New England (HHS Region 1)

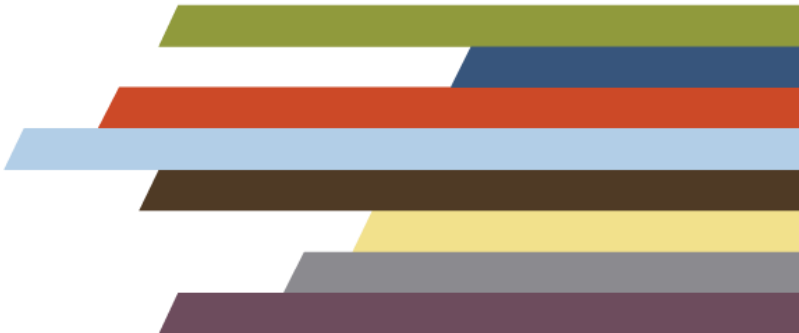
ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Medication Assisted Treatment:
A Training for Multidisciplinary Addiction Professionals

Opioid Use Disorder (OUD) and Medication Assisted Treatment (MAT) 201:

Treatment Protocols



Revised 2019

Disclosures

- The development of these training materials were supported by grant H79 TI080209 (PI: S. Becker) from the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The views and opinions contained within this document do not necessarily reflect those of the US Department of Health and Human Services, and should not be construed as such.

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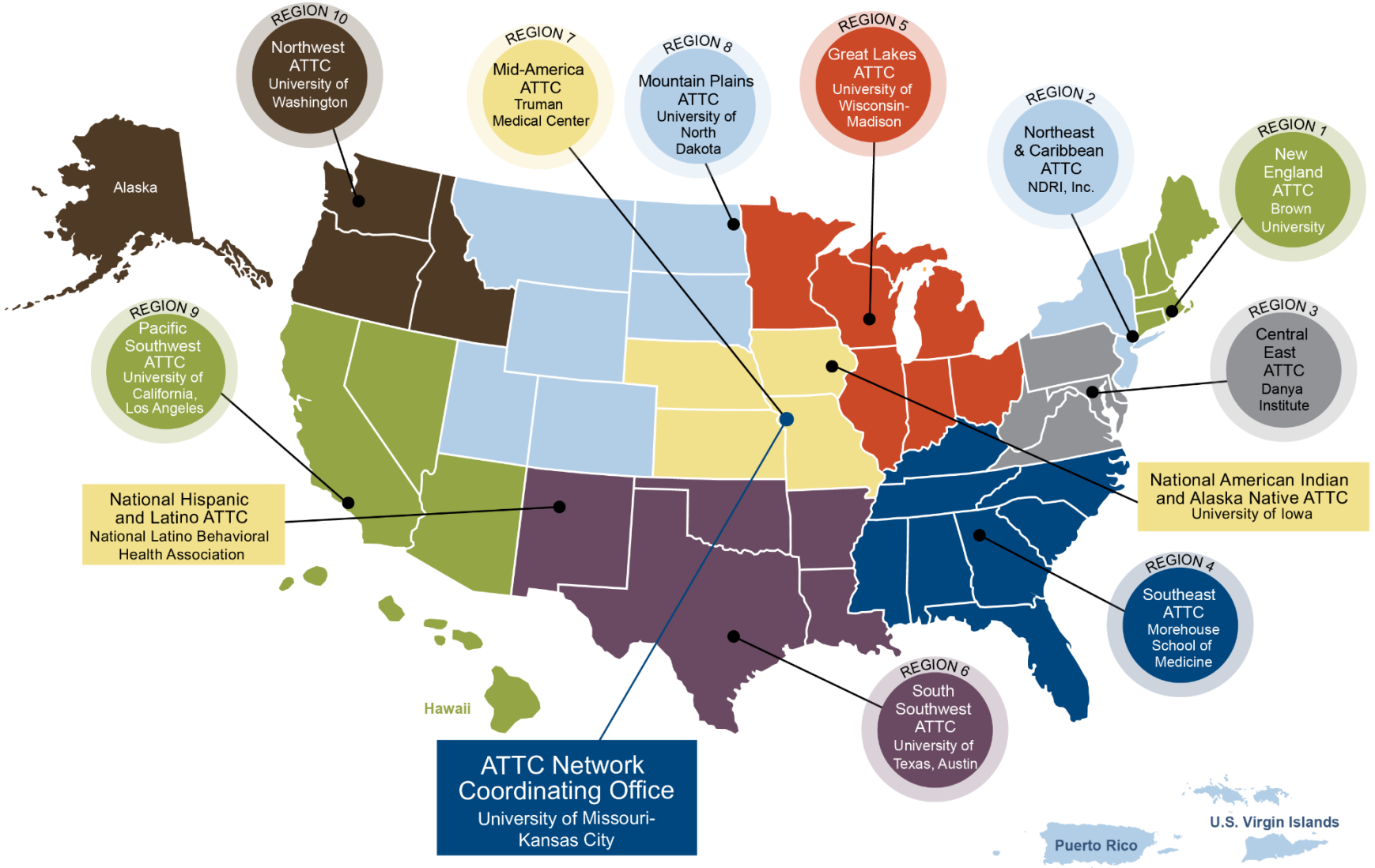


Goals for this Training

- Participants will state no fewer than 3 client-selection criteria:
  - Define the components of the client selection process
  - List circumstances where someone may not meet full criteria for opioid addiction and yet still be appropriate for medication assisted treatment.
  - Describe the medical contraindications for medication assisted treatment

Goals for this Training

Participants will be able to:

- Identify no fewer than 3 counseling issues in Opioid Recovery:
  - Overview of dynamics of Triggers and Cravings
  - Identification of Special Populations' Needs
  - Overview of MAT Client Management Issues

- Identify no fewer than 3 ways to enhance coordination of care:
  - Develop strategies to form links between physicians who are authorized to prescribe medications and substance abuse treatment providers
  - Identify the role of the addiction programs/ professionals in providing MAT.

- Identify components of effective Treatment Protocols

Quick Overview of the Medications

Comparison of OUD Medications to Guide Shared Decision-Making			
Category	**Buprenorphine**	**Methadone**	**Naltrexone**
Outcome; tx retention	Higher than without medication	Higher than without medication	Naltrexone: no difference. Vivitrol: higher that without medication.
Outcome; suppression of illicit opioid use	Effective	Effective	Effective
Outcome: overdose mortality	Lower for people in tx.	Lower for people in tx.	Unknown
Location/frequency of visits		6-7 days/wk until takehomes approved	Varies from weekly to monthly

Quick Overview of the Medications

Comparison of OUD Medications to Guide Shared Decision-Making			
Category	**Buprenorphine**	**Methadone**	**Naltrexone**
Misuse/diversion potential	Low in OTP's or other settings with observed administration Moderate for take-home doses	Low in OTP's or other settings with observed administration Moderate for take-home doses	None
Sedation	Low unless use of other substances	Low unless does titration is too quick or concurrent substance use	None
Risk of Respiratory Depression	Rare. Lower than with Methadone	Rare. May be elevated in first 2 weeks.	None
Risk of Precipitated W/D	Can occur if started too soon after recent use of other opioids	None	Severe w/d if abstinence inadequate before starting.
W/D sx's on discontinuation	Present; lower than methadone	Present	None
Common side effects	Constipation, vomiting, headache, sweating, insomnia, blurred vision.	Constipation, vomiting, sweating, dizziness, sedation	Difficulty sleeping, anxiety, joint pain, headache, injection site pain, toothache, liver enzyme elevation.

Quick Overview of the Medications

Comparison of OUD Medications to Guide Shared Decision-Making			
Category	**Buprenorphine**	**Methadone**	**Naltrexone**
Appropriate Clients	Typically for patients with OUD who are physiologically dependent on opioids.	Typically for patients with OUD who are physiologically dependent on opioids and who meet federal criteria for OTP admission.	Typically for patients with OUD who have abstained from short-acting opioids for at least 7–10 days and long-acting opioids for at least 10–14 days.
Pharmacology	Partial Agonist	Agonist	Antagonist
Client Education	•That they will need to be in opioid withdrawal to receive their first dose to avoid buprenorphine-precipitated opioid withdrawal. •About the risk of overdose with concurrent benzodiazepine or alcohol use, with injecting buprenorphine, and after stopping the medication.	•That their dose will start low and build up slowly to avoid oversedation; it takes several days for a given dose to have its full effect. •About overdose risk in the first 2 weeks of treatment, especially with concurrent benzodiazepine or alcohol use, and after stopping the medication.	That they will need to be opioid f ree for at least7–10 days for short-acting opioids and at least10–14 days for long-acting opioids before their first dose to avoid XR-NTX-precipitated opioid withdrawal (which may require hospitalization). •About the risk of overdose after stopping the medication.

Quick Overview of the Medications

Comparison of OUD Medications to Guide Shared Decision-Making			
Category	**Buprenorphine**	**Methadone**	**Naltrexone**
Administration	Daily (or off-label less-than-daily dosing regimens) administration of sublingual or buccal tablet or film. Subdermal implants every 6 months, for up to 1 year, for stable patients. Monthly subcutaneous injection of extended-release formulation in abdominal region for patients treated with transmucosal buprenorphine for at least 1 week.	Daily oral administration as liquid concentrate, tablet, or oral solution f rom dispersible tablet or powder (unless patients can take some home).	Every 4 weeks or once-per-month intramuscular injection.
Prescribing	Physicians, nurse practitioners (NPs), and physician assistants (PAs) need a waiver to prescribe. Any pharmacy can fill a prescription for sublingual or buccal formulations. OTPs can administer/ dispense by OTP physician order without a waiver.	SAMHSA-certified OTPs can provide methadone for daily onsite administration or at-home self-administration for stable patients.	Physicians, NPs, or PAs prescribe or order administration by qualified healthcare professionals.

Quick Overview of the Medications

- *Long-acting buprenorphine implants (every 6 months) for patients on a stable dose of buprenorphine are also available through implanters and prescribers with additional training and certification through the Probuphine Risk Evaluation and Mitigation Strategy (REMS) Program. Extended-release buprenorphine monthly subcutaneous injections are available only through prescribers and pharmacies registered with the Sublocade REMS Program.

- **Naltrexone hydrochloride tablets (50 mg each) are also available for daily oral dosing but have not been shown to be more effective than treatment without medication or placebo because of poor patient adherence.

Class Discussion

- A) What are some of the challenges you've encountered when speaking with clients and colleagues about MAT approaches to recovery?

- B) What are some of the challenges you've encountered when providing clinical and/or case-management services to persons with OUD on MAT?

Patient Selection: Assessment Questions

Determining appropriateness for MAT

- Is the person addicted to opioids?
- Is the person aware of other available treatment options?
- Does the person understand the risks, benefits, and limitations of medication assisted treatment?
- Is the person expected to be reasonably compliant?
- Is the person expected to follow safety procedures? Is the person psychiatrically stable?
- Is the person taking other medications that may interact with their addiction recovery medication?
- Are the psychosocial circumstances of the person stable and supportive?
- In which medication is the person voicing interest and do they meet eligibility requirements?
- Are there resources available in the office to provide appropriate treatment?

Patient Selection:
Issues Involving Consultation with the Physician

Several factors may indicate a patient is less likely to be an appropriate candidate, including:

- Patients taking high doses of benzodiazepines, alcohol or other central nervous system depressants
- Significant psychiatric co-morbidity
- Multiple previous opioid addiction treatment episodes with frequent relapse during those episodes (may also indicate a perfect candidate)
- Non-response or poor response to the specific medication treatment in the past

Patient Selection:
Issues Involving Consultation with the Physician

Several factors may indicate a patient is less likely to be an appropriate candidate, including:

- Active or chronic suicidal or homicidal ideation or attempts
- Patient needs that cannot be addressed with existing resources or through appropriate referrals
- High risk for relapse to opioid use
- Poor social support system
- Many of these ‘issues’ are assessed in the current version of the ASAM PPC.

Patient Selection:
Issues Involving Consultation with the Physician

Patients with these conditions must be evaluated by a physician for appropriateness prior to medication assisted treatment:

- Seizures
- HIV and STDs
- Hepatitis and impaired hepatic function (Carrieri et al., 2000)
- Use of alcohol, sedative-hypnotics, and stimulants (Reynaud, Petit, Potard, & Courty, 1998; Reynaud et al., 1998)
- Other drugs of abuse

Patient Selection

- Patients who do not meet criteria for opioid addiction may still be appropriate for treatment with medication assisted treatment:
  - Patients who are 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

Patient Selection: Additional Details

- Suitability determined by a physician

- What is the relevance to counselors?
  - Patient’s appropriateness may change during treatment
  - Potential patients or other providers may inquire about treatment
  - More useful and informed communication with physician

Treatment Protocols

- Treatment should be delivered within a formal structure.

- Relapse prevention is not a matter of will power.

- Drug cessation and early recovery skills
  - Disposing of drugs and related paraphernalia
  - Creating Relapse Prevention Plan
  - Creating Recovery Plan
  - Dealing with triggers and cravings

Triggers & Cravings

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.

Triggers & Cravings

- 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 AbuseTreatment, 2006)

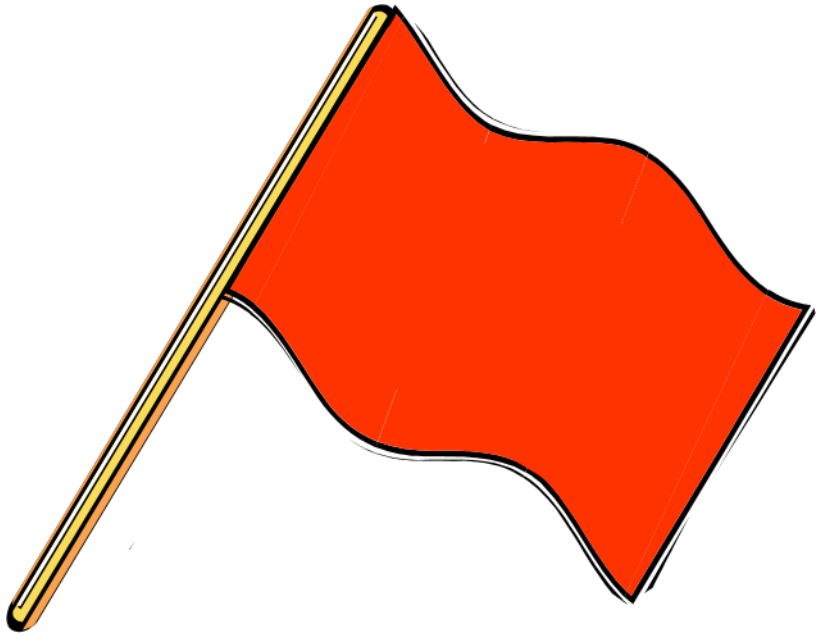
Triggers & Cravings

- 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)

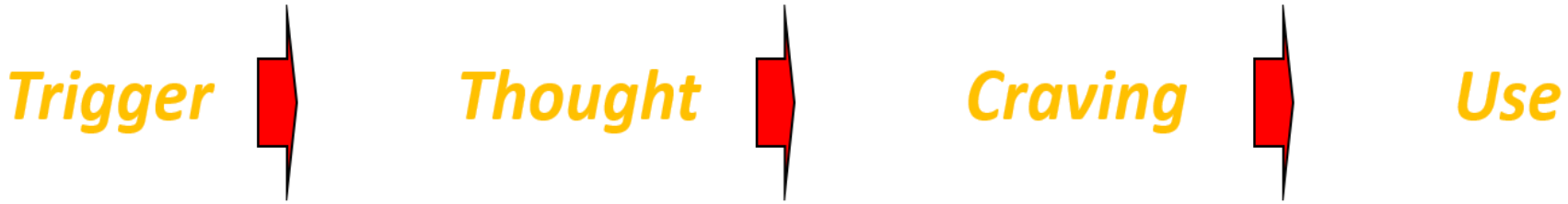
Triggers & Cravings

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



Triggers & Cravings

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



The key to dealing with this process is to not allow for it to start.

(Center for Substance Abuse Treatment, 2006)

Triggers and Cravings

- Stopping the thought when it first begins helps prevent it from building into a craving.

- Three parts to a craving:
  - Frequency
  - Duration
  - Intensity

- Ways to offset cravings:
  - Surf the urge
  - Brush your teeth and gargle with an antiseptic mouthwash like Listerine. ...
  - Distract yourself. ...
  - Exercise.
  - Relax with deep breathing exercises or meditation.
  - Choose a healthy substitute. ...
  - Listen to your **cravings**. ...
  - If you know what situations trigger your **cravings**, avoid them if possible.

Treatment Protocol: 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

Treatment Protocol: Patient Management: Treatment Monitoring

Focus of sessions:

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 medication regimen

4. Assess ability to safely store medication

5. Evaluate treatment progress

Treatment Protocol: Patient Management: Treatment Monitoring

- Drug Screening/Testing
  - National guideline available through ASAM
  - At time of admission, during treatment and, if possible, at time of discharge.
  - Collect with dignity
  - DO NOT MAKE A TX DECISION BASED SOLELY ON RESULTS
  - Review results with client
    - Positive results can confirm recent use and may delay starting Naltrexone/Vivitrol
    - Negative results indicates little or no presence of opioids in system
    - There can be false positives and negatives

Treatment Protocol: Approximate Drug Detection Times

Substance	Detection window
amphetamines	2 days
barbiturates	2 to 15 days
benzodiazepines	2 to 10 days
cannabis	3 to 30 days, depending on frequency of use
cocaine	2 to 10 days (up to 22 days with heavy use)
methadone	2 to 7 days
methaqualone	10 to 15 days
opioids	1 to 3 days
phencyclidine	8 days
propoxyphene	2 days
Fentanyl	1-2 days
Buprenorphine	3-4 days

Treatment Protocol: Patient Management: Treatment Monitoring

- Diversion monitoring:
  - Call backs
  - Potential indicators of diversion:
    - Failed appt's,
    - Early refills
    - Questionable screening results
    - Requests for higher doses without s/s of w/d
    - Requests to move from combination to monoproduct

Special Populations

- Patients with co-occurring medical disorders
- Patients with co-occurring psychiatric disorders
- Pregnant women
- Adolescents and young adults
- Managing Multiple Substance Use

Treatment Protocol: Co-occurring Medical Disorders

- Some medical problems are more prevalent in persons with opioid use disorder than in the general population.
- Infectious diseases that are prevalent include: TB, STD's, viral hepatitis and HIV infection are monitored by the CDC's.
- Acute infections and chronic disease are important to take into consideration when deciding upon MAT.
- Periodic Assessments should be taken…things change.

Treatment Protocol: Co-Occurring Medical Disorders

- Clinicians should keep in mind that consultation with specialists in infectious diseases, cardiology, pulmonary medicine, hematology, neurology, and surgery may be warranted.

- Whenever possible, consent should be sought to involve the patient's primary healthcare provider in the coordination of care.

- Attending medical staff should be aware that co-occurring medical conditions present an opportunity to engage patients. By focusing on the adverse effects of the substance abuse on the overall health of patients, staff members are in a position to help patients see the importance of engaging in treatment for their substance use disorders.

- Patients should have appointments for follow-up care made prior to detoxification discharge for all chronic medical conditions, conditions needing further evaluation, and substance abuse treatment.

Treatment Protocol:
Co-occurring Medical Disorders

- Acute Life-Threatening Infections:
  - Endocarditis
  - Soft-tissue Infections
  - Necrotizing Fasciitis
  - Wound Botulism
  - MRSA

Treatment Protocol:
Co-occurring Medical Disorders

- Infectious Diseases:
  - Tuberculosis
  - STD’s (Syphilis, Genital Chlamydia, Gonococcus Infections)
  - Hepatitis A, B, C
  - HIV/AIDS
  - Co-Infections

Treatment Protocol:
Co-occurring Medical Disorders

- Chronic Conditions:
  - Cardiac Events
  - Cirrhosis
  - Liver diseases
  - Respiratory problems
  - Lung disease
  - Endocrine disorders
  - Insomnia
  - Acute/Chronic Pain

Treatment Protocol: Co-occurring Medical Disorders/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”.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

- Pain is clearly a stressor
- May predispose those in recovery to relapse
- It stands to reason that if the patient who is in recovery with or without opioid agonist therapy (OAT) and the pain is undertreated or not treated
  - The patient may turn to the street for diverted prescription medication or illicit drugs
  - Or may use legal drugs such as alcohol to anesthetize him or herself to the pain

D Gourlay, HA Heit, A Almahrezi

Universal Precautions in Pain Medicine:

A Rational Approach to the Treatment of Chronic Pain

Pain Medicine. 2005;6(2):107-12

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

- No peer-reviewed published data or clinical practice guidelines are available to advise as to the type of pain, the severity of pain, appropriate dose or appropriate dosing intervals of buprenorphine SL or buprenorphine/naloxone SL for the management of acute or chronic pain.
- 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.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

- General Principles:

  -1. Sublingual (SL) tablet formulations of buprenorphine and buprenorphine/naloxone are only FDA-approved for the treatment of severe opioid use disorder (addiction).

  -2. Sublingual (SL) tablet formulations of buprenorphine and buprenorphine/naloxone are not FDA-approved for the treatment of pain. Use of the medications in this manner is not illegal but constitutes off-label prescribing.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

-3. Sublingual (SL) formulations of buprenorphine and buprenorphine/naloxone may provide mild analgesia in opioid-dependent (addicted) individuals with acute and chronic pain

- Dividing the dose of buprenorphine SL and buprenorphine/naloxone SL to twice, or three times a day may impart more consistent analgesia effect than single daily doses.

Source: Providers' Clinical Support System for Medication Assisted Treatment. 2013.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

A common misconception in evaluating pain is that a patient maintained on a stable dosage of methadone does not require additional pain relief for a medical or surgical procedure. Methadone-maintained patients are often tolerant to their dosage, however, and receive no analgesic effect.

General guidelines for treating acute pain in these patients include continuing daily methadone maintenance at the prescribed dosage.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

It is also reasonable to divide a patient's dose in half and administer one half intramuscularly before a surgical procedure and the other half afterward.

Nonnarcotic agents should be considered the first option for the treatment of pain. If nonnarcotic analgesics are inadequate in managing acute pain, it is appropriate to prescribe short-acting opioid agonists.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

Chronic pain is more difficult to treat than acute pain in this population. These patients typically have a history of multiple surgical procedures, unsuccessful pain treatment and increased drug abuse.

Pain clinics offer a broad spectrum of interventions to address chronic pain syndromes. Adjunctive therapies such as biofeedback, acupuncture, behavioral management and neuro-ablative procedures are often available at such clinics.

Treatment Protocol: Co-occurring Medical Disorders/Pain Management

Those on medications, including Vivitrol, should wear a med-alert tag or ID card so that providers of emergency medical care will know that you are being prescribed.

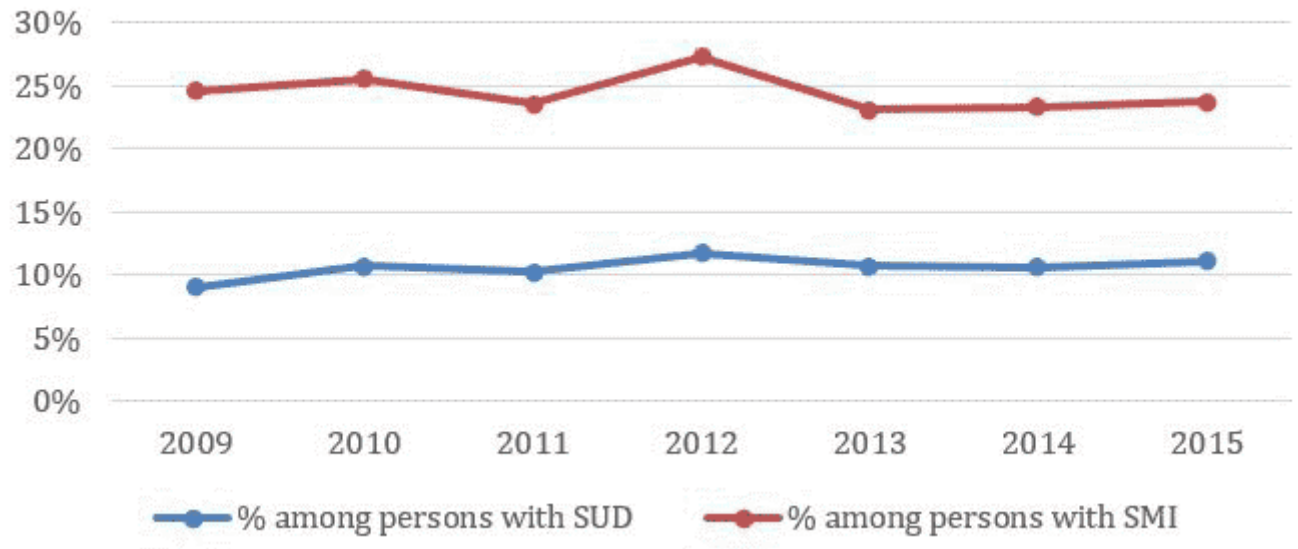
After receiving Vivitrol, the person may be more sensitive to the effects of narcotic pain medications.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Co-occurring Disorder: Co-existing Mental Disorder with a Substance Use Disorder

- Common Disorders:
  - Mood Disorders
  - Anxiety Disorders
  - ADHD
  - Cognitive Disorders
  - Eating Disorders
  - Impulse Control Disorders
  - Sleep Disorders
  - Personality Disorders

Treatment Protocol:
Co-Occurring Psychiatric Disorders



Co-Occurring Substance Use Disorder and Serious Mental Illness in Past Year among Persons Aged 18 or Older

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Opioid users frequently have concurrent psychiatric diagnoses and need proper diagnosis/treatment.
- Anecdotal reports from the field suggest that up to half of adults with SMI in our urban areas, particularly those with schizophrenia or bipolar disorder, have this comorbidity. (Ron Manderscheid)
- Clinicians must consider the duration, recentness, and amount of drug use when selecting appropriate patients.
- Within as short as 30 days of starting to use opioids, the likelihood doubles that one also will develop depression.
- Signs of anxiety, depression, thought disorders or unusual emotions, cognitions, or behaviors should be reported to physician and discussed with the treatment team.
- Sometimes the effects of drug use and/or withdrawal can mimic or induce psychiatric symptoms.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Research suggests that adolescents with substance use disorders also have high rates of co-occurring mental illness; over 60 percent of adolescents in community-based substance use disorder treatment programs also meet diagnostic criteria for another mental illness.

- Persons with co-occurring disorders often have poorer prognoses.
  - Untreated co-occurring disorders can impede progress and can lead to difficulties in establishing therapeutic relationship.
  - Symptom severity of the co-occurring disorder should not be considered predictive of treatment outcomes, but may impact treatment intensity.
  - Research suggests that persons with co-occurring are at a higher risk of suicide, psychiatric hospitalization, homelessness, infectious diseases, malnutrition, domestic violence, unemployment, etc.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- According to NIDA:
  - The high prevalence of comorbidity between substance use disorders and other mental illnesses does not necessarily mean that one caused the other, even if one appeared first.
  - Establishing causality or directionality is difficult for several reasons. For example, behavioral or emotional problems may not be severe enough for a diagnosis (called subclinical symptoms), but subclinical mental health issues may prompt drug use.
  - Also, people's recollections of when drug use or addiction started may be imperfect, making it difficult to determine whether the substance use or mental health issues came first.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Three main pathways can contribute to the comorbidity between substance use disorders and mental illnesses:
  1. Common risk factors can contribute to both mental illness and substance use and addiction.
     - Genetic Influence in 40-60% of situations
     - Epigenetic Influence such as effects of stress, trauma, drug exposure to genetic responses
     - Brain Region: changes in circuitry, impact on neurotransmitters such as dopamine, serotonin, epinephrine, glutamate and GABA.
     - Environmental factors
  2. Mental illness may contribute to substance use and addiction.
  3. Substance use and addiction can contribute to the development of mental illness.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Three Models of Treating Co-occurring Disorders:
  - Sequential Model: treat one disorder then the other.
  - Parallel Model: Treat both disorders at the same time but in different treatment settings; mental health center and substance use recovery center.
  - Integrated Model: Patient-centered treatment in which both disorders are treated simultaneously by the same clinician, and involves the whole continuum of care.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- Pharmacological Interventions
  - Some conditions require additional medications in order to stabilize psychiatrically and medically.
  - Some medications are contra-indicated.
  - Close monitoring is important, and any expressed concerns or observations that cause questioning should be reported immediately to the prescriber(s).
  - Important that ALL prescribers are on the same page.

Treatment Protocol: Co-Occurring Psychiatric Disorders

Medication	Action with Methadone
Selective Serotonin Reuptake Inhibitors (SSRI's)	May inhibit metabolism of methadone and increase methadone blood levels
Fluoxetine (Prozac) Sertraline (Zoloft) Fluvoxamine (Luvox)	Fluvoxamine is the most dangerous SSRI interms of Methadone interaction and should be avoided for clients on MAT.
Carbamazepine (Tegretol)	Increases production of liver enzymes that metabolize Methadone and can cause opioid withdrawal symptoms.
Tricyclics Desipramine Nortriptyline Imipramine Doxepin	Methadone impairs the metabolism of tricyclics and can cause increase tricyclic medication blood levels.
MOA Inhibitors	MOA Inhibitors may have dangerous interactions with substances of abuse.

Treatment Protocol: Co-Occurring Psychiatric Disorders

Medication	Action with Buprenorphine
Ambien Lyrica Valium Xanax Alcohol	May cause respiratory distress, coma, or even death. Client may need a dose adjustment or more frequent monitoring by the prescriber to safely use both medications.
Cymbalta Lexapro	Using buprenorphine together with Duloxetine may increase side effects such as dizziness, drowsiness, confusion, and difficulty concentrating. Some people, especially the elderly, may also experience impairment in thinking, judgment, and motor coordination.
OxyContin	Buprenorphine may also cause the client to experience unpleasant withdrawal symptoms.
Wellbutrin	Wellbutrin and Buprenorphine may rarely cause seizures, and combining it may increase that risk. Prescribers need to be consulted.

Treatment Protocol:
Co-Occurring Psychiatric Disorders

Medication	Action with Vivitrol
Cymbalta	Naltrexone may cause liver problems, and using it with other medications that can also affect the liver such as Duloxetine may increase that risk.
Buprenorphine Full-Agonist Medications	Using naltrexone together with buprenorphine and/or full agonist medications such as Codeine is not recommended. Naltrexone can block the effects and make the medication less effective in treating the co-existing condition.
Alcohol	Naltrexone may cause liver problems, and using it with other medications that can also affect the liver such as ethanol may increase that risk.

Treatment Protocol:
Co-Occurring Psychiatric Disorders

- Non-Pharmacological Treatment Approaches:
  - Behavioral, psychological therapy using best-practice, evidence-based approaches.
    - CBT
    - DBT
    - MET
    - Individual, group, family.

  - Self-help groups such as 12-step based programs, SMART Recovery, Rational Recovery, Women for Sobriety.

Treatment Protocol: Co-Occurring Psychiatric Disorders

- With respect to the treatment of Co-occurring D/O's:
  - Many individuals who would benefit from treatment are in the criminal justice system. It is estimated that about 45 percent of individuals in state and local prisons and jails have a mental health problem comorbid with substance use or addiction.
- What are other challenges and/or barriers with providing treatment?
- What are the challenges and/or barriers with the use of self-help groups?
- What are some barrier removers?

Treatment Protocol: Pregnancy-Related Considerations

- Methadone maintenance and Buprenorphine are the treatment of choice for pregnant opioid-addicted women however neither are FDA approved for that purpose.
- Opioid withdrawal should be avoided during pregnancy.
- Vivitrol is FDA pregnancy category C. It is not known whether Vivitrol will harm an unborn baby and is therefore not prescribed.

(Jones et al ., 2005)

Treatment Protocol: Pregnancy-Related Considerations

- A 2012 study on Fetal monitoring has suggested that buprenorphine results in less fetal cardiac and movement suppression than does methadone.

- In addition, buprenorphine results in less severe neonatal abstinence syndrome than does methadone

- Both Methadone and Buprenorphine are Category C medications.

- Studies have shown the benefits of pharmacotherapy for opioid use disorder (OUD) during pregnancy outweigh the risks of untreated OUD.
  - Treatment of OUD helps to block the cyclic withdrawal symptoms associated with misuse of opioids and provide a more stabilized intrauterine environment.
  - Untreated opioid addiction is associated with adverse obstetrical outcomes such as low birth weight, preterm birth, and fetal death; untreated opioid addiction often results in continued or relapsing illicit opioid use.

Treatment Protocol: Pregnancy-Related Considerations

- It may be difficult to identify pregnancy because the early signs (fatigue, headache, nausea, vomiting, etc.) mimic withdrawal symptoms.

- Onset of pregnancy may cause an increase in illicit use if it is thought to be withdrawal.

- Using an opioid ANTAGONIST to diagnose addiction is pregnant women is absolutely contraindicated as it can lead to premature labor or other adverse fetal effects.

Treatment Protocol: Pregnancy-Related Considerations

- Obstetrical Complications:
  - Placental abruption, intrauterine death, intrauterine growth retardation, placental insufficiency, premature delivery, septic thrombophlebitis, spontaneous abortion.

- Medical Complications:
  - Anemia, poor nutrition, increase blood pressure, hyperglycemia, STD's, Hepatitis, Preeclampsia, etc.
  - Be sure to have consent forms to speak directly with Ob-Gyn. If client refuses, document request and subsequent refusal.

Treatment Protocol: Pregnancy-Related Considerations

- Barriers to treatment:
  - Legal consequences imposed on women with OUD and their infants
  - Shame during pregnancy and the desire to hide use
  - Misinformation among healthcare professionals

Treatment Protocol: Pregnancy-Related Considerations

- Polysubstance use is common among pregnant women with a diagnosis of OUD.

- Thorough assessment should include:
  - Nature of current use
  - Underlying co-morbidity
  - Physical and psychological functioning
  - Outcomes of past treatment episodes
  - Toxicological screens

- Care Coordination among all healthcare professionals is especially important

Treatment Protocol: Pregnancy-Related Considerations

- Women who are new to MAT for OUD may struggle to adjust to the changes related to pregnancy as well as those related to taking a new medication.

- Moving from one medication to another can place the woman at risk of relapse.

Treatment Protocol: Pregnancy-Related Considerations

- Healthcare professionals should discuss:
  - the benefits of smoking cessation if relevant
  - Importance of Weight management and prenatal vitamin regimen
  - Preparation for and the risks and benefits associated with breastfeeding
    - **Pregnant mothers need to know when they should or should not breastfeed**
    - **a stable mother being treated for opioid use disorder is encouraged to breastfeed, although there are situations where breastfeeding is not recommended (e.g., the mother is HIV-positive, has tuberculosis, has cracked or bleeding nipples, is hepatitis C-positive, has returned to illicit drug use including cannabis).**
  - Enrolling in parenting classes if relevant
  - The potential need to readjust medication in response to physiological changes during pregnancy
  - The need for continued treatment postpartum.

Treatment Protocol: Pregnancy-Related Considerations

- Healthcare professionals should be sensitive to:
  - The potential for depression and other psychiatric conditions
  - Drug interactions that could impact effectiveness
  - Assessing appropriate level of care
  - The impact of some medications such as antidepressants on severity of NAS
  - Medication metabolism increases as pregnancy advances
  - The potential for needing to increase psychiatric medication dose during third trimester

Treatment Protocol: Pregnancy-Related Considerations

- Neo-natal Outcomes:
  - Infants prenatally exposed to opioids have a high incidence of neonatal abstinence syndrome (NAS) characterized by hyperactivity of the central and autonomic nervous systems that are reflected in changes in the GI tract and respiratory system.
  - NAS is influenced by type of substances used by the mother, timing and dosage of methadone before delivery, characteristics of labor, nutrition, etc. However the severity of NAS does not appear to be impacted by dose level, therefore reduction of maternal dose is unwarranted.
  - NAS may be mild and transcient, delayed in onset or incremental in severity.

Treatment Protocol: Pregnancy-Related Considerations

- NAS can be treated satisfactorily without any severe effects upon the new born.
- Two medications most commonly used to treat NAS: methadone and morphine. Phenobarbital and other sedative-type meds are often used as an adjunct.

Treatment Protocol: Pregnancy-Related Considerations

- There are no specific studies examining maternal and neonatal outcomes following buprenorphine treatment during pregnancy using women who were dependent on prescription opioids.

- Overall, findings from comparative studies of methadone and buprenorphine, including randomized clinical trials, indicate that both medications are effective in preventing relapse to illicit opioids in opioid-dependent pregnant patients.

- Although methadone maintenance is associated with better treatment retention than buprenorphine, buprenorphine maintenance during pregnancy was associated with improved maternal and fetal outcomes, compared with no medication-assisted treatment.

Source: Providers' Clinical Support System for Medication Assisted Treatment. 2014.

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- “In a recent study looking at youth with OUD, MAT use at first increased significantly, from 3.0% in 2002 to 31.8% in 2009, but then declined in subsequent years even as the prevalence of OUD among youth continued to rise.
- In adjusted analyses, being young or female or belonging to a racial or ethnic minority group were all associated with lower odds of receiving MAT.
- Most youth who received MAT were given buprenorphine (89.2%), but naltrexone was prescribed more commonly to females, younger individuals, and persons residing in more disadvantaged areas.”

What is the message?

Closing the Medication-Assisted Treatment Gap for Youth With Opioid Use Disorder

Brendan Saloner, PhD, Kenneth A. Feder, BA, and Noa Krawczyk, BA. 2017

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- The American Academy of Pediatrics (AAP) advocates for increasing resources to improve access to medication-assisted treatment of opioid-addicted adolescents and young adults. This recommendation includes both increasing resources for medication-assisted treatment within primary care and access to developmentally appropriate substance use disorder counseling in community settings.

- The AAP recommends that pediatricians consider offering medication-assisted treatment to their adolescent and young adult patients with severe opioid use disorders or discuss referrals to other providers for this service.

- The AAP supports further research focus on developmentally appropriate treatment of substance use disorders in adolescents and young adults, including primary and secondary prevention, behavioral interventions, and medication treatment.

Medication-Assisted Treatment of Adolescents With Opioid Use Disorders: Committee on Substance Use and Prevention. Pediatrics. September 2016, VOLUME 138 / ISSUE 3

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

BRAIN DEVELOPMENT IN ADOLESCENCE:

- Strengthening the Circuitry: Synaptic connections are strengthened
- Pruning Unused Connections
  - Adolescent brain is in a unique state of flux
  - Neurons are eliminated, pruned and shaped
  - This process is influenced by interactions with the outside world (Gogtay et al., 2004)
  - Pruning occurs from back to front so frontal lobes mature the last

- Other brain areas are also growing during adolescence (e.g., subcortical areas, receptors)

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- Cognitive development refers to changes in the brain that prepare people to think and learn. Just as in early childhood, brains in adolescence undergo a lot of growth and development. These changes will reinforce adolescents' abilities to make and carry out decisions that will help them thrive now and in the future. The brain grows and strengthens itself in three ways:

- **Growing new brain cells**. Adolescence is one of the few times in which the brain produces a large number of cells at a very fast rate. In fact, the brain creates many more cells than will be needed. The extra brain cells give adolescents more places to store information, which helps them learn new skills.

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- **Pruning some of the extra growth**. The disadvantage of having extra brain cells is that they also decrease the brain's efficiency. As adolescents go to school, live, and work, the brain trims down the extra growth based on the parts of the brain the adolescent actively uses. This pruning process creates a brain structure than enables adolescents to easily access the information they use most.

- **Strengthening connections**. The connections between brain cells are what enable the information stored in the brain to be used in daily life. The brain strengthens these connections by wrapping a special fatty tissue around the cells to protect and insulate them. These changes help adolescents recall information and use it efficiently.

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- The Adolescent Brain, not fully developed, is manifested by:
  - Difficulty in decision making
  - Difficulty understanding the consequences of behavior
  - Increased vulnerability to memory and attention problems

This can lead to:

  - Increased experimentation
  - Opioid (and other substance) addiction

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- Alcohol and drugs affect the brains of adolescents and young adults differently than they do adult brains
  - Adolescent rats are more sensitive to the memory and learning problems than adults.
  - Conversely, they are less susceptible to intoxication (motor impairment and sedation) from alcohol.

- These factors may lead to higher rates of dependence in these groups

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

Increased Risk for Use	Decreased Risk for Use
Has acute and chronic pain	Is doing well in school
Has physical health problems	Is concerned about the dangers of prescription drugs.
Has a history of mental or behavioral disorders	Has a strong bond with parents
Has other substance use or misuse	Has parents who express disapproval of substance use
Has family history of SUD or witnessed a family member overdose	
Has a large number of friends who misuse prescription drugs	
ACEs (Adverse Childhood Experiences), Trauma	
Impulse Control issues	
National data show that nearly half of adolescents ages 12 to 17 who reported misusing pain relievers said they were given or bought them from a friend or relative. This number is over half for young adults ages 18 to 25 who reported misusing pain relievers.	

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- **Demographic factors**
  - Early age of onset
  - Gender difference; heavier use among males

- **Social-environmental factors**
  - Family/peer approval
  - Family/peer role models for use
  - Incompatibility between parents and peers
  - Absence of closeness to parents
  - Weak parental controls
  - Accessibility to drugs
  - Cultural Aspects and Contributors

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- **Intrapersonal factors**
  - Greater value on independence
  - Lower value on achievement
  - Lower expectations for academic achievement
  - Greater tolerance for deviant behavior
  - Lower religiosity
  - Greater expectations of failure

- **Behavioral factors**
  - Various forms of delinquency
  - sexual activity at a young age
  - Political activism
  - Declining academic performance

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- Barriers to treatment:
  - Limited number are trained in addiction medicine
  - Few understand addiction/recovery dynamics
  - Misinformation and stigma regarding MAT
  - Misnomer ‘Replacement or Substitute’ Therapy
  - Adolescents are legally restricted from receiving methadone treatment unless medication-free treatment has failed a minimum of two times.
  - Other barriers?

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- 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.

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- Approved minimum ages for medications:
  - Buprenorphine is approved for use with opioid dependent persons age 16 and older.
  - Vivitrol has not been studied with children and geriatric patients.
  - Minimum age for methadone is 18 however 16-18 year olds can be prescribed via exception.

- Research supports the belief that medical treatment likely needs to be longer than current standard treatment indicates.

Treatment Protocol:
Opioid-Addicted Adolescents and Young Adults

- To enhance potential for successful and effective treatment with adolescents:
  - Clinical staff trained in adolescent development, substance use disorders, MAT and family therapy
  - Clinical program is age-specific and includes family involvement
  - Care-coordination to include all systems with which the person has involvement: school, medical, dental, social, spiritual
  - Multiple sessions per week (OP=under 6hrs, IOP=6+hrs, PHP=5 days/5=hrs.)
  - Utilization of psychoeducation, CBT, MET, Relapse Prevention, toxicological screening.
  - Coach/Mentor services

Treatment Protocol: Managing Multiple Substance Use

- Persons in MAT commonly use alcohol, amphetamines, benzodiazepines and other prescribed sedatives, cocaine, marijuana and nicotine.

- CNS depressants are especially dangerous when used with opioids.

- Whether to use MAT with a person who abuses multiple substances should be determined on an individual basis.

Treatment Protocol: Managing Multiple Substance Use

	Percentage of individuals who also have:					
Persons with:	Alcohol Use Disorder	Nicotine Dependence	Marijuana Use Disorder	Cocaine Use Disorder	**Prescription Opioid Use Disorder**	**Heroin Use Disorder**
Alcohol Use Disorder	-	23.8	9.5	3.3	3.9	0.9
Nicotine Dependence	12.9	-	4.3	1.4	2.7	1.3
Marijuana Use Disorder	38.7	32.6	-	4.8	7.9	1.8
Cocaine Use Disorder	59.8	47.7	21.3	-	16.4	13.4
Prescription Opioid Use Disorder	35.2	45.4	17.6	8.2	-	11.2
Heroin Use Disorder	24.5	66.3	12.3	20.9	34.9	-

Treatment Protocol: Managing Multiple Substance Use

- Alcohol-related factors are a major cause of death among persons on MAT.
- Alcohol can lead to overdose, liver damage, increased methadone metabolism.
- Benzo's can increase the effects of methadone ("boosting").
- Cocaine and stimulants can:
  - Have cardiovascular effects
  - Respiratory effects
  - Mood swings
  - Decrease methadone concentration in blood.

Treatment Protocol:
Managing Multiple Substance Use

- Marijuana use is prevalent among persons on MAT and is often used to self-medicate anxiety or insomnia

- Persons and many professionals will overlook marijuana use, especially as it becomes more legally acceptable.

- What are you thoughts about this?

Treatment Protocol: Managing Multiple Substance Use

- Nicotine-related illnesses are a major cause of morbidity and mortality among MAT clients.

- A 2000 study found that persons in MAT who smoked heavily were more likely to abuse cocaine and opioids.

- How does your program address nicotine use?

Treatment Protocol: Counseling Patients on MAT

- Counselor competencies:
  - Basic Information about MAT and OUT
  - Ways to create a supportive environment
  - Recovery-oriented treatment

- 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
  - Co-Counselors need to have accurate information

Treatment Protocol: Counseling Patients on MAT

- Recovery and Pharmacotherapy:
  - Focus on “getting off” medication 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”

Treatment Protocol: Counseling Patients on MAT

- Dealing with Ambivalence:
  - Impatience, confrontation, “you’re not ready for treatment”

    or,
  - Deal with patients at their stage of acceptance and readiness

Treatment Protocol: Counseling Patients on MAT

- Counselor Responses:
  - Be flexible
  - Don’t impose high expectations
  - Don’t argue with the patient
  - Be corrective, not punitive
  - Be non-judgmental
  - Use a motivational interviewing approach
  - Provide reinforcement

Treatment Protocol: Counseling Patients on MAT

- Encouraging Participation in 12-Step Meetings:
  - What is the 12-Step Program?
  - Meetings: speaker, discussion, Step study, Big Book readings
  - How does Self-help differ from treatment?
  - How to deal with the stigma often surfacing at meetings
  - The POWER of self-help (Participating, Observing, Wakening, Evaluating, Recovering)

Treatment Protocol: Counseling Patients on MAT

- 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 (MAT friendly vs. unfriendly)

Treatment Protocol: Counseling Patients on MAT

- Early Recovery Skills:
  - Getting Rid of Paraphernalia
  - Scheduling
  - Triggers and Cravings Charts

- 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.

SAMHSA’s Guiding Principles of Recovery

- Recovery….
  - Emerges from hope
  - Is person driven
  - Occurs via many pathways
  - Is holistic
  - Is supported by peers and allies
  - Is supported through relationships and social networks
  - Is culturally based and influenced
  - Is supported by addressing trauma
  - Involves individual, family and community strengths and responsibilities
  - Is based on respect

Family Therapy/Treatment

- Enhances the recovery efforts of the person with SUD
- Address shaming, blaming dynamics
- Identify dysfunctional interaction patterns
- Provide education regarding the role of medication in recovery
- Discuss the ‘what to do ifs….’

Guidelines for Facilitating Groups

- Foster Acceptance of choice including MAT
  - Establish ground rules of respect
  - Be proactive in support of the ground rules
  - Solicit suggestions on how to deal with negativity
  - Reframe negative comments to express underlying motivations based on fear or misunderstanding
  - Treat all clients equally whether on MAT or not
  - Maintain group focus on recovery
  - Reinforce messages of acceptance
  - Honor confidentiality and reinforce those rules

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 vs. naltrexone), 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	Nurse	Pharmacist	Addiction Counselor	12 Step Program	Community Support Provider
Screening and Assessment	X	X		X		X
Diagnosing Opioid Addiction	X	X		X		
Patient Education	X	X	X	X	X	
Referral for Treatment	X	X		X		X
Prescribing or Dispensing Buprenorphine	X		X			
Urinalysis Testing	X					
Psychosocial Treatment				X		
Recovery Support	X	X	X	X	X	X
Case Management & Coordination		X		X		X
Family Services & Treatment				X		X
Meeting Ancillary Needs of the Patient						X

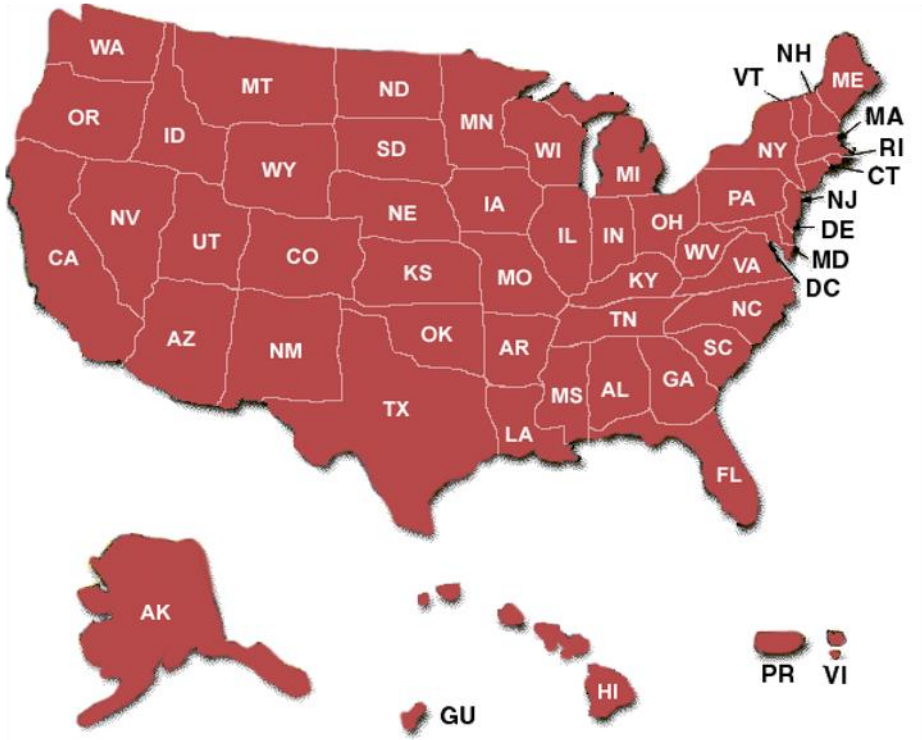
SAMHSA
Substance Abuse & Mental Health Services Administration
U.S. Department of Health and Human Services

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 physicians) authorized to prescribe Buprenorphine nearest you, find your State on the map below and click on it.

- home
- about the physician locator
- physician list search
- state substance abuse agencies
- frequently asked questions
- additional resources
- comments or questions
- treatment facility locator



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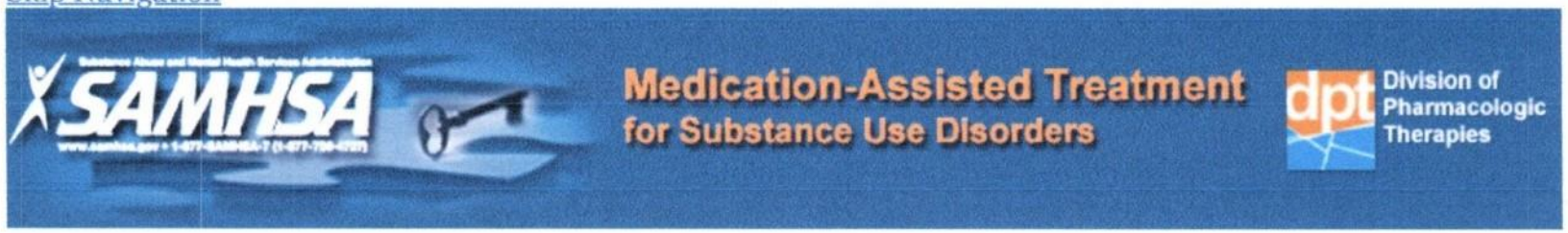

Opioid Treatment Program Directory

Select to view the opioid treatment programs in a State

- Select - ▼

Note to users of screen readers and other assistive technologies: Please report your problems to us at OTP-Help@jbsinternational.com.

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment
Division of Pharmacologic Therapies
5600 Fishers Lane • Rockville, MD 20857 • 240-276-2700 • OTP-Help@jbsinternational.com

For Opioid Dependence

FIND A TREATMENT PROVIDER

Find A Treatment Provider

Use the Provider Locator tool below to locate a healthcare professional in your area who can discuss VIVITROL. If you are a healthcare professional and would like to be listed as a provider, please download the form. (https://www.vivitrol.com/content/pdfs/provider-locator-agreement.pdf)

IMPORTANT SAFETY INFORMATION

Challenges for Addiction Treatment Professionals

- Not all physicians who are trained have consented to be listed on Physician locator.
  Community outreach is still critical.
- Linking patients to primary care who have not been within the medical mainstream
- Coordination with other professionals not accustomed to working with non-medical partners
- Covering the cost of medication

Barriers to Effective Care Coordination

- Misunderstanding respective roles
- Conflicting goals for treatment
- Confidentiality restrictions
- Control issues
- Misconception of other professional perspectives

Barriers to Effective Care Coordination

- What are some of the barriers that you have encountered with respect to care coordination?

- What are some potential barrier-removers?

Attributes of Successful Care Coordination

- Understanding roles for each participant in the treatment team
- Ongoing communication across professions
- Personal contact between partners in the system

Generic Treatment Protocols: Phase 1

Withdraw from the illicit Opioid: Contemplation to Preparation Stage of Change.

- ❑ Begin the process of recovery by deciding to stop use of the opioid drug.
- ❑ Identify potential support systems
- ❑ Complete an assessment with counselor to determine treatment needs.
- ❑ Complete medical/psychiatric assessment to determine treatment needs.
- ❑ Discuss options of MAT vs. non-MAT and identify preference.
- ❑ Identify any special needs/considerations such as co-occurring medical or psychiatric conditions, co-occurring substance use disorders, pregnancy, age-specific issues, etc.
- ❑ Discuss options with prescriber and identify preference based on eligibility.
- ❑ Reflect on current use of alcohol or other drugs and determine if use is interfering or will interfere with recovery efforts.
- ❑ Begin counseling to address biopsychosociofamilioeconospiritual needs.
- ❑ Begin process of learning about addiction and recovery dynamics in counseling.
- ❑ Create initial Relapse Prevention Plan as part of Treatment Planning Process.
- ❑ Receive initial dose of medication and participate in induction process.

Generic Treatment Protocols: Phase 2

Achieve Stabilization: Preparation Stage to Action Stage of Change.

- ❑Cooperate with the prescriber to adjust the medication and dose as needed.
- ❑Identify Care-coordination and case-management needs
- ❑Address any lapses or relapses in order to strengthen recovery efforts
- ❑Create a list of healthy behavioral alternatives such as attending self-help, joining a gym, etc.
- ❑Identify and avoid triggers (places or activities that cause drug cravings to come back).
- ❑Tweak Relapse Prevention Plan as needed.
- ❑Provide toxicological screen samples as requested and negotiated on Treatment Plan.
- ❑Meet with counselor and prescriber as negotiated on Treatment Plan based on individual needs.
- ❑Begin connection with Recovery Coach/Mentor

Generic Treatment Protocols: Phase 3

Continue in Recovery: Action Stage of Change.

- ❑ Establish a routine. For example, work or go to school, go to support groups and/or counseling, go to the gym, enjoy healthy activities, etc.
- ❑ Schedule regular visits with the Prescriber to check dose levels and to get refills.
- ❑ Continue to meet with counselor and Recovery Coach/Mentor.
- ❑ Continue to identify and avoid triggers and relapse.
- ❑ Identify steps to improve or repair relationships
- ❑ Continue to provide toxicological screens as requested based on individual need.

Generic Treatment Protocols: Phase 4

Reparation Process: Maintenance Stage of Change

- ❑Identify and maintain healthy behaviors and activities.
- ❑Meet with the Prescriber at a frequency that will enhance recovery efforts (Typically once every 1 – 3 months).
- ❑Continue counseling to address recovery issues and fine-tune recovery plan.
- ❑Continue to strengthen relationships with family, sober friends and sober support systems.

Multi-phase Generic Treatment Protocols based on: Closing the Medication-Assisted Treatment Gap for Youth With Opioid Use Disorder. Brendan Saloner, PhD, Kenneth A. Feder, BA, and Noa Krawczyk, BA

Treatment Protocols: Sample

- Review Sample Protocol provided in your handouts and discuss in small groups:
  - How does it reflect stages of change
  - What are the strengths
  - What are the challenges
  - What’s missing

Determining Individualized Treatment

Case Study #1:

Lena is a 30-yeal old mother of twin 7-year old boys. She uses prescription opioids and heroin (snorts, no IV use). She is facing 3 counts of forgery and 1 count of prescription fraud. Her sons are in kinship placement with her sister. Lena formerly worked as an LPN but her license was revoked due to diversion. She has had multiple treatments but relapsed within 2 months of treatment. Lena has a significant history of sexual abuse and trauma.

"*I just want my boys back. I'll do whatever I have to do."*

What would the challenges be if Lena decides she wants Non-MAT recovery treatment?

Based on your understanding of the 3 medications should Lena decide to go the route of MAT, which medication would make most sense for her?

- ☐ Methadone
- ☐ Buprenorphine with naloxone
- ☐ Buprenorphine mono formulation
- ☐ Naltrexone pills
- ☐ Naltrexone long acting injection

Determining Individualized Treatment

Case Study #2:

Nick is a 26-year old long time heroin users. He is affiliated with a gang and has had numerous arrests for violent crimes. He is awaiting trial for aggravated felonious assault. He was on parole after serving 4 years for a home invasion. He has scars on his neck from IV use. He has been on and off methadone several times.

“I can do good if I can get back on the clinic”

What would the challenges be if Nick decides he wants Non-MAT recovery treatment?

Based on your understanding of the 3 medications should Nick decide to go the route of MAT, which medication would make most sense for him?

- ☐ Methadone
- ☐ Buprenorphine with naloxone
- ☐ Naltrexone pills
- ☐ Buprenorphine mono formulation
- ☐ Naltrexone long acting injection

Determining Individualized Treatment

Case Study #3:

Stan is a 42-year old man who has been using heroin for at least 2 decades. When possible he likes to inject speedball (heroin/cocaine mix). Stan has early criminal justice involvement. He began using tobacco, alcohol and drugs in his early teens. He's had repeated arrests and multiple treatment episodes. When he has stopped heroin in the past, he drinks heavily. He engages in daily criminal activities to support his addiction. Stan has a family history of alcoholism and mental illness.

"*I am getting too old for this crap"*

What would the challenges be if Stan decides he wants Non-MAT recovery treatment?

Based on your understanding of the 3 medications should Stan decide to go the route of MAT, which medication would make most sense for him?

- ☐ Methadone
- ☐ Buprenorphine with naloxone
- ☐ Naltrexone pills
- ☐ Buprenorphine mono formulation
- ☐ Naltrexone long acting injection

Determining Individualized Treatment

Case Study #4:

Renee is a 36-year old pregnant woman who prefers using oxycodone, but has used heroin and other opioids. She has a long history of arrests for prostitution and shoplifting. She experienced juvenile detention, foster homes and multiple traumas. She has a daughter placed in foster care by DCF. She wants to get in a pre-release program for mothers and babies.

“I can’t lose this baby. This is my time to step up and be a mom.”

What would the challenges be if Renee decides she wants Non-MAT recovery treatment?

Based on your understanding of the 3 medications should Renee decide to go the route of MAT, which medication would make most sense for her?

- ☐ Methadone
- ☐ Buprenorphine with naloxone
- ☐ Naltrexone pills
- ☐ Buprenorphine mono formulation
- ☐ Naltrexone long acting injection

OUD 201 – Summary

- Not all opioid-addicted patients are good candidates for all of the medications used to assist recovery.
- Ten simple criteria can help to guide assessment of appropriateness for buprenorphine treatment.
- Patients who have certain medical conditions such as HIV, STDs, hepatitis, etc., should be carefully screened by a physician prior to being started on medication assistance.

OUD 201 - Summary

- Patients on medication assistance 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 patients.

OUD 201 - 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.

OUD 201 - Summary

- Not all opioid-addicted patients are good candidates for medication assisted treatment.
- Selection of treatment type and setting should be done to maximize fit with patient needs
- Treatment success is enhanced by good patient assessment and selection.
- Open communication amongst the various care providers helps to ensure successful coordination of care.