/her state
- Have the capacity to refer patients for psychosocial treatment
- Limit their practice to 30 patients receiving buprenorphine at any given time
- Be qualified to provide buprenorphine and receive a license waiver

DATA 2000: Physician Qualifications

A physician must meet one or more of the following qualifications:

- Board certified in Addiction Psychiatry
- Certified in Addiction Medicine by ASAM or AOA
- Served as Investigator in buprenorphine clinical trials
- Completed 8 hours of training by ASAM, AAAP, AMA, AOA, APA (or other organizations that may be designated by Health and Human Services)
- Training or experience as determined by state medical licensing board
- Other criteria established through regulation by Health and Human Services

Treatment of Opioid Addiction

How Can You Treat Opioid Addiction?

- Medically-Assisted Withdrawal
- Long-Term Residential Treatment
- Outpatient Psychosocial Treatment
- Behavioral Therapies
- Agonist Maintenance Treatment
- Antagonist Maintenance Treatment

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Medically-Assisted Withdrawal

- Relieves withdrawal symptoms while patients adjust to a drug-free state
- Can occur in an inpatient or outpatient setting
- Typically occurs under the care of a physician or medical provider
- Serves as a precursor to behavioral treatment, because it is designed to treat the acute physiological effects of stopping drug use

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Long-Term Residential Treatment

- Provides care 24 hours per day
- Planned lengths of stay of 6 to 12 months
- Highly structured
- Models of treatment include Therapeutic Community (TC), cognitive behavioral treatment, etc.
- Many TCs are quite comprehensive and can include employment training and other supportive services on site.

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Outpatient Psychosocial Treatment

- Varies in types and intensity of services offered
- Costs less than residential or inpatient treatment
- Often more suitable for individuals who are employed or who have extensive social supports

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Outpatient Psychosocial Treatment

- Group counseling is emphasized
- Detox often done with clonidine
 - Ancillary medications used to help with withdrawal symptoms
 - People often report being uncomfortable
 - Often people cannot tolerate withdrawal symptoms and discontinue treatment

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Behavioral Therapies

- **Contingency management**
 - Based on principles of operant conditioning
 - Uses reinforcement (e.g., vouchers) of positive behaviors in order to facilitate change
- **Cognitive-behavioral interventions**
 - Modify patient's thinking, expectancies, and behaviors
 - Increase skills in coping with various life stressors

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Agonist Maintenance Treatment

- Patients stabilized on adequate, sustained dosages of these medications can function normally.
- They can hold jobs, avoid crime and violence of the street culture, and reduce their exposure to HIV by stopping or decreasing IV drug use and drug-related sexual behavior.
- Can engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Agonist Maintenance Treatment

- Usually conducted in outpatient settings
- Treatment provided in opioid treatment programs or, with buprenorphine, in office-based settings
- Use a long-acting synthetic opioid medication, usually methadone
- Administer the drug orally for a sustained period at a dosage sufficient to prevent opioid withdrawal, block the effect of illicit opiate use, and decrease opioid craving

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Agonist Maintenance Treatment

- The best, most effective opioid agonist maintenance programs include individual and/or group counseling, as well as provision of, or referral to other needed medical, psychological, and social services.

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

Benefits of Methadone Maintenance Therapy

- Used effectively and safely for over 30 years
- Not intoxicating or sedating, if prescribed properly
- Effects do not interfere with ordinary activities
- Suppresses opioid withdrawal for 24-36 hours

How Can You Treat Opioid Addiction?

Antagonist Maintenance Treatment

- Usually conducted in outpatient setting
- Initiation of naltrexone often begins after medical detoxification in a residential setting
- Individuals must be medically detoxified and opioid-free for several days before naltrexone is taken (to prevent precipitating an opioid withdrawal syndrome).

SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

How Can You Treat Opioid Addiction?

Antagonist Maintenance Treatment

- Repeated lack of desired opioid effects, as well as the perceived futility of using the opiate, will gradually over time result in breaking the habit of opiate addiction.
- Patient noncompliance is a common problem. A favorable treatment outcome requires that there also be a positive therapeutic relationship, effective counseling or therapy, and careful monitoring of medication compliance.

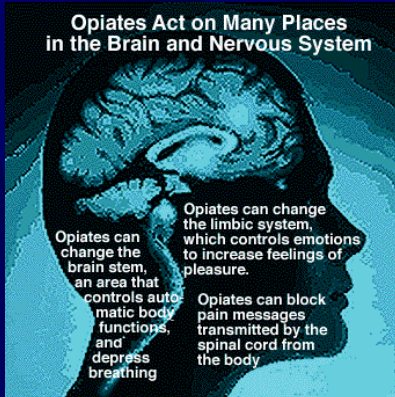
SOURCE: Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 2000.

Treatment Options for Opioid-Addicted Individuals

- Behavioral treatments educate patients about the conditioning process and teach relapse prevention strategies.
- Medications such as methadone and buprenorphine operate on the opioid receptors to relieve craving.
- **Combining the two types of treatment enables patients to stop using opioids and return to more stable and productive lives.**

Review of Opioid Pharmacology, Buprenorphine Treatment, and the Role of the Multidisciplinary Treatment Team

Opiates Act on Many Places in the Brain and Nervous System



SOURCE: National Institute on Drug Abuse, www.nida.nih.gov.

Opioid Addiction and the Brain

- Opioids attach to specific receptors in the brain called mu receptors.
- Activation of these receptors causes a pleasure response.
- Repeated stimulation of these receptors creates a tolerance – requiring more drug for same effect.

Opioid Addiction and the Brain



Opioids attach to receptors in brain → **Pleasure**

Repeated opioid use → **Tolerance**

Absence of opioids after prolonged use → **Withdrawal**

What Happens When You Use Opioids?

- **Acute Effects:** Sedation, euphoria, pupil constriction, constipation, itching, and lowered pulse, respiration and blood pressure
- **Results of Chronic Use:** Tolerance, addiction, medical complications
- **Withdrawal Symptoms:** Sweating, gooseflesh, yawning, chills, runny nose, tearing, nausea, vomiting, diarrhea, and muscle and joint aches

Opiate/Opioid : What's the Difference?

Opiate

- A term that refers to drugs or medications that are derived from the opium poppy, such as heroin, morphine, codeine, and buprenorphine.

Opioid

- A more general term that includes opiates as well as the synthetic drugs or medications, such as buprenorphine, methadone, meperidine (Demerol®), fentanyl—that produce analgesia and other effects similar to morphine.

Basic Opioid Facts

Description: Opium-derived, or synthetics which relieve pain, produce morphine-like addiction, and relieve withdrawal from opioids

Medical Uses: Pain relief, cough suppression, diarrhea

Methods of Use: Intravenously injected, smoked, snorted, or orally administered

What's What? Agonists, Partial Agonists, and Antagonists

Agonist Morphine-like effect (e.g., heroin)

Partial Agonist Maximum effect is less than a full agonist (e.g., buprenorphine)

Antagonist No effect in absence of an opiate or opiate dependence (e.g., naloxone)

Dependence vs. Addiction: What's the Difference?

Terminology Dependence versus Addiction

- The DSM-IV defines problematic substance use with the term **substance dependence**. It does not use the term addiction. This has been the source of much confusion.
- According to the DSM-IV definition, substance dependence is defined as **continued use despite the development of negative outcomes** including physical, psychological or interpersonal problems resulting from use.
- Most providers refer to this as addiction and **ADDICTION** is the term we will use throughout the rest of the training.

Terminology Dependence versus Addiction

- Addiction may occur with or without the presence of **physical dependence**.
- Physical dependence results from the **body's adaptation** to a drug or medication and is defined by the presence of
 - **Tolerance** and/or
 - **Withdrawal**

Terminology Dependence versus Addiction

Tolerance:
the loss of or reduction in the normal response to a drug or other agent, following use or exposure over a prolonged period

Terminology Dependence versus Addiction

Withdrawal:
a period during which somebody addicted to a drug or other addictive substance stops taking it, causing the person to experience **painful or uncomfortable symptoms**

OR

a person **takes a similar substance** in order to avoid experiencing the effects described above.

DSM IV Criteria for Substance Dependence

☛ Three or more of the following occurring at any time during the same 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts over time
- Persistent desire and unsuccessful efforts to cut down or stop
- A lot of time and activities spent trying to get the drug
- Disturbance in social, occupational or recreational functioning
- Continued use in spite of knowledge of the damage it is doing to the self

SOURCE: DSM-IV-TR, American Psychiatric Association, 2000.

Terminology Dependence versus Addiction Summary

- To avoid confusion, in this training, “Addiction” will be the term used to refer to the pattern of continued use of opioids despite pathological behaviors and other negative outcomes.
- “Dependence” will only be used to refer to physical dependence on the substance as indicated by tolerance and withdrawal as described above.

Buprenorphine: An Exciting New Option

Development of Tablet Formulations of Buprenorphine

- Buprenorphine is marketed for opioid treatment under the trade names of Subutex® (buprenorphine) and Suboxone® (buprenorphine/naloxone)
- Over 25 years of research
- Over 5,000 patients exposed during clinical trials
- Proven safe and effective for the treatment of opioid addiction

Moving Science-Based Treatments into Clinical Practice

- A challenge in the addiction field is moving science-based treatment methods into clinical settings.
- NIDA and CSAT initiatives are underway to bring research and clinical practice closer.
- Buprenorphine treatment represents an achievement in this effort.

Buprenorphine: A Science-Based Treatment

Clinical trials have established the effectiveness of buprenorphine for the treatment of heroin addiction. Effectiveness of buprenorphine has been compared to:

- Placebo (Johnson et al. 1995; Ling et al. 1998; Kakko et al. 2003)
- Methadone (Johnson et al. 1992; Strain et al. 1994a, 1994b; Ling et al. 1996; Schottenfield et al. 1997; Fischer et al. 1999)
- Methadone and LAAM (Johnson et al. 2000)

Buprenorphine as a Treatment for Opioid Addiction

- A synthetic opioid
- Described as a mixed opioid agonist-antagonist (or partial agonist)
- Available for use by certified physicians outside traditionally licensed opioid treatment programs

The Role of Buprenorphine in Opioid Treatment

- Partial Opioid Agonist
 - Produces a ceiling effect at higher doses
 - Has effects of typical opioid agonists—these effects are dose dependent up to a limit
 - Binds strongly to opiate receptor and is long-acting
- Safe and effective therapy for opioid maintenance and detoxification

Buprenorphine Treatment: The Myths and The Facts



MYTH #1: Patients are still addicted

FACT: Addiction is pathologic use of a substance and *may* or *may not* include physical dependence.

- Physical dependence on a medication for treatment of a medical problem **does not** mean the person is engaging in pathologic use and other behaviors.

MYTH #2: Buprenorphine is simply a substitute for heroin or other opioids

FACT: Buprenorphine *is* a replacement medication; it is *not simply* a substitute

- Buprenorphine is a legally prescribed medication, not illegally obtained.
- Buprenorphine is a medication taken sublingually, a very safe route of administration.
- Buprenorphine allows the person to function normally.

MYTH #3: Providing medication alone is sufficient treatment for opioid addiction

FACT: Buprenorphine is an important treatment option. However, the *complete* treatment package must include other elements, as well.

- Combining pharmacotherapy with counseling and other ancillary services increases the likelihood of success.

MYTH #4: Patients are still getting high

FACT: When taken sublingually, buprenorphine is slower acting, and does not provide the same "rush" as heroin.

- Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses.

Who is Appropriate for Buprenorphine Treatment?



Factors for Addiction Professionals to Consider

1. Is the patient addicted to opioids?
2. Is the patient interested in office-based buprenorphine treatment?
3. Is the patient aware of other treatment options?
4. Does the patient understand the risks and benefits of this treatment approach?
5. Is the patient expected to be reasonably compliant?

Factors for Addiction Professionals to Consider

6. Is the patient expected to follow safety procedures?
7. Is the patient psychiatrically stable?
8. Are the psychosocial circumstances of the patient conducive to treatment success?
9. Are there resources available to ensure the link between physician and treatment provider?
10. Is the patient taking other medications that may interact adversely with buprenorphine?

Issues Requiring Consultation with the Physician

- Dependence upon high doses of benzodiazepines or other CNS depressants
- Significant psychiatric co-morbidity
- Multiple previous opioid treatment episodes with frequent relapse

Issues Requiring Consultation with the Physician

- High level of dependence on high doses of opioids
- High risk for relapse based on psychosocial or environmental conditions
- Pregnancy
- Poor support system

Issues Requiring Consultation with the Physician

- HIV and STDs
- Hepatitis or impaired liver function



Issues Requiring Consultation with the Physician

- Use of alcohol
- Use of sedative-hypnotics
- Use of stimulants
- Poly-drug addiction

General Counseling Issues

- Confidentiality
- Drug testing
- Working with, not against, medication
- Patient comfort during withdrawal

Patient Selection

- Patients who do not meet criteria for opioid addiction may still be appropriate for treatment with buprenorphine
 - Patients who are at risk of progression to addiction or who are injecting
 - Patients who have had their medication discontinued and who are now at high risk for relapse

The Use of Buprenorphine in the Treatment of Opioid Addiction

Induction
Maintenance
Tapering Off/Medically-Assisted
Withdrawal

Induction

Induction Phase

*Working to establish the appropriate
dose of medication for patient to
discontinue use of opiates with
minimal withdrawal symptoms, side-
effects, and craving*

Direct Buprenorphine Induction from Short-Acting Opioids

- Ask patient to abstain from short-acting opioid (e.g., heroin) for at least 6 hrs. and be in mild withdrawal before administering buprenorphine/naloxone.
- When transferring from a short-acting opioid, be sure the patient provides a methadone-negative urine screen before 1st buprenorphine dose.

SOURCE: Amass, et al., 2004, Johnson, et al. 2003.

Direct Buprenorphine Induction from Long-Acting Opioids

- Controlled trials are needed to determine optimal procedures for inducing these patients.
- Data is also needed to determine whether the buprenorphine only or the buprenorphine/naloxone tablet is optimal when inducing these patients.

SOURCE: Amass, et al., 2004, Johnson, et al. 2003.

Direct Buprenorphine Induction from Long-Acting Opioids

- Clinical experience has suggest that induction procedures with patients receiving long-acting opioids (e.g. methadone-maintenance patients) are basically the same as those used with patients taking short-acting opioids, except:
 - The time interval between the last dose of medication and the first dose of buprenorphine must be **increased**.
 - **At least 24 hrs should elapse** before starting buprenorphine and longer time periods may be needed (up to 48 hrs).
 - Urine drug screening should indicate no other illicit opiate use at the time of induction.

Stabilization and Maintenance

Stabilization Phase

Patient experiences no withdrawal symptoms, side-effects, or craving

Maintenance Phase

Goals of Maintenance Phase:
Help the person stop and stay away from illicit drug use and problematic use of alcohol

1. Continue to monitor cravings to prevent relapse
2. Address psychosocial and family issues

Maintenance Phase

Psychosocial and family issues to be addressed:

- a) Psychiatric comorbidity
- b) Family and support issues
- c) Time management
- d) Employment/financial issues
- e) Pro-social activities
- f) Legal issues
- g) Secondary drug/alcohol use

Buprenorphine Maintenance: Summary

- Take-home dosing is safe and preferred by patients, but patient adherence will vary and this can impact treatment outcomes.
- 3x/week dosing with buprenorphine/naloxone is safe and effective as well (Amass, et al., 2001).
- ***Counseling needs to be integrated into any buprenorphine treatment plan.***

Medically-Assisted Withdrawal

(a.k.a. Dose Tapering)

Buprenorphine Withdrawal

- Working to provide a smooth transition from a physically-dependent to non-dependent state, with medical supervision
- Medically supervised withdrawal (detoxification) is accompanied with and followed by psychosocial treatment, and sometimes medication treatment (i.e., naltrexone) to minimize risk of relapse.

Medically-Assisted Withdrawal (Detoxification)

- Outpatient and inpatient withdrawal are both possible
- How is it done?
 - Switch to longer-acting opioid (e.g., buprenorphine)
 - Taper off over a period of time (a few days to weeks depending upon the program)
 - Use other medications to treat withdrawal symptoms
 - Use clonidine and other non-narcotic medications to manage symptoms during withdrawal

Counseling Buprenorphine Patients

Counseling Buprenorphine Patients

- Address issues of the necessity of counseling with medication for recovery.
- **Recovery and Pharmacotherapy:**
 - Patients may have ambivalence regarding medication.
 - The recovery community may ostracize patients taking medication.
 - Counselors need to have accurate information.

Counseling Buprenorphine Patients

- **Recovery and Pharmacotherapy:**
 - Focus on “getting off” buprenorphine may convey taking medicine is “bad.”
 - Suggesting recovery requires cessation of medication is inaccurate and potentially harmful.
 - Support patient’s medication compliance
 - “Medication,” not “drug”

Counseling Buprenorphine Patients

- **Dealing with Ambivalence:**
 - Impatience, confrontation, “you’re not ready for treatment”
or,
 - Deal with patients at their stage of acceptance and readiness



Counseling Buprenorphine Patients

● Counselor Responses:

- Be flexible
- Don't impose high expectations
- Don't confront
- Be non-judgmental
- Use a motivational interviewing approach
- Provide reinforcement

Counseling Buprenorphine Patients

● Encouraging Participation in 12-Step Meetings:

- What is the 12-Step Program?
- Benefits
- Meetings: speaker, discussion, Step study, Big Book readings
- Self-help vs. treatment

Counseling Buprenorphine Patients

● Issues in 12-Step Meetings:

- Medication and the 12-Step program
 - Program policy
 - "The AA Member: Medications and Other Drugs"
 - NA: "The ultimate responsibility for making medical decisions rests with each individual"
 - Some meetings are more accepting of medications than others

Counseling Buprenorphine Patients

● A Motivational Interviewing Approach:

- Dealing with other drugs and alcohol
- Doing more than not-using

Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Support self-efficacy
- Ask open-ended questions
- Be affirming
- Listen reflectively
- Summarize

Counseling Buprenorphine Patients

● Early Recovery Skills:

- Getting Rid of Paraphernalia
- Scheduling
- Trigger Charts

Counseling Buprenorphine Patients

- **Relapse Prevention:**
 - Patients need to develop new behaviors.
 - Learn to monitor signs of vulnerability to relapse
 - Recovery is more than not using illicit opioids.
 - Recovery is more than not using drugs and alcohol.

Counseling Buprenorphine Patients

- **Relapse Prevention: Sample Topics**
 - *Relapse Prevention*
 - Overview of the concept
 - *Using Behavior*
 - Old behaviors need to change
 - Re-emergence signals relapse risk
 - *Relapse Justification*
 - "Stinking thinking"
 - Recognize and stop

Counseling Buprenorphine Patients

- **Relapse Prevention: Sample Topics**
 - *Dangerous Emotions*
 - Loneliness, anger, deprivation
 - *Be Smart, not Strong*
 - Avoid the dangerous people and places
 - Don't rely on will power
 - *Avoiding Relapse Drift*
 - Identify "mooring lines"
 - Monitor drift

Counseling Buprenorphine Patients

● Relapse Prevention: Sample Topics

- *Total Abstinence*
 - Other drug/alcohol use impedes recovery growth
 - Development of new dependencies is possible
- *Taking Care of Business*
 - Addiction is full-time
 - Normal responsibilities often neglected
- *Taking Care of Yourself*
 - Health, grooming
 - New self-image

Counseling Buprenorphine Patients

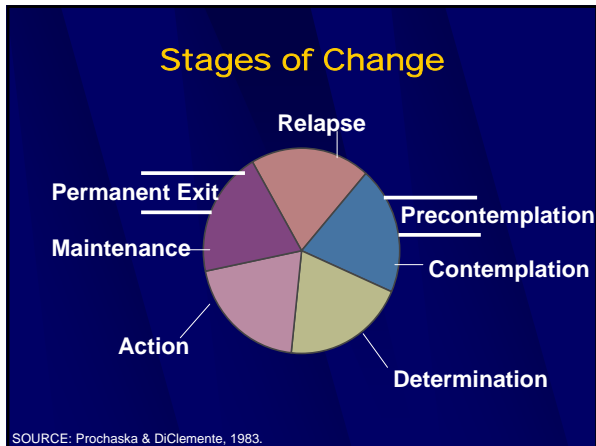
● Relapse Prevention: Sample Topics

- *Repairing Relationships*
 - Making amends
- *Truthfulness*
 - Counter to the drug use style
 - A defense against relapse
- *Trust*
 - Does not return immediately
 - Be patient

Counseling Buprenorphine Patients

● Relapse Prevention: Sample Topics

- *Downtime*
 - Diversion, relief, escape without drugs
- *Recognizing and Reducing Stress*
 - Stress can cause relapse
 - Learn signs of stress
 - Learn stress management skills



Stages of Change

- **Pre-contemplation:** Not yet considering change or is unwilling or unable to change.
- **Contemplation:** Sees the possibility of change but is ambivalent and uncertain.
- **Determination (or preparation):** Committed to making change but is still considering what to do.

Stages of Change, Continued

- **Action:** Taking steps to change but hasn't reached a stable state.
- **Maintenance:** Has achieved abstinence from illicit drug use and is working to maintain previously set goals.
- **Recurrence:** Has experienced a recurrence of symptoms, must cope with the consequences of the relapse, and must decide what to do next

Patient Management Issues

- Pharmacotherapy alone is insufficient to treat drug addiction.
- Physicians are responsible for providing or referring patients to counseling.
- Contingencies should be established for patients who fail to follow through on referrals.

Patient Management: Treatment Monitoring

Goals for treatment should include:

- No illicit opioid drug use
- No other drug use
- Absence of adverse medical effects
- Absence of adverse behavioral effects
- Responsible handling of medication
- Adherence to treatment plan



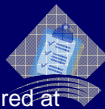
Patient Management: Treatment Monitoring

Weekly visits (or more frequent) are important to:

1. Provide ongoing counseling to address barriers to treatment, such as travel distance, childcare, work obligations, etc
2. Provide ongoing counseling regarding recovery issues
3. Assess adherence to dosing regimen
4. Assess ability to safely store medication
5. Evaluate treatment progress



Patient Management: Treatment Monitoring



- Urine toxicology tests should be administered at least monthly for all relevant illicit substances.
- Buprenorphine can be tapered while psychosocial services continue.
- The treatment team should work together to prevent involuntary termination of medication and psychosocial treatment.
- In the event of involuntary termination, the physician and/or other team members should make appropriate referrals.
- Physicians should manage appropriate withdrawal of buprenorphine to minimize withdrawal discomfort.

Issues in Recovery

Issues in Recovery

- 12-Step meetings and the use of medication
- Drug cessation and early recovery skills
 - Getting rid of drugs and paraphernalia
 - Dealing with triggers and cravings
- Treatment should be delivered within a formal structure.
- Relapse prevention is not a matter of will power.

Triggers & Cravings

During addiction, triggers, thoughts, and craving can run together. The usual sequence, however, is as follows:

Trigger → **Thought** → **Craving** → **Use**

The key to dealing with this process is to not allow for it to start. Stopping the thought when it first begins helps prevent it from building into a craving.

SOURCE: Matrix Model of Individualized Intensive Outpatient Drug and Alcohol Treatment: Therapist Manual.

Thought-Stopping Techniques

- Visualization
- Snapping
- Relaxation
- Calling someone




SOURCE: Matrix Model of Individualized Intensive Outpatient Drug and Alcohol Treatment: Therapist Manual.

Special Populations

- Patients with co-occurring psychiatric disorders
- Pregnant women
- Adolescents






Co-occurring Psychiatric Disorders

- Opioid users frequently have concurrent psychiatric diagnoses.
- Sometimes the effects of drug use and/or withdrawal can mimic psychiatric symptoms.
- Clinicians must consider the duration, recentness, and amount of drug use when selecting appropriate patients.
- Signs of anxiety, depression, thought disorders or unusual emotions, cognitions, or behaviors should be reported to physician and discussed with the treatment team.

Pregnancy-Related Considerations

- Methadone maintenance is the treatment of choice for pregnant opioid-addicted women.
- Opioid withdrawal should be avoided during pregnancy.
- Buprenorphine may eventually be useful in pregnancy, but is currently not approved.



SOURCE: Johnson, et al., 2003

Opioid-Addicted Adolescents

- Current treatments for opioid-addicted adolescents and young adults are often unavailable and when found, clinicians report that the outcome leaves much to be desired.
- States have different requirement for admitting clients under age 18 to addictions treatment. It is important to know the local requirements.



Opioid-Addicted Adolescents

- Buprenorphine is not approved for treatment of patients under age 18.
- Clinical trials are currently underway to assess safety and efficacy of buprenorphine in the treatment of adolescents.
 - On example: NIDA CTN 0010 is testing safety and efficacy of introducing buprenorphine/naloxone to treat adolescents aged 14-21.



Only physicians can prescribe the medication.

However, the entire treatment system should be engaged.



Effective treatment generally requires many facets. Treatment providers are important in helping the patients to:

- Manage physical withdrawal symptoms
- Understand the behavioral and cognitive changes resulting from drug use
- Achieve long-term changes and prevent relapse
- Establish ongoing communication between physician and community provider to ensure coordinated care
- Engage in a flexible treatment plan to help them achieve recovery

Effective Coordination of Care

Effective coordination combines the strengths of various systems and professions, including: physicians, addiction counselors, 12-step programs, and community support service providers. The roles of certain providers may vary by state, depending upon the identified scope of practice for each profession.



The Benefits of Coordinated Care

- Capacity for physician to refer to treatment is required under the law (DATA 2000)
- Substance abuse treatment providers have expertise in managing and coordinating care for substance using clients
- Combines goals of the medical and behavioral health systems—holistic care rather than compartmentalized care
- Treatment modality (e.g., inpatient vs. outpatient), type (e.g, methadone vs. buprenorphine), and setting (office based vs. OTP) can be made to maximize fit with patient needs

Roles of the Physician

- Screening
- Assessment
- Diagnosing Opioid Addiction
- Patient Education
- Prescribing Buprenorphine
- Urinalysis Testing
- Recovery Support



Roles of the Multidisciplinary Team

- Screening
- Assessing and Diagnosing of Opioid Addiction
- Psychosocial Treatment
- Patient Education
- Referral for Treatment
- Urinalysis Testing
- Recovery Support
- Case Management and Coordination



Roles of the Community Support Provider

- Screening
- Assessment
- Referral for Treatment
- Recovery Support
- Meeting Ancillary Needs of the Patient



Roles of the 12-Step Program

- Recovery Support
 - Being on an opioid treatment medication may be an issue in some 12-step meetings.
 - Program staff should be prepared to coach patients on how to handle this issue.



A Model of Coordinated Care

Role	Physician	Addiction Counselor	12-Step Program	Community Support Provider
Screening	✓	✓		✓
Assessment	✓	✓		✓
Diagnosing Opioid Addiction	✓	✓		
Patient Education	✓	✓		
Referral for Treatment		✓		✓
Prescribing/Dispensing Buprenorphine	✓	✓		
Urinalysis Testing	✓	✓		
Psychosocial Treatment		✓		
Recovery Support	✓	✓	✓	✓
Case Management & Coordination		✓		
Meeting ancillary needs of the patient				✓

Use The SAMHSA Physician Locator Service To Find a Physician Authorized To Prescribe Buprenorphine in Your State

www.buprenorphine.samhsa.gov/bwns_locator

SAMHSA
Substance Abuse & Mental Health Services Administration
U.S. Department of Health and Human Services

Buprenorphine
PHYSICIAN LOCATOR

Notice: The Drug Addiction Treatment Act of 2000 limits physicians or physician group practices to prescribing buprenorphine for opioid addiction to a maximum of 30 patients at one time. Because of this, some physicians listed on the Locator may not be accepting new patients at this time. If you are unable to find a physician within your area who is accepting new patients, please check our site later, as new physicians are being added weekly.

To locate the physician(s) authorized to prescribe Buprenorphine nearest you, find your State on the map below and click on it.

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Advantages of Buprenorphine in the Treatment of Opioid Addiction

1. Patient can participate fully in treatment activities and other activities of daily living easing their transition into the treatment environment
2. Limited potential for overdose
3. Minimal subjective effects (e.g., sedation) following a dose
4. Available for use in an office setting
5. Lower level of physical dependence

Advantages of Buprenorphine/Naloxone in the Treatment of Opioid Addiction

- Combination tablet is being marketed for U.S. use
6. Discourages IV use
 7. Diminishes diversion
 8. Allows for take-home dosing

Disadvantages of Buprenorphine in the Treatment of Opioid Addiction

1. Greater medication cost
2. Lower level of physical dependence (i.e., patients can discontinue treatment)
3. Not detectable in most urine toxicology screenings

Summary

- Use of medications as a component of treatment can be an important in helping the person to achieve their treatment goals.
- DATA 2000 expands the options to include both opioid treatment programs and the general medical system.
- Opioid addiction affects a large number of people, yet many people do not seek treatment or treatment is not available when they do.
- Expanding treatment options can
 - make treatment more attractive to people;
 - expand access; and
 - reduce stigma.

Summary

- Medications operating through the opioid receptors, such as buprenorphine, prevent withdrawal symptoms and help the person function normally.
- Various empirically-supported therapeutic approaches are available for use in counseling Buprenorphine patients.
- Buprenorphine patients need to learn the skills to stop drug thoughts before they become full-blown cravings.

Summary

- Opioid addiction has both physical and behavioral dimensions. As a result, a clinical partnership consisting of a physician, counselor and other supportive treatment providers is an ideal team approach.
- The addiction professionals should work to ensure the successful coordinated functioning of this partnership.
