

Module VI

Counseling Buprenorphine Patients



Module VI: Counseling Buprenorphine Patients

This is the final module in the six-module training. The one major issue left to address is a discussion of strategies to treat patients who are taking buprenorphine as part of their opioid treatment.

 <p>BUPRENORPHINE TREATMENT: A Training For Multidisciplinary Addiction Professionals</p> <p>Module VI: Counseling Buprenorphine Patients</p>	<p>Slide 1: Title Slide</p> <p>This final module specifically addresses issues involved with counseling buprenorphine patients, including needs assessment, patient monitoring and management, and counseling strategies to use when providing psychosocial treatment to these individuals.</p>	<p>Slide 1</p>
 <p>Myths About the Use of Medication in Recovery</p> <ul style="list-style-type: none"> • Patients are still addicted • Buprenorphine is simply a substitute for heroin or other opioids • Providing medication alone is sufficient treatment for opioid addiction • Patients are still getting high 	<p>Slide 2: Myths About the Use of Medication in Recovery</p> <p><i>Briefly review the myths that were presented in Module I.</i></p> <ul style="list-style-type: none"> • Myth #1: Patients are still addicted • Myth #2: Buprenorphine is simply a substitute for heroin or other opioids • Myth #3: Providing medication alone is sufficient treatment for opioid addiction • Myth #4: Patients are still getting high 	<p>Slide 2</p> 
 <p>Goals for Module VI</p> <p>This module reviews the following:</p> <ul style="list-style-type: none"> • Issues in Opioid Recovery • Craving and Triggers • Special Populations • Buprenorphine-Related Patient Management Issues 	<p>Slide 3: Goals for Module VI</p> <p><i>This module focuses on the various aspects of opioid addiction treatment and the use of buprenorphine in treating opioid addiction.</i></p> <p>This module reviews the following:</p> <ul style="list-style-type: none"> • Issues in Opioid Recovery • Cravings and Triggers • Special Populations • Buprenorphine-Related Patient Management Issues 	<p>Slide 3</p> 

<div data-bbox="110 216 511 514"> <p>Issues in Recovery</p> <ul style="list-style-type: none"> • 12-Step meetings and the use of medication • Drug cessation and early recovery skills <ul style="list-style-type: none"> – Disposing of drugs and related paraphernalia – Dealing with triggers and cravings • Treatment should be delivered within a formal structure. • Relapse prevention is not a matter of will power. </div>	<p>Slide 4: Issues in Recovery</p> <p>Bullet #1: Introducing 12-Step meetings to a patient can be considered a coaching process; the addiction professional should discuss potential scenarios the patient may encounter at a 12-Step meeting. The patient should be encouraged to choose a sponsor who is supportive of their use of buprenorphine as part of their overall opioid treatment plan.</p> <p>Bullet #2: Counselors can assist patients by educating them about the importance of disposing of drugs and related paraphernalia, as well as ways to address triggers and cravings, understand addictive behaviors and thinking, and avoid relapse drift.</p> <p>Bullet #3: Treatment should be delivered within a formal structure</p> <p>Bullet #4: Relapse prevention involves a series, or process, of learning the skills necessary to stay away from drugs. Relapse prevention techniques help the patient learn these skills.</p> <p><i>Relapse prevention techniques will be covered in more detail later in this module.</i></p>	<p>Slide 4</p>
<div data-bbox="110 1113 511 1407"> <p>Trigger</p>  <p>A trigger is a stimulus which has been repeatedly associated with the preparation for, anticipation of, or use of drugs and/or alcohol. These stimuli include people, things, places, times of day, and emotional states</p> </div>	<p>Slide 5: Trigger</p> <p><i>Read the definition of a trigger aloud. You can ask trainees to volunteer to give examples of triggers (places, people, things, times of the day, emotional states, etc.).</i></p>	<p>Slide 5</p> 

Issues in Recovery: Triggers

- People, places, objects, feelings and times can cause cravings.
- An important part of treatment involves stopping the craving process:
 - Identify triggers
 - Present exposure to triggers
 - Deal with triggers in a different way

(Center for Substance Abuse Treatment, 2006)

Slide 6: Issues in Recovery: Triggers

Triggers are people, places, objects, feelings, and times that cause cravings. Your addicted brain associates the triggers with alcohol and drug use. For example, if every Friday night you cash a paycheck, go out with friends, and use drugs, the triggers might be:

- Friday night;
- After work;
- Money;
- Friends who use drugs; or
- The bar or club at which you hang out with your drug-using friends.

It is important to remember that triggers will affect a user's brain and cause cravings even though the person has decided to stop using alcohol and drugs. An intention to stop using must translate into behavior changes, which will steer the person away from possible triggers.

Reference:

Center for Substance Abuse Treatment. *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders*. DHHS Publication No. (SMA) 06-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006, reprinted 2007.

Slide 6



Issues in Recovery: Triggers

- Secondary drug use
- Internal vs. external triggers
- "Red flag" emotional states
 - Loneliness
 - Anger
 - Deprivation
 - Stress
- Others?



Slide 7: Issues in Recovery: Triggers, Continued

There are two types of triggers – *internal* and *external*.

Internal triggers include:

- Feelings or emotions (afraid, confident, excited, inadequate, lonely, sad, bored, etc.).

External triggers include:

- Parties;
- Liquor stores;
- Driving past a dealer's house;
- Payday; or
- Time of day.

You can ask trainees to volunteer additional examples of internal and external triggers.

Slide 7



Issues in Recovery: Craving

- A strong desire for something
- Does not always occur in a straightforward way
- It takes effort to identify and stop a drug-use related thought.
- The further the thoughts are allowed to go, the more likely the individual is to use drugs.

(Center for Substance Abuse Treatment, 2006)

Slide 8: Issues in Recovery: Craving

An important part of treatment involves stopping the craving process. To do this, the patient must: (1) identify triggers; (2) prevent exposure to triggers whenever possible; and (3) deal with triggers in a different way.

Bullet #1: ***Read the definition of craving***

Bullet #2: Often, drug-using thoughts occur with little or no effort. It takes effort to identify and stop a thought.

Bullet #3: It is necessary to stop a drug-related thought before that thought becomes a full-blown craving. The further the thoughts are allowed to go, the more likely the person is to relapse.

Reference:

Center for Substance Abuse Treatment. *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders*. DHHS Publication No. (SMA) 06-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006, reprinted 2007.

Slide 8



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.

(Center for Substance Abuse Treatment, 2006)

Slide 9: Triggers and Cravings

Slide 9

This is a process; it is not automatic. Patients need to be told that they can control their thoughts, but it will take time and practice. It helps if the addiction professional finds a constructive way for patients to deconstruct the thought/using process.

To the actively using substance abuser and those in early recovery, the **Trigger-Thought-Craving-Use** sequence feels as if it happens simultaneously. You feel triggered, and you immediately want to use. Knowing about the specifics of this process can be very helpful to the recovering individual. The successful key in dealing with the process is to avoid it getting started.

It is extremely important to stop the thought when it first begins and to prevent it from building into an overpowering craving. It is vitally important to do this as soon as the patient recognizes the thought is occurring. This can be accomplished by using a number of **Thought-Stopping** techniques.

Reference:

Center for Substance Abuse Treatment. *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders*. DHHS Publication No. (SMA) 06-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006, reprinted 2007.



Thought-Stopping Techniques

- Visualization
- Snapping
- Relaxation
- Calling someone



(Center for Substance Abuse Treatment, 2006)

Slide 10: Thought-Stopping Techniques

Slide 10

It is necessary to interrupt the thought process, by finding something to replace the drug/alcohol the patient uses. Here are examples of thought-stopping techniques:

Visualization: Picture a switch or lever in your mind. Imagine yourself actually moving it from ON to OFF to stop the drug or alcohol thoughts. Have another picture ready to think about in place of those thoughts. You may have to change what you are already doing to make the switch.

Snapping: Wear a rubber band loosely on your wrist. Each time you become aware of drug or alcohol thoughts, snap the band and say “NO” to the thoughts as you make yourself think about another subject.

Relaxation: Feelings of hollowness, heaviness, and cramping in the stomach are cravings. These can often be relieved by breathing in deeply and breathing out slowly.

Call someone: Talking to another person provides an outlet for your feelings and allows you to hear your own thought process.

Areas of Needs Assessment

- Drug use
- Alcohol use
- Social Issues
- Social Services
- Psychological history and status
- Education
- Vocational



Slide 11: Areas of Needs Assessment

Slide 11

Many opioid-addicted individuals have complicated lives. They often recognize the physical components of their addiction; however, they may not recognize the breadth of the disorder or the need to make changes in their lives.

A **THOROUGH** needs assessment is a useful process to help a buprenorphine patient identify problem areas beyond the immediate problem of their opioid addiction, and is an intricate part of the provision of quality care. Issues may come up during the needs assessment that weren’t previously discussed or assessed. The addiction professional should look at previous assessments that may have been done on the patient – this will help to find a balance and fill in any gaps, without being repetitive.

Social issues may include amount of drug and alcohol use in the social environment; unemployment; dependence on illegal sources of income; eligibility for public assistance; need for housing; and legal problems.

 <p>Patient Management Issues</p> <ul style="list-style-type: none"> • 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. 	<p>Slide 12: Patient Management Issues</p> <p>Bullet #1: Recovery is more than medication. Many buprenorphine patients may feel that once they have dealt with the physical aspect of their opioid addiction and have received a medication, they do not need additional treatment in the form of psychosocial counseling. At the same time, the addiction professional should not diminish the importance of medication compliance.</p> <p>Bullet #2: Despite the fact that physicians must have the “capacity” to refer their patients for additional counseling, they may not have knowledge of the psychosocial treatment providers in their local community. Therefore, treatment providers may need to perform outreach to inform local physicians of their existence and of their willingness to collaborate in treating patients receiving buprenorphine.</p> <p>Bullet #3: Contingencies should be established for patients who fail to follow through on referrals.</p>	<p>Slide 12</p>
 <p>Patient Management: Treatment Monitoring</p> <p>Goals for treatment should include:</p> <ul style="list-style-type: none"> • 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 	<p>Slide 13: Patient Management: Treatment Monitoring</p> <p><i>Read the goals for treatment aloud. Mention that this list is not exhaustive, and ask the trainees to provide additional components of a comprehensive treatment plan.</i></p> <p>Bullet #1: No illicit opioid drug use</p> <p>Bullet #2: “No other drug use” may also include alcohol use. Different treatment programs handle the issue of alcohol use very differently. The important issue to keep in mind is that possible alcohol use should be assessed and the goals for treatment should be agreed upon by all of the treating professionals (physician, substance abuse counselor, etc.) and the patient.</p> <p>Bullet #3: Absence of adverse medical effects</p> <p>Bullet #4: Absence of adverse behavioral effects</p> <p>Bullet #5: Responsible handling of medication</p> <p>Bullet #6: Adherence to treatment plan</p>	<p>Slide 13</p> 

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

Slide 14: Patient Management: Treatment Monitoring

Weekly visits are important – at least early on in the treatment and recovery process. During this time, it provides an opportunity for the addiction professional to:

- Provide ongoing counseling to address barriers to treatment, such as travel distance, childcare, work obligations, etc.;
- Provide ongoing counseling regarding recovery issues;
- Assess adherence to dosing regimen;
- Assess ability to safely store medication; and
- Evaluate treatment progress.

If medical issues are identified throughout the course of psychosocial treatment, be sure to refer those questions back to the treating physician.

Slide 14

<p>Patient Management: Treatment Monitoring</p> <ul style="list-style-type: none"> • 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. 	<p>Slide 15: Patient Management: Treatment Monitoring</p> <p>Bullet #1: Urine toxicology testing (<u>drug testing</u>) is a common practice and is conducted primarily to assess treatment efficacy. The physician, counselor, and/or other staff may conduct urine testing. Testing provides the patient with an additional tool to prevent drug use. Counselors should stress that testing is a standard procedure that can help their treatment and is not a surveillance tool based on an assumption of patients' dishonesty.</p> <p>Bullet #2: It is not up to the addiction counselor to decide whether or not buprenorphine should be discontinued. <u>Tapering off</u> of buprenorphine is a medical decision, and should be reserved for the treating physician and patient to discuss.</p> <p>Note to the Trainer(s): <i>Bullets #3-5: The message here is that lines of communication between all treatment providers should remain open at all times, to ensure that the patient is receiving high-quality, comprehensive care.</i></p> <p>Bullet 3: The treatment team should work together to prevent involuntary termination of medication and psychosocial treatment.</p> <p>Bullet #4: In the event of involuntary termination, the physician and/or other team members should make appropriate referrals.</p> <p>Bullet #5: Physicians should manage appropriate withdrawal of buprenorphine to minimize withdrawal discomfort.</p>	<p>Slide 15</p> 
<p>Special Populations</p> <ul style="list-style-type: none"> • Patients with co-occurring psychiatric disorders • Pregnant women • Adolescents and young adults 	<p>Slide 16: Special Populations</p> <p>The following discussion highlights a few of the many special populations, including patients with co-occurring psychiatric disorders, pregnant women, and adolescents.</p>	<p>Slide 16</p>



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.

Slide 17: Co-Occurring Psychiatric Disorders

Opioid users frequently have concurrent psychiatric diagnoses, ranging from anxiety or depressive disorders to antisocial personality disorder. However, drug effects and withdrawal symptoms can sometimes mimic psychiatric symptoms. It is necessary to consider the duration, how recent the drug use, and amount of drug use when making a psychiatric diagnosis.

Counselors should consult with the DSM-IV-TR to review “substance-induced disorders.” It is also necessary to review the patient’s psychiatric history, and consult with the buprenorphine-prescribing physician and other mental health providers.

Any of the following should prompt further action:

- Suicidal thoughts or plans;
- Extreme changes in mood;
- Extreme changes in sleep or activity patterns;
- Hyperactivity;
- Paranoid thinking;
- Hallucinations;
- Unresponsiveness; and/or
- Confusion.

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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.

(Jones, et al., 2005)

Slide 18: Pregnancy-Related Considerations

Slide 18

Bullet #1: Methadone maintenance is the treatment of choice for pregnant opioid-addicted women.

Bullet #2: Pregnancy itself is traumatic to the body (especially if the woman is experiencing “morning sickness”). Generally, it is not recommended for a woman who is already in a vulnerable condition to go through any additional trauma/discomfort of withdrawing from an opioid. If withdrawal is indicated in the treatment plan, most physicians will urge the patient to wait until after delivery. Methadone plus behavioral treatment would then be considered for the immediate treatment plan.

Bullet #3: Buprenorphine may eventually be useful in pregnancy, but is currently not FDA approved.

Reference:

Jones, H. E., Johnson, R. E., Jasinski, D. R., O’Grady, K. E., Chisholm, C. A., Choo, R. E., ... & Milio, L. (2005). Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: Effects on the neonatal abstinence syndrome. *Drug and Alcohol Dependence, 79*, 1-10.



The Use of Buprenorphine During Pregnancy

- Currently buprenorphine is a Category C medication. This means it is not approved for use during pregnancy.
- Studies conducted to date suggest that buprenorphine *may be* an excellent option for pregnant women.
- Randomized trials are underway to determine the safety and effectiveness of using buprenorphine during pregnancy.



Slide 19: The Use of Buprenorphine During Pregnancy

Slide 19

There is no evidence of any harmful effects of buprenorphine relative to pregnancy, but in the absence of controlled clinical trials, risk cannot be ruled out.

Bullet #1: Currently buprenorphine is a Category C medication. This means it is not approved for use during pregnancy.

Bullet #2: Studies conducted to date suggest that buprenorphine *may be* an excellent option for pregnant women.

Bullet #3: Randomized trials are underway to determine the safety and effectiveness of using buprenorphine during pregnancy.

<p>Specific Research on Buprenorphine and Pregnancy</p> <ul style="list-style-type: none"> • Case series in France: safe and effective, possibly reducing NAS • One preliminary study in US: examining the use of buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: effects on the neonatal abstinence syndrome (Jones et al., 2005) 	<p>Slide 20: Specific Research on Buprenorphine and Pregnancy</p> <p>Research on the use of buprenorphine is limited. In a case series conducted in France, buprenorphine was found to be safe and effective and to possibly reduce neonatal abstinence syndrome (NAS).</p> <p>There has been one preliminary study conducted in the United States by Jones and colleagues (2005). This study examined the use of buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients and effects on NAS.</p> <p><u>Reference:</u></p> <p>Jones, H. E., Johnson, R. E., Jasinski, D. R., O’Grady, K. E., Chisholm, C. A., Choo, R. E., ... Milio, L. (2005). Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: Effects on the neonatal abstinence syndrome. <i>Drug and Alcohol Dependence</i>, 79, 1-10.</p>	<p>Slide 20</p> 
<p>Specific Research on Buprenorphine and Pregnancy</p> <ul style="list-style-type: none"> • Head to head randomized blinded comparison between methadone and buprenorphine in pregnant women • Women admitted during second trimester • One statistically significant finding: shorter stay for buprenorphine • Other trends for buprenorphine: fewer infants treated for NAS, less NAS medication used. • Multi-site trial in progress now. 	<p>Slide 21: Specific Research on Buprenorphine and Pregnancy</p> <p>This research was conducted as a head to head randomized, blinded comparison between methadone and buprenorphine in pregnant women. Women were admitted during their second trimester.</p> <p>One statistically significant finding was that the length of hospitalization was shorter for buprenorphine-exposed neonates than for methadone-exposed neonates.</p> <p>Other trends showed that fewer buprenorphine-exposed infants were treated for neonatal abstinence syndrome; of those treated for NAS, less medication was administered.</p> <p>Results suggest that buprenorphine is not inferior to methadone on outcome measures assessing NAS and maternal and neonatal safety when administered starting in the second trimester of pregnancy.</p> <p>A multi-site trial is now in progress.</p> <p><u>Reference:</u></p> <p>Jones, H. E., Johnson, R. E., Jasinski, D. R., O’Grady, K. E., Chisholm, C. A., Choo, R. E., ... Milio, L. (2005). Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: Effects on the neonatal abstinence syndrome. <i>Drug and Alcohol Dependence</i>, 79, 1-10.</p>	<p>Slide 21</p> 

<p>Summary: Opioid Addiction and Pregnancy</p> <ul style="list-style-type: none"> • Methadone maintenance is still the treatment of choice and standard of care in the US. • Buprenorphine treatment is possible, evidence still lacking. • Detoxification is relatively contraindicated unless conducted in hospital setting where the patient can be closely monitored. 	<p>Slide 22: Summary: Opioid Addiction and Pregnancy</p> <p>Bullet #1: Methadone maintenance is still the treatment of choice and standard of care in the United States.</p> <p>Bullet #2: Buprenorphine treatment is possible, evidence still lacking.</p> <p>More research is needed before buprenorphine is approved for this indication. In the meantime, it can be used off-label if methadone is not available or appropriate AND the benefits of treatment outweigh the risk of using this medication.</p> <p>Note to the Trainer(s): <i>In cases where it is determined that the benefits of buprenorphine treatment during pregnancy outweigh the risks, it is important to utilize the mono-product to minimize the chance of precipitated withdrawal.</i></p> <p>Bullet #3: Detoxification is generally contraindicated unless conducted in a hospital setting where the patient can be closely monitored.</p> <p>In general, complete withdrawal from opioids is contraindicated. If indicated:</p> <ul style="list-style-type: none"> • It should be done in a hospital with careful monitoring. • Risk of relapse is high and detrimental; ongoing care with monitoring is essential. 	<p>Slide 22</p> 
<p>Opioid-Addicted Adolescents and Young Adults</p> <ul style="list-style-type: none"> • 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. 	<p>Slide 23: Opioid-Addicted Adolescents and Young Adults</p> <p><i>Reiterate the importance of finding out the local requirements regarding opioid treatment for individuals under age 18.</i></p>	<p>Slide 23</p> 

<p>Opioid-Addicted Adolescents and Young Adults</p> <ul style="list-style-type: none"> • Buprenorphine is approved for use with opioid dependent persons age 16 and older • Research conducted through the NIDA Clinical Trials Network (CTN 010) demonstrated that it can be safely and effectively used with young adults. • This research also indicated that medical treatment likely needs to be longer than current standard treatment indicates. 	<p>Slide 24: Opioid-Addicted Adolescents and Young Adults</p> <p>Buprenorphine is approved for use with opioid dependent persons age 16 and older. Research conducted through the NIDA Clinical Trials Network (CTN) had demonstrated that it can be safely and effectively used with adolescents and young adults.</p> <p>Note to the Trainer(s): This information is a very brief summary of using buprenorphine with adolescents. For a more detailed explanation including results from the NIDA CTN Study, insert optional <i>Buprenorphine Treatment for Young Adults Module</i> here.</p>	<p>Slide 24</p> 
<p>Buprenorphine and Pain Management</p>	<p>Slide 25: Buprenorphine and Pain Management</p> <p>The next two slides will briefly address medication-assisted treatment and pain management</p>	<p>Slide 25</p>

**Medication-Assisted Treatment
and Pain Management**
Common Misconceptions

- Maintenance opioid agonists provide pain relief.
- Use of opioids for pain relief may result in addiction or relapse
- Combining opioid analgesics and opioid agonist therapy may cause respiratory and central nervous system depression.
- The pain complaint may be a manipulation to obtain medications to feel "high."

Slide 26: Medication-Assisted Treatment and Pain Management – Common Misconceptions

Bullet #1: Maintenance opioid agonists (methadone or buprenorphine) provide pain relief.

Pain relief depends on maintaining the established tolerance (i.e., maintenance of the methadone dose) with an opioid agonist **and** providing additional pain relief.

***Note to the Trainer(s):** Stress the importance of understanding that long-term use of opioids is associated with neurological changes, thus the analgesic effects of these medications may diminish; and that the treatment profiles of opioid medications differ.*

Bullet #2: Use of opioids for pain relief may result in addiction or relapse.

A common concern of primary care providers is that the use of opioids for pain relief in patients receiving opioid agonist therapy may result in relapse to active drug use. However, there is **no** evidence that relapse rates increase secondary to exposure to opioid analgesics in the presence of acute pain. In fact, relapse prevention theories would suggest that the stress associated with unrelieved pain is more likely to be a trigger for relapse than adequate analgesia

Bullet #3: Combining opioid analgesics and opioid agonist therapy may cause respiratory and central nervous system (CNS) depression.

Primary health care providers are often concerned that combining opioid analgesics and opioid agonist therapy will cause respiratory or CNS depression. This has never been clinically demonstrated. In fact, tolerance to side effects develops quickly, thus allowing doses to be increased as necessary to achieve effective pain relief.

Slide 26



Slide 26: Medication-Assisted Treatment and Pain Management – Common Misconceptions, Continued

Bullet #4: The pain complaint may be a manipulation to obtain medications to feel “high.”

It can be difficult to distinguish between a patient’s desire to use opioids for pain relief and their desire to feel “high.” This may be especially true in patients who have become physically dependent secondary to the treatment of a pain condition. A careful assessment will assist in determining the appropriate treatment plan. For additional information regarding the clinical features that distinguish opioid use in patients with pain versus patients who are addicted to opioids, please refer to TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*.

References: Bullet #1

Alford, D. P., Compton, P., & Samet, J. H. (2006). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Annals of Internal Medicine, 144*, 127-134.

Zweben, J. E., & Payte, J. T. (1990). Methadone maintenance in the treatment of opioid dependence. A current perspective. *Western Journal of Medicine, 152*, 588-599.

Reference: Bullet #2

Alford, D. P., Compton, P., & Samet, J. H. (2006). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Annals of Internal Medicine, 144*, 127-134.

References: Bullet#3

Alford, D. P., Compton, P., & Samet, J. H. (2006). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Annals of Internal Medicine, 144*, 127-134.

Savage, S. R., Kirsh, K. L., & Passik, S. D. (2008). Challenges in using opioids to treat pain in persons with substance use disorders. *Addiction Science & Clinical Practice, 4*(2), 4-25.

References: Bullet #4

Alford, D. P., Compton, P., & Samet, J. H. (2006). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Annals of Internal Medicine, 144*, 127-134.

Center for Substance Abuse Treatment. (2004). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40 (DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration.



Buprenorphine and Pain Management

- Little clinical experience documented
- Acute Pain
 - Initially treat with non-opioid analgesics
 - Pain not relieved by non-opioid medications, follow usual pain management protocol
- Chronic Pain
 - May not be good candidate for buprenorphine treatment because of the ceiling effect

Slide 27: Buprenorphine and Pain Management

Little clinical experience is documented regarding the treatment of pain in patients receiving buprenorphine. Patients receiving buprenorphine who are experiencing pain should initially be treated with non-opioid analgesics when appropriate.

If acute pain is not relieved by non-opioid medications, patients should receive the usual pain management protocol, which may include the use of short-acting opioid pain relievers. *It is important to note that the administration of buprenorphine should be discontinued while patients are receiving opioid pain medications.*

As when initially inducting a patient onto buprenorphine, administration should not begin until sufficient time has elapsed for the opioid pain medication to have cleared from the patient's system, as demonstrated by the onset of early withdrawal symptoms. If buprenorphine is started prior to the opioid pain medication clearing from the patient's system, acute withdrawal may be precipitated.

Patients receiving long-acting opioids for chronic severe pain may not be good candidates for buprenorphine treatment because of the ceiling effect.

Reference:

Center for Substance Abuse Treatment. (2004). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40 (DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 27



Using Buprenorphine in the Treatment of Opioid Addiction

Slide 28: Buprenorphine in the Treatment of Opioid Addiction (Transition Slide)

We will spend the rest of the training reviewing various approaches used in treating opioid-addicted individuals.

Slide 28



<p>Buprenorphine-Related Patient Management Issues</p> <ul style="list-style-type: none"> • Discuss the benefits of maintenance treatment • Evaluate the readiness to taper medication • Explain issues in evaluating the discontinuation of buprenorphine treatment • Identify the components of a healthy counselor-physician partnership 	<p>Slide 29: Buprenorphine-Related Patient Management Issues</p> <p>Bullet #1: Discuss the benefits of maintenance treatment</p> <p>Bullet #2: With regards to evaluating readiness to taper medication, ask the patient if:</p> <ul style="list-style-type: none"> • He/she has had previous attempts at medically supervised withdrawal. If so, have the attempts been successful or unsuccessful? • Illicit opioids are avoidable or unavoidable in his/her living or working situation. • His/her living situation is stable or unstable. <p>Bullet #3: Explain issues in evaluating the discontinuation of buprenorphine treatment</p> <p>Bullet #4: When collaborating with a physician, the multidisciplinary addiction professional should:</p> <ul style="list-style-type: none"> • Develop open, ongoing lines of communication; • Avoid manipulation; and • Support the physician (not work against him/her). 	<p>Slide 29</p>
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Address issues of the necessity of counseling with medication for recovery. • Recovery and Pharmacotherapy: <ul style="list-style-type: none"> – Patients may have ambivalence regarding medication. – The recovery community may ostracize patients taking medication. – Counselors need to have accurate information. 	<p>Slide 30: Counseling Buprenorphine Patients</p> <p>Note to the Trainer(s): <i>Again, it is important to stress that the multidisciplinary addiction professional should work with, not against, the medication.</i></p>	<p>Slide 30</p> 
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Recovery and Pharmacotherapy: <ul style="list-style-type: none"> – 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” 	<p>Slide 31: Counseling Buprenorphine Patients</p> <p>Suggesting the need to discontinue medication can convey the idea that the medication is a necessary evil and somehow wrong. It is important to refer to buprenorphine as a medication and frame it as one component of the comprehensive opioid treatment plan.</p>	<p>Slide 31</p>

<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Dealing with Ambivalence: <ul style="list-style-type: none"> – Impatience, confrontation, “you’re not ready for treatment” or, – Deal with patients at their stage of acceptance and readiness 	<p>Slide 32: Counseling Buprenorphine Patients</p> <p>Some patients are ambivalent about or averse to medication. They may acquire negative attitudes from previous treatment experiences, methadone-related stigma, or from other people in recovery who are using medications.</p> <p>Medication is not essential to a treatment plan or the recovery process, and in fact, effective treatment and recovery can occur without it. However, it is important to talk with the patient about the realities of withdrawal and the low success rate of people who try it without medical assistance. Counselors can help patients by dispelling myths about buprenorphine and providing accurate information about the use of buprenorphine for treating opioid addiction.</p>	<p>Slide 32</p>
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Counselor Responses: <ul style="list-style-type: none"> – Be flexible – Don’t impose high expectations – Don’t confront – Be non-judgmental – Use a motivational interviewing approach – Provide reinforcement 	<p>Slide 33: Counseling Buprenorphine Patients</p> <p><u>Be flexible:</u> An opioid-addicted person’s life is often out of control. The transition from active drug use to recovery via buprenorphine treatment is a major lifestyle change. Patients may be late for appointments, reschedule, or fail to show. Applying rigid standards and expressing disapproval may prompt patients to feel negatively about counseling, and they may choose to avoid appointments or discontinue psychosocial treatment altogether.</p> <p><u>Don’t impose high expectations:</u> Patients who have taken steps to address their drug addiction have already achieved a significant accomplishment. An immediate major change in the person’s general lifestyle may be an unrealistic expectation.</p> <p><u>Don’t confront:</u> Instead of being confrontational, it is better to develop discrepancy (which is a gentler counseling approach). Direct and harsh confrontation is more likely to drive a person out of treatment than to maintain them in treatment.</p> <p><u>Non-judgmental acceptance:</u> Drug addiction is associated with many unappealing behaviors, such as lying, stealing, and unreliability. Some of these behaviors may continue during treatment. View these behaviors as symptoms of the drug problem. Do not be critical or judgmental.</p> <p><u>Utilize a motivational interviewing approach</u> (<i>this topic is covered in more detail in a few more slides</i>).</p>	<p>Slide 33</p>

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

Slide 34: Counseling Buprenorphine Patients

Slide 34

What is the 12-Step program?: Two men who were unable to deal with their own alcoholism through psychiatry or medicine founded Alcoholics Anonymous (AA) in the 1930s. They discovered several principles that helped people overcome their addictions. They founded AA to introduce alcoholics to these principles of self-help.

The AA principles and concepts have been adapted for addiction to opioids, stimulants, other drugs, and even to compulsive behaviors such as gambling, overeating, and sex.

Benefits of participating in 12-Step meetings: Many treatment providers believe that participating in 12-Step meetings can be an important component of buprenorphine treatment. Individuals addicted to alcohol and drugs have found that other addicted persons in recovery can provide enormous support and help to one another. In addition, meetings are free, and are generally available throughout the day and in the evening. 12-Step meetings can be found throughout the world.

Types of meetings: Speaker meetings (recovering person tells his/her story); topic meetings (discuss a specific topic, such as fellowship, honesty, acceptance, or patience); and step/tradition meetings (the 12 steps and 12 traditions are discussed). Some people are able to stop using substances through 12-Step participation alone. However, for many, this self-help approach is not enough. In this case, participation in 12-step meetings may be a valuable adjunct to other medical and/or psychosocial 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

Slide 35: Counseling Buprenorphine Patients

Some patients may have had negative experiences in the past at 12-Step meetings because they were taking medication for their drug addiction or for psychiatric disorders.

Although 12-Step programs accept people who are taking medications, some 12-Step participants do not discriminate between drugs of abuse and appropriately used medications, and are therefore intolerant of medication-taking individuals.

AA has developed an AA-approved publication called “*The AA Member – Medications and Other Drugs*.” Addiction professionals should become familiar with this publication.

Addiction professionals can help patients by educating them about the official position of 12-Step programs regarding the use of prescribed medications, describing the benefits of 12-Step programs, and promoting the use of these self-help programs as part of their overall recovery process.

Despite the official views of 12-Step programs, patients may need to seek 12-Step meetings that include members who are accepting of the use of properly prescribed medication.

12-Step Meetings are one source of social support. However, these meetings may not work for everyone. Providers generally recommend to these patients in treatment that they find some source of support to help them in the recovery process (e.g., other self-help meetings, churches, recreational groups, etc.).

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Counseling Buprenorphine Patients

- A Motivational Interviewing Approach:
 - Dealing with other drugs and alcohol
 - Doing more than not-using
- MIA-STEP
 - Developed through the Blending Initiative
 - Empirically supported mentoring products to enhance the MI skills of treatment providers
 - Provides tools to help supervisors offer structured, focused, and effective supervision.
 - The blending products are available at www.drugabuse.gov/Blending/ and www.attcnetwork.org

Slide 36: Counseling Buprenorphine Patients

Patients receiving buprenorphine may not be ready to stop using illicit drugs and alcohol. Even patients expressing the desire to stop using will have ambivalent feelings about the change process. Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) are therapeutic approaches to help patients move more quickly through the process of change (Prochaska & DiClemente, 1982).

Miller and Rollnick (1995) developed these client-centered, yet directive approaches, which are designed to explore and reduce the inherent ambivalence regarding change. These approaches rely on the Stages of Change model as the theoretical foundation for understanding the change process.

The *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP)* Blending Product was developed through the Blending Initiative. The MIA:STEP Blending Team designed empirically supported mentoring products to enhance the MI skills of treatment providers, as well as supervisory tools to fortify a supervisor's ability to provide structured, focused, and effective clinical supervision. MIA:STEP introduces an effective strategy for observation-based clinical supervision, the use of which has potential to improve counselor skills beyond MI.

This Blending Product is available at :
www.drugabuse.gov/Blending/
www.attcnetwork.org

Reference:

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 161-173.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334.

Slide 36



Principles of Motivational Interviewing

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

Slide 37: Principles of Motivational Interviewing

With MI, the counselor has certain goals in mind when conducting patient interviews. These goals are formulated with an awareness of the underlying principles of the approach.

When strategizing an intervention, the counselor should try to:

- Express empathy;
- Develop discrepancy;
- Avoid argumentation; and
- Support self-efficacy.

Achieving these goals and helping people to move through the Stages of Change are accomplished by using the microskills of MI. They are:

- Asking open-ended questions;
- Being affirming;
- Listening reflectively; and
- Summarizing.

Becoming adept in the use of MI takes practice. For more information on the use of MI, please refer to TIP 35: *Enhancing Motivation for Change in Substance Abuse Treatment*.

Reference:

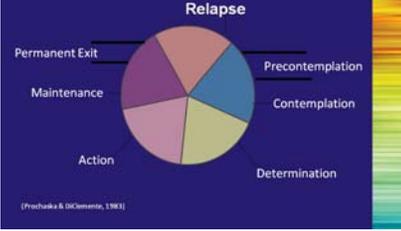
Center for Substance Abuse Treatment. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Slide 37



<p>Using Motivational Incentives</p> <ul style="list-style-type: none"> • NIDA CTN research shows that treatment retention and drug abstinence are improved by providing low-cost reinforcement (prizes, vouchers, clinic privileges, etc.), for drug negative urine tests. • The Blending Product Promoting Awareness of Motivational Incentives (PAMI) provides information on this effective technique. • The blending products are available at: www.drugabuse.gov/Blending/ www.attcnetwork.org 	<p>Slide 38: Using Motivational Incentives</p> <p>Research has shown that motivational incentive programs that use low-cost reinforcement (prizes, vouchers, clinic privileges, etc.), delivered in conjunction with on-site urine screening promotes higher rates of treatment retention and abstinence from drug abuse.</p> <p><i>Promoting Awareness of Motivational Incentives (PAMI)</i> Blending Product, developed through the Blending Initiative is based on the positive research outcomes and lessons learned from the NIDA CTN study, Motivational Incentives for Enhanced Drug Abuse Recovery (MIEDAR). The tools contained in this training package are designed to build awareness of motivational incentives as a research-based therapeutic strategy within the addiction treatment field.</p> <p>This Blending Product is available at : www.drugabuse.gov/Blending/ www.attcnetwork.org</p>	<p>Slide 38</p>
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • <u>Early Recovery Skills:</u> <ul style="list-style-type: none"> – Getting Rid of Paraphernalia – Scheduling – Trigger Charts 	<p>Slide 39: Counseling Buprenorphine Patients</p> <p><u>Early Recovery Skills:</u> Addiction professionals can help patients by educating them about the importance of developing skills related to drug cessation, early recovery, and relapse prevention.</p> <p>Professionals can help patients through the recovery process by educating them about the need to discard drug paraphernalia, address triggers and cravings, understand addictive behaviors and thinking, avoid relapse drift, not focus on willpower, and address ignored responsibilities. Likewise, addiction professionals have an important role in helping patients to resume optimal health and hygiene, make amends, deal with intense emotions, and engage in healthy recreation activities.</p>	<p>Slide 39</p>

<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: <ul style="list-style-type: none"> – 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. 	<p>Slide 40: Counseling Buprenorphine Patients</p> <p>Relapse does not suddenly occur. It occurs gradually and with warning signs. The gradual movement can be subtle and easily explained away or denied, and therefore, relapse can feel as if it occurred suddenly and without warning.</p> <p>Relapse prevention involves the following:</p> <p><i>Review the bullet points.</i></p> <p>Bullet #1: Patients need to develop new behaviors.</p> <p>Bullet #2: Learn to monitor signs of vulnerability to relapse.</p> <p>Bullet #3: Recovery is more than not using illicit opioids.</p> <p>Bullet #4: Recovery is more than not using drugs and alcohol.</p>	<p>Slide 40</p> 
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: Sample Topics <ul style="list-style-type: none"> – <i>Relapse Prevention</i> <ul style="list-style-type: none"> • Overview of the concept – <i>Using Behavior</i> <ul style="list-style-type: none"> • Old behaviors need to change • Re-emergence signals relapse risk – <i>Relapse Justification</i> <ul style="list-style-type: none"> • "Stinking thinking" • Recognize and stop 	<p>Slide 41: Counseling Buprenorphine Patients</p> <p>Because relapse is a common occurrence during the process of substance abuse recovery, it is imperative that it be examined carefully.</p> <p><i>Read through the sample topics and move on to the next slide.</i></p>	<p>Slide 41</p> 
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: Sample Topics <ul style="list-style-type: none"> – <i>Dangerous Emotions</i> <ul style="list-style-type: none"> • Loneliness, anger, deprivation – <i>Be Smart, not Strong</i> <ul style="list-style-type: none"> • Avoid the dangerous people and places • Don't rely on will power – <i>Avoiding Relapse Drift</i> <ul style="list-style-type: none"> • Identify "mooring lines" • Monitor drift 	<p>Slide 42: Counseling Buprenorphine Patients</p> <p><i>Read through the sample topics and move on to the next slide.</i></p>	<p>Slide 42</p> 
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: Sample Topics <ul style="list-style-type: none"> – <i>Total Abstinence</i> <ul style="list-style-type: none"> • Other drug/alcohol use impedes recovery growth • Development of new dependencies is possible – <i>Taking Care of Business</i> <ul style="list-style-type: none"> • Addiction is full-time • Normal responsibilities often neglected – <i>Taking Care of Yourself</i> <ul style="list-style-type: none"> • Health, grooming • New self-image 	<p>Slide 43: Counseling Buprenorphine Patients</p> <p><i>Read through the sample topics and move on to the next slide.</i></p>	<p>Slide 43</p> 

<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: Sample Topics <ul style="list-style-type: none"> – Repairing Relationships <ul style="list-style-type: none"> • Making amends – Truthfulness <ul style="list-style-type: none"> • Counter to the drug use style • A defense against relapse – Trust <ul style="list-style-type: none"> • Does not return immediately • Be patient 	<p>Slide 44: Counseling Buprenorphine Patients</p> <p><i>Read through the sample topics and move on to the next slide.</i></p>	<p>Slide 44</p> 
<p>Counseling Buprenorphine Patients</p> <ul style="list-style-type: none"> • Relapse Prevention: Sample Topics <ul style="list-style-type: none"> – Downtime <ul style="list-style-type: none"> • Diversion, relief, escape without drugs – Recognizing and Reducing Stress <ul style="list-style-type: none"> • Stress can cause relapse • Learn signs of stress • Learn stress management skills 	<p>Slide 45: Counseling Buprenorphine Patients</p> <p><i>Read through the sample topics and move on to the next slide.</i></p>	<p>Slide 45</p> 
<p>Stages of Change</p>  <p>(Prochaska & DiClemente, 1982)</p>	<p>Slide 46: Stages of Change</p> <p>As was previously stated, patients receiving buprenorphine treatment may not be ready to stop using all illicit drugs and alcohol. Even patients expressing the desire to stop using will have ambivalent feelings about the change process.</p> <p>Patients enter treatment at varying stages of readiness for treatment and openness to counseling. Interventions effective at one stage of readiness may not be as effective when used during another stage.</p> <p><i>Each stage will be described in greater detail in the following couple of slides.</i></p> <p><u>Reference:</u></p> <p>Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. <i>Psychotherapy: Theory, Research and Practice</i>, 19(3), 161-173.</p>	<p>Slide 46</p>  

<p style="text-align: center;">Stages of Change</p> <ul style="list-style-type: none"> • <u>Pre-contemplation</u>: Not yet considering change or is unwilling or unable to change. • <u>Contemplation</u>: Sees the possibility of change but is ambivalent and uncertain. • <u>Determination</u> (or preparation): Committed to making change but is still considering what to do. 	<p>Slide 47: Stages of Change</p> <p><u>Pre-Contemplation</u>: Provide the patient with factual information; explore the meaning of events that brought the patient to treatment and the results of previous treatments; explore the pros and cons of using alcohol and other illicit drugs.</p> <p><u>Contemplation</u>: Talk about the patient’s sense of self-efficacy (the belief that you can influence your own thoughts and behavior) and expectations regarding treatment; summarize self-motivational statements; continue exploring pros and cons of substance use.</p> <p><u>Determination</u>: Offer a menu of options for change or treatment; negotiate a change (treatment) plan and behavioral contract; identify and lower barriers to change; help patients enlist social support; have patients publicly announce plans to change.</p> <p><u>Reference</u>:</p> <p>Prochaska, J. O. & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. <i>Psychotherapy: Theory, Research and Practice</i>, 19(3), 161-173.</p>	<p>Slide 47</p> 
<p style="text-align: center;">Stages of Change</p> <ul style="list-style-type: none"> • <u>Action</u>: Taking steps to change but hasn’t reached a stable state. • <u>Maintenance</u>: Has achieved abstinence from illicit drug use and is working to maintain previously set goals. • <u>Recurrence</u>: Has experienced a recurrence of symptoms, must cope with the consequences of the relapse, and must decide what to do next 	<p>Slide 48: Stages of Change</p> <p><u>Action</u>: Support a realistic view of change through small steps; help patients identify high-risk situations and develop appropriate coping strategies; help patients find new reinforcers of positive change; help patients access family and social support.</p> <p><u>Maintenance</u>: Help patients identify and try drug-free sources of pleasure; maintain supportive contact with patients; encourage patients to develop a “fire escape” plan; work with patients to set new short- and long-term goals.</p> <p><u>Recurrence</u>: Explore with patients the meaning and reality of recurrence as a learning opportunity; explain the stages of change, and encourage patients to remain engaged in the process; help patients to find alternative coping strategies.</p> <p><u>Reference</u>:</p> <p>Prochaska, J. O. & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. <i>Psychotherapy: Theory, Research and Practice</i>, 19(3), 161-173.</p>	<p>Slide 48</p> 

<p>Buprenorphine Treatment Works in Multiple Settings</p> <ul style="list-style-type: none"> National studies conducted through the CTN have shown that buprenorphine treatment can be integrated into diverse settings, such as specialized clinics, hospital settings and drug-free programs, and including settings with no prior experience using agonist-based therapies. Additional information about interventions that may be useful along with buprenorphine treatment include the MIA: STEP and PAMI Blending Products available at: www.attcnetwork.org and www.drugabuse.gov/Blending/ 	<p>Slide 49: Buprenorphine Treatment Works in Multiple Settings</p> <p><i>Read slide aloud.</i></p>	<p>Slide 49</p> 
<p>Module VI - Summary</p> <ul style="list-style-type: none"> Buprenorphine patients need to learn the skills to stop drug thoughts before they become full-blown cravings. A thorough needs assessment should be conducted at the beginning of treatment. Various empirically-supported therapeutic approaches are available for use in providing psychosocial treatment to buprenorphine patients. 	<p>Slide 50: Module VI – Summary</p> <p>Bullet #1: Buprenorphine patients need to learn the skills to stop drug thoughts before they become full-blown cravings.</p> <p>Bullet #2: A thorough needs assessment should be conducted at the beginning of substance abuse treatment.</p> <p>Bullet #3: Various empirically-supported therapeutic approaches are available for use in providing psychosocial treatment to buprenorphine patients.</p>	<p>Slide 50</p>
<p>Module VI - Summary</p> <ul style="list-style-type: none"> 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. 	<p>Slide 51: Module VI – Summary</p> <p>An ideal buprenorphine treatment team is made up of a physician, substance abuse counselor, and other supportive treatment providers.</p> <p><i>Ask the trainees if they have any final questions.</i></p>	<p>Slide 51</p> 

Note to the Trainer(s): This concludes the buprenorphine awareness training. Thank the trainees for taking the time to learn about this new option for the treatment of opioid dependence. Answer any questions and adjourn the training.