National American Indian & Alaska Native
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Essential Substance Skills Training:

Treatment Knowledge

Avis Garcia, PhD, LAT, LPC, NCC, Northern Arapaho

March 1, 2023

IOWA

SAMHSA
Substance Abuse and Mental Health Services Administration

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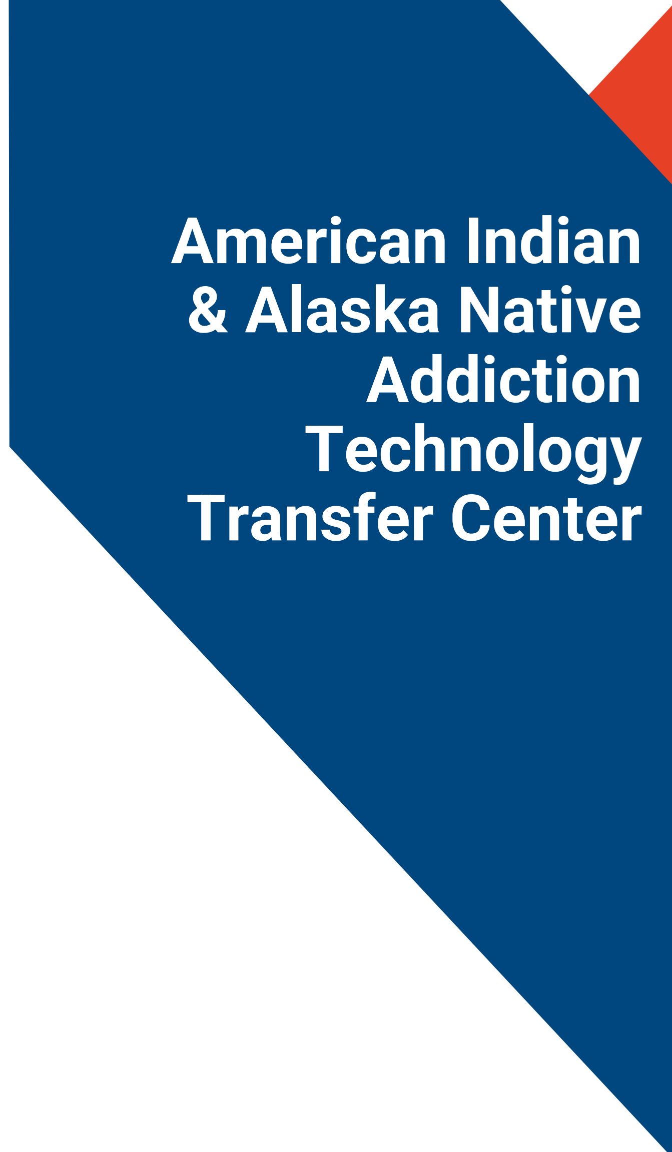

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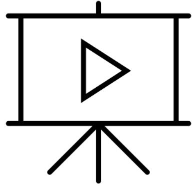
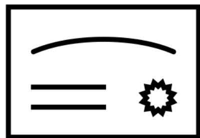


Links to the presentation slides and recording, if applicable



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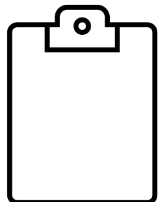

Link to our evaluation survey (GPRA)

Land Acknowledgement

We would like to take this time to acknowledge the land and pay respect to the Indigenous Nations whose homelands were forcibly taken over and inhabited.
Past and present, we want to honor the land itself and the people who have stewarded it throughout the generations.

This calls us to commit to forever learn how to be better stewards of these lands through action, advocacy, support, and education.
We acknowledge the painful history of genocide and forced occupation of Native American territories, and we respect the many diverse indigenous people connected to this land on which we gather from time immemorial.

While injustices are still being committed against Indigenous people on Turtle Island, today we say thank you to those that stand with Indigenous peoples and acknowledge that land reparations must be made to allow healing for our Indigenous peoples and to mother earth, herself.

Today's Speaker

Avis Garcia, PhD, NCC, LPC, LAT
Avis Garcia is an enrolled member of the Northern Arapaho Tribe and is affiliated with the Eastern Shoshone Tribes of the Wind River Reservation in Wyoming. Avis is a Licensed Professional Counselor and Addictions Therapist. Avis holds a doctorate in Counselor Education and Supervision who specializes in SUD treatment and work with Native Americans. Avis works with individuals of all ages and does, individual, group, couples, and family therapy. She specializes in the treatment of substance use disorders and trauma. Her therapeutic approach is to privilege Indigenous knowledge and draw on the strengths of individuals and families to promoting intergenerational healing, through research and clinical work.

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Treatment Knowledge

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IOWA

SAMHSA
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Training Objectives

1. Gain a better understanding of Evidence-Based practices, best practices and promising practices
2. Gain a better understanding of the importance of the treatment alliance
3. Become familiar with commonly used evidence-based and best practice approaches
4. Better understand Co-occurring Disorders and integrated care
5. Explore medication-assisted treatment (Buprenorphine)

Evidence-Based & Best Practices

Evidence-Based, Best & Promising Practices

- **Evidence-based practices** are methods or techniques that have documented outcomes, have an ability to replicate key factors, and have been recognized in scientific journals by one or more published articles. Evidence-based practices are often manualized, for instance in SAMHSA's Technical Assistance Publication Series (TAPs).

- A **best practice** is a method or technique that has consistently shown results superior to those achieved by other means. In addition, a "best" practice will evolve as empirical research advances.

- A **promising practice** is generally described as having a body of evidence (either evaluation studies or expert consensus) to support efficacy, is likely to raise to the next level when scientific studies can be conducted, and/or has been endorsed by one or more groups whose opinions matter producing specific desired outcomes.

Characteristics of Substance Use Disorders

- The American Society of Addiction Medicine (ASAM), 3rd Edition, describes the characteristics of addiction as:

- "An inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response."

Our Goals for Treating Substance Use and Co-Occurring Disorders

- To properly assess the patient using multi-dimensional tools
- To provide Integrated, coordinated longitudinal care using evidence-based approaches
- To provide an optimum opportunity for healthy behavior change through the therapeutic alliance
- To improve the patient s overall health and wellness
- To measure outcomes
- To provide informed consent

- Individual, family, and community ***Recovery-Oriented Systems of Care***

What Does All This Mean?

- We have a responsibility to improve service delivery and monitor patient outcomes
- The field of SUD treatment is evolving and will require a broader understanding of the term “treatment”
- We have a responsibility to stay informed about evidence-based practices, best practices and promising practices
- Those in leadership positions have a responsibility to prepare and mentor the next generation of addiction professionals

Therapeutic Relationship

“The more we involve our patient in the decisions about their treatment process, the more meaning and purpose they will likely associate with their treatment experience…”

S. Steine

Therapeutic Relationship

- The Therapeutic Alliance
  - Develop:
    - Rapport
    - Common or shared goals
    - Safety & Trust
  - Ethical Responsibilities
  - Power distribution

Therapeutic Relationship: Function

- Positive reinforcement, encouragement, instill hope, build self-efficacy
- Provide the patient with support and accurate, genuine empathy
- In partnership with the patient , develop goals that are realistic, attainable and adaptable
- Model adaptive interpersonal functioning

Therapeutic Relationship: Patient Development

- Patient feels heard, understood, accepted, respected, and empowered
- Feels the therapist is concerned
- Feels the therapist is working with them
- Feels the therapist is realistically optimistic
- Feels (and recognizes) that positive change is possible and/or occurring

THE ASAM CRITERIA

Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions

American Society of Addiction Medicine
Third Edition, 2013

Assessment: ASAM, 3rd Edition

- American Society of Addiction Medicine (ASAM) Criteria:
  - Clinically driven, not program driven
  - Criteria do not involve a prescribed length of stay, but promote a flexible continuum of care
  - Involve an interdisciplinary approach to care
  - Include informed consent
  - Are outcomes driven
  - Clarify medical necessity

Continuum of Treatment Care

- ASAM (1996,2003) created criteria to allow for a broader continuum of care
- Differentiates between adult & adolescent care
- Common set of criteria helps determine client's severity and place the client in appropriate level of care (LOC).

ASAM Levels of Care

- Level 1: Outpatient treatment
- Level 2: Intensive outpatient (IOP) and partial hospitalization program (PHP)
- Level 3: Medically monitored inpatient (residential treatment)
- Level 4: Medically managed inpatient treatment

Dimensions of ASAM

1. Acute intoxication and withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery/Living environment
   - *Severity in each dimension can be rated as mild, moderate or severe

Adult ASAM Placement Criteria Crosswalk

Adult ASAM Worksheet	Level 0.5: Early Intervention	OTP Level 1: Opioid Treatment Program	Level 1: Outpatient Services	Level 2.1: Intensive Outpatient Treatment	Level 2.5: Partial Hospitalization	Level 3.1: Clinically – Managed Low-intensity Residential Services	Level 3.3: Clinically-Managed Population Specific High-intensity Residential Services	Level 3.5:Clinically Managed High Intensity Residential Services	Level 3.7: Medically Monitored Intensive Inpatient Services	Level 4: Medically Managed Intensive Inpatient Services
Dimension 1: Acute Intoxication and/or Withdrawal Potential	No withdrawal risk	Physiologically dependent on opioids and requires OTP to prevent withdrawal	Manageable at Level 1-WM	Manageable at Level 2–WM	Manageable at Level 2-WM	Concurrently receiving Level 1–WM or Level 2-WM services	If withdrawal is present, manageable at Level 3.2-WM	If withdrawal is present, manageable at Level 3.2-WM.	At high risk of withdrawal, but manageable at Level 3.7-WM and does not require the full resources of a licensed hospital	At high risk of withdrawal and requires Level 4-WM and the full resources of a licensed hospital
Dimension 2: Biomedical Conditions and Complications	None or very stable	None or manageable with outpatient medical monitoring	None or very stable, or is receiving concurrent medical monitoring	None or not a distraction from treatment	None or not sufficient to distract from treatment	None or stable, or receiving concurrent medical monitoring	None or stable, or receiving concurrent medical monitoring	None or stable, or receiving concurrent medical monitoring	Requires 24 hours medical monitoring but not intensive treatment	Requires 24 hour medical and nursing care and the full resources of a licensed hospital
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications	None or very stable	None or manageable in an outpatient structured environment	None or very stable, or is receiving concurrent medical monitoring	Mild severity with the potential to distract from recovery; needs monitoring	Mild to Moderate severity with the potential to distract from recovery; needs stabilization	None or minimal; not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. Tx should be designed to address significant cognitive deficits. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required	Demonstrates repeated inability to control impulses, or unstable and dangerous signs/sx require stabilization. Other functional deficits need stabilization and 24-hour setting to prepare for community integration and continuing care. A co-occurring enhanced setting required for those with severe and chronic MI	Moderate severity; needs a 24-hour structured setting, If the consumer has a co-occurring mental disorder, requires concurrent MH services in a medically monitored setting	Because of severe and unstable problems, requires 24 hour psychiatric care with concomitant addiction tx (co-occurring enhanced)
Dimension 4: Readiness to Change	Consumer is willing to explore how current alcohol, tobacco, other drug or medication use and/or high risk behaviors may affect personal goals	Ready to change the negative effects of opioid use, but is not ready for total abstinence from illicit prescription or non-prescription drug use	Ready for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management . Or high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies.	Has variable engagement in treatment, ambivalence, or a lack of awareness of the substance use or MH problem, and requires a structured program several times a week to promote progress through the stages of change	Has poor engagement in tx, significant ambivalence or a lack of awareness of the substance use or MH problem, requiring a near-daily structured program or intensive engagement service to promote progress through the stages of change	Open to recovery, but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level 3.3 to engage and stay in tx. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	Has marked difficulty with, or oppositional to, tx, with dangerous consequences. If there is high severity in Dimension 4 but not in any other dimension, motivation enhancement strategies should be provided in Level 1	Low interest in tx and impulse control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is high severity in Dimension 4 but not in any other dimension, motivational enhancement strategies should be provided in Level 1	Problems in this dimension do not qualify the consumer for Level 4 services. If the consumer's only severity is in Dimension 4,5 and/or 6 without high severity in Dimensions 1,2,and /or 3, then the consumer does not qualify for Level 4

Dimensions 5 and 6 on next page

Adult ASAM Placement Criteria Crosswalk

Dimension 5: Relapse, Continued Use or Continued Problem Potential	Needs an understanding of, or skills to change, current alcohol, tobacco, other drug, or medication use patterns and/or high risk behavior	At high risk of relapse or continued use without OTP and structured therapy to promote tx progress	Able to maintain abstinence or control use and/or addictive behaviors and pursue recovery or motivational goals with minimal support	Intensification of addition or MH sx indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week	Intensification of addiction or MH sx, despite active participation in a Level 1 or 2.1 program; indicates a high likelihood of relapse or continued use or continued problems without near daily monitoring and support	Understands relapse, but needs structure to maintain therapeutic gains	Has little awareness and needs interventions available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction	Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences	Unable to control use, with imminently dangerous consequences despite active participation at less intensive levels of care	Problems in this dimension do not qualify the consumer for Level 4 services. See further explanation in Dimension 4
Dimension 6: Recovery Environment	Social support system or significant others increase the risk of personal conflict about alcohol, tobacco, and/or other drug use	Recovery environment is supportive and/or consumer has the skills to cope	Recovery environment is supportive and/or the consumer has skills to cope	Recovery environment is not supportive, but with structure and support the consumer can cope	Recovery environment is not supportive, but with structure and support and relief form the home environment, the consumer can cope	Environment is dangerous, but recovery is achievable if Level 3.1, 24-hour structure is available	Environment is dangerous and consumer needs 24-hour structure to learn to cope	Environment is dangerous and the consumer lacks skills to cope outside of a highly structured 24- hour setting	Environment is dangerous and the consumer lacks skills to cope outside of a highly structured 24- hour setting	Problems in this dimension do not qualify the consumer for Level 4 services. See further explanation in Dimension 4

To select the correct level of care, choose the highest level of care that has two or more criteria met. Review admission criteria for chosen level of care to ensure proper clinical fit.

NAME or SM ID#: ______________________________

CURRENT ASAM LEVEL: ______________________________

RECOMMENDED LEVEL OF CARE AND SUBSTANCE ABUSE SERVICES: ______________________________

CLINICIAN SIGNATURE: ______________________________ DATE: ______________

Whole-Person / Patient-Centered Care

- Establishing the therapeutic alliance begins with the patient's initial contact with the helping professional/organization

- Proper treatment requires proper assessment: The American Society of Addiction Medicine (ASAM, 3rd Edition) is a commonly used multi-dimensional assessment tool

Whole-Person / Patient-Centered Care

- Multi-disciplinary team approach, using community support systems (ROSC)
- Selecting a particular theoretical approach that is most likely to result in the patient ’s improved health

Person-centered Therapy

- Carl Rogers in the mid-1940's
- Therapy does not have to revolve around therapist's advice, direction & interpretation
- Clients own personal understanding self-realization ad problem-solving techniques.
- Counselor or helping professional comprehend how client sees themselves in the world.

Main Principles

- **Humanism**: Innate nature within all humans to achieve our potential and find meaning in life.
- **Congruence:** Counselor is genuine or real.
- **Unconditional Positive Regard:** Counselor shows client constant acceptance and caring.
- **Accurate Empathic Understanding:** Identify with and understand client subjective world.

Counseling Theories and
Practice

Theoretical-Based Approaches

- Concrete methods for assessing and conceptualizing individual conditions.
- Assist in increasing motivation to effectively follow a path to successful recovery.
- No one approach appropriate for for all.
- “Theoretical tool bag” select best “tools” for the job at hand.

Evidence-Based Practices

- Behavioral Theory (Skinner)
- Cognitive/Behavioral Therapy (CBT) (Beck)
- Contingency Management/Incentivizing
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Rational Emotive Behavior Theory (Ellis)
- Motivational Interviewing (Miller)
- Stages of Change/Transtheoretical Model (DiClemente)
- Medication-Assisted Therapy (MAT)

Behavioral Theory

- Some constructs to consider:
  - **Behavior is learned**, therefore it can be unlearned
  - New behaviors can replace old ones
  - **Focus on the observable**: How people act, react, and behave
  - Less interested in cognitive/emotional states, believe that behavior represents learned habits

Behavioral Theory: Conditioning

- **Classical Conditioning** refers to the association between a stimulus and an involuntary or automatic behavior (response)
  - Craving can be a conditioned response triggered by stimuli that the patient may or may not be conscious of (Pavlov)

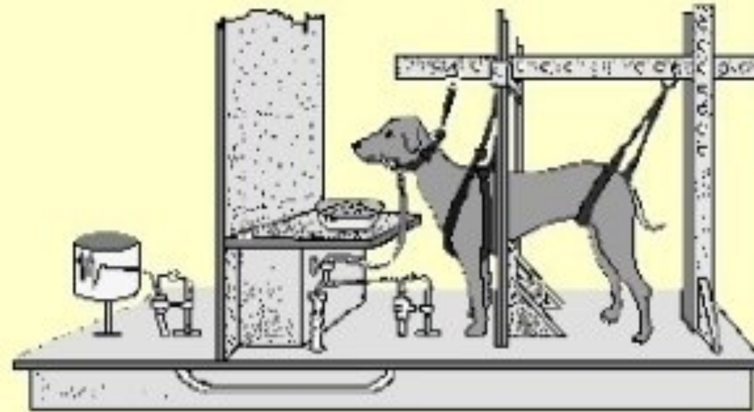
- **Operant Conditioning** refers to an association between a voluntary behavior and a consequence (Skinner)
  - The nature of the consequence will impact whether the behavior occurs again (legal, health-related consequences, etc.)

Behavior Therapy Key Concepts

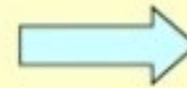
- Ivan Pavlov, B.F. Skinner, Albert Bandura
- Classical conditioning
- Operant conditioning
- Social learning theory

Classical Conditioning: The Elements of Associative Learning

Ivan Pavlov

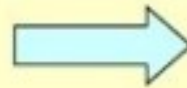


Conditioning Trial:



Salivation

Test Trial:



Salivation

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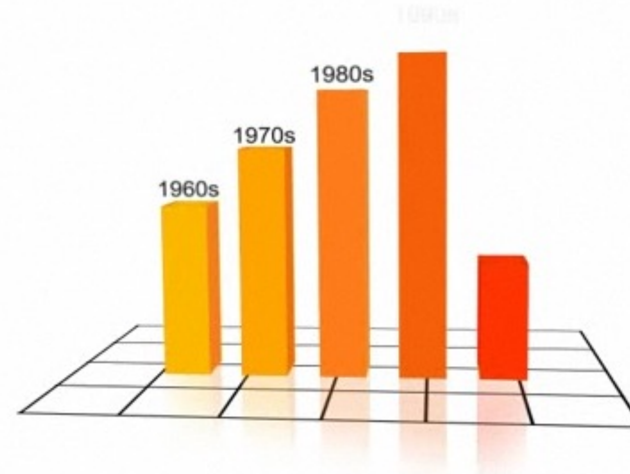
MOTIVATIONAL INCENTIVES SUITE

A Proven Approach to Treatment

Welcome to **Motivational Incentives-A Proven Approach to Treatment**, a collection of products which offer tools needed to learn about and use Motivational Incentives. Also, referred to as Contingency Management, Motivational Incentives has been subject to decades of research in the addiction treatment field; beginning in the 1960s. This collection of products assists organizations along a continuum from raising awareness about Motivational Incentives through dissemination and implementation activities.

Promoting Awareness of Motivational Incentives (PAMI) is an introductory training that exposes organizations to the principles of Motivational Incentives and demonstrates evidence of clinical effectiveness. Behavioral healthcare practitioners can then deepen their knowledge about Motivational Incentives through participating in the ***free***, self-guided, interactive on-line course, Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes (MI:PRESTO). Treatment organizations can also access additional implementation support through the Motivational Incentives Implementation Software (MIIS), developed by the National Institute on Drug Abuse and available at no cost. This desktop software provides mechanisms for maintaining patient information and Motivational Incentive activities.



PAMI - Promoting Awareness of Motivational Incentives

MI:PRESTO - Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes

MIIS - Motivational Incentives Implementation Software

Motivational Incentives = Contingency Management

Motivational Incentives = Contingency Management

- Providing reinforcement for healthy behavior

- Promoting Awareness of Motivational Incentives (PAMI) is based on the positive research outcomes and lessons learned from the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) study, titled Motivational Incentives for Enhanced Drug Abuse Recovery (MIEDAR).

- For more information: http://www.bettertxoutcomes.org/bettertxoutcomes/

Why Use Motivational Incentives?

- Help patients stay in treatment and abstain from drug use.
- Using low-cost reinforcements (e.g., prizes, vouchers, leave group early, etc.)
- Praise and not as bribery but for recognition.
- Fishbowls and Candy Bars: tickets for a prize, notebook, pens, small book, small planner.

Cognitive Behavioral Theory

- Cognitive behavior therapy (CBT) combines
  - **Behavior therapy** helps to weaken the connections between troublesome situations and your reactions to them
  - **Cognitive therapy** teaches you how certain thinking patterns/feelings impact behavior
- Very simply put, CBT attempts to help patients recognize, avoid, and cope

Relapse Prevention (CBT)

- ✓ Identify High Risk Situations
- ✓ Coping Skills Training
- ✓ Enhance Self-Efficacy
- ✓ Relapse Reframed as "teachable moment"
- ✓ Challenge Positive Alcohol Expectancies
- ✓ Lifestyle Balance

Key CBT concepts

- Founder – Aaron Beck
- Focus is on the here-and-now.
- Client takes on active role.
- ABC model

Therapeutic Techniques

- Behavioral rehearsal
- Homework
- Motivational interviewing
- Relaxation training
- Systematic desensitization
- Social skills training
- Assertion training

Definition: REBT

- Is a cognitive-oriented counseling approach that focuses on changing the attitudes, beliefs and negative self-statements that drive and maintain problematic behavior.
- Created by Albert Ellis, in 1955

Rational Emotive Behavioral Theory (REBT)

- In a nutshell…

- Something happens (to the patient)
- patient has an irrational belief about the situation
- patient has an emotional reaction to the belief
- Therapist helps the patient recognize errors in thinking that led to the irrational belief and find alternative ways of thinking about the event

- Example: “I was only arrested for drunk driving because that cop has it out for me”

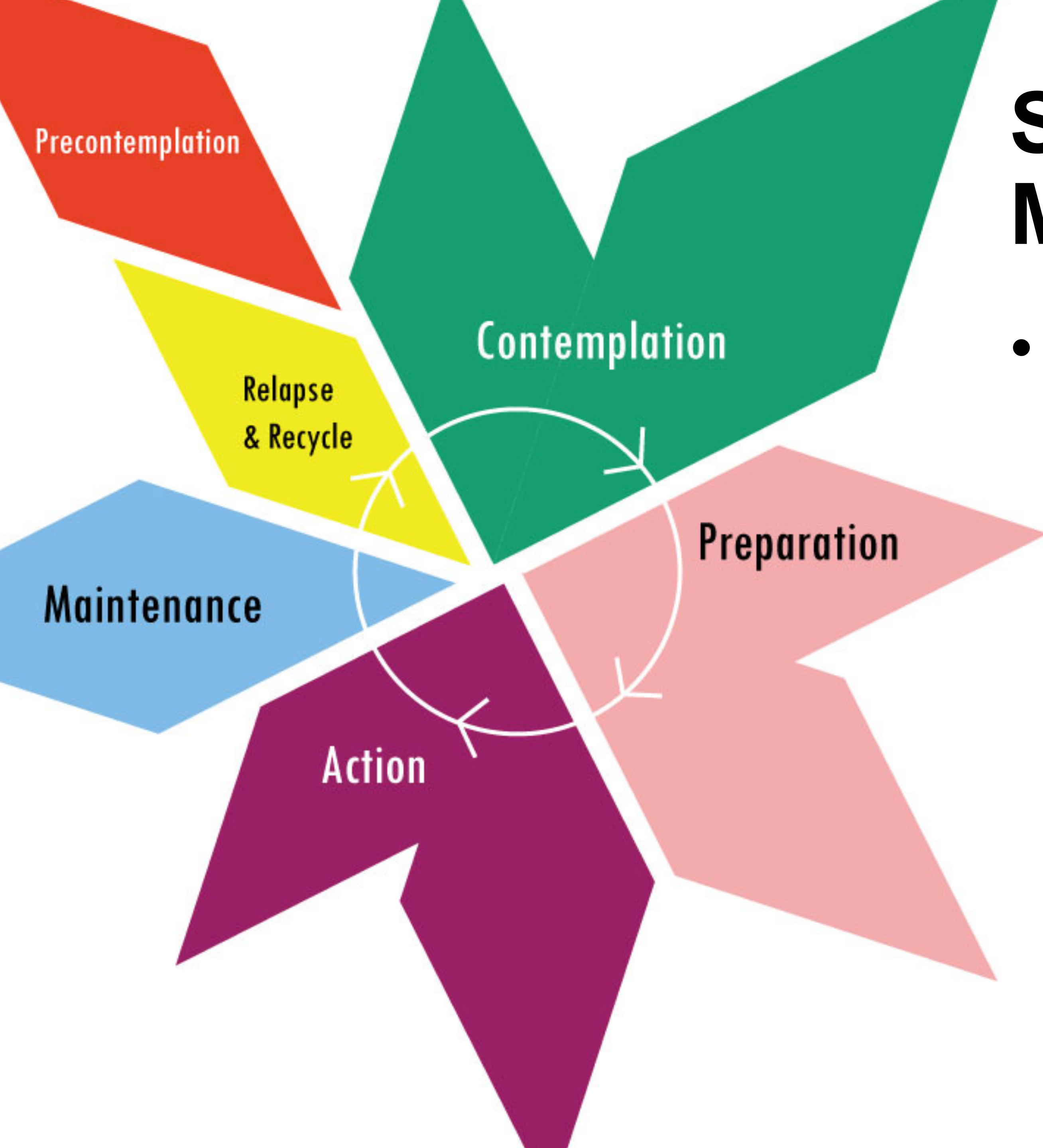
ABC Model of REBT

- **A = activating event**

  Events that occur in life that lead to reaction
- **B = beliefs**

  How person feels or thinks about activating event.
- **C** = emotional and behavioral **consequences**

  How individual behaves based on beliefs concerning an activating event.



Stages of Change Model

- Prochaska & DiClemente
  - Pre-Contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Relapse & Recycle

MOTIVATIONAL INTERVIEWING

PREPARING PEOPLE FOR CHANGE

WILLIAM R. MILLER
STEPHEN ROLLNICK

second edition

Motivational Interviewing (MI)

- "If motivational interviewing is a way of being with people, then its underlying spirit lies in understanding and experiencing the human nature that gives rise to that way of being. How one thinks about and understands the interview process is vitally important in shaping the interview".
  - *Miller and Rollnick, Motivational Interviewing, pg. 34*
- Motivational Interviewing was originally developed in an effort to increase the motivation of patients with alcohol problems to change behavior
- As part of that process, Miller found that approaching patients with a modified patient -Centered approach increased the impact of the interview
- What has evolved is a communication style and focus that increases patients' motivation to work on their problems

Motivational Interviewing

- Fundamental Approach
  - Collaboration
  - Evocation/suggestion
  - Autonomy/self rule

- Four Principles
  - Express empathy (not sympathy)
  - Develop discrepancy
  - Roll with resistanc
  - Support self-efficacy

MI Continued

- Clinicians commonly think they already practice Motivational Interviewing…though that's often not the case

- What makes Motivational Interviewing a unique communication approach is how its constructs are employed by the clinician

- Motivational Interviewing requires attention to timing issues, specific strategies, application methods, and maximizing the effectiveness of these skills

SBIRT

- S- Screening tool is used to assess patient 's risk of having an SUD.
- B,I- Brief intervention consists of a 3-5 minute, motivational discussion with patient concerning the screening results
- R- Referral to a specific resource for additional assessment and/or treatment service
- T-Treatment provider: process should allow for a “warm hand-off” from referral source to treatment provider.

Other theories worth mentioning…

- **Social Cognitive Theory:** Personal factors, environmental influences and behavior continually interact. People learn from their own experiences and from observing the actions of others

- **Health Belief Model:** Helps to explain why people do or do not use preventive services. Has to do with perception of reward/risk

- **Social Ecological Model:** Considers multiple influences on behavior and states that behaviors both shape and are shaped by the social environment

Behavioral Health Care
Substance Use
and Mental Health

Behavioral Health Integrated Care

- A patient's substance use is <u>not</u> the problem, but rather a sign or symptom of other underlying issues driving the substance use.

Co-Occurring Disorder: What does this mean?

- In medicine, **comorbidity** is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.
- The term **dual diagnosis** is used to describe the co-morbid condition of a person considered to be experiencing difficulties related to a mental illness **and** a substance abuse problem.
- Other ideas?

What are “Co-occurring Disorders”?

- The presence of at least two disorders:
- One being substance use disorders
- The other being a DSM-5 mental health disorder, such as:
  - Major Depression
  - Bipolar Disorder
  - Schizophrenia
  - PTSD/Anxiety

Characteristics of Co-occurring Disorders (General)

- Repeatedly cycle through treatment, emergency departments, detox and jail.
  - More likely to re-offend or to receive sanctions when: Not taking medication, not in treatment, experiencing mental health symptoms, using substances
  - Use of even small amounts of substances may trigger recurrence of mental health symptoms

General Assessment Approach for Co-occurring Disorders

1. ASAM dimensions can also be used as a multi-dimensional assessment tool for co-occurring disorders

2. Assess the significance of the substance use disorder
   - Obtain longitudinal history of Mental Health and substance use symptom onset
   - Analyze whether Mental Health symptoms occur only in the context of Substance use (substance-induced)
   - Determine whether sustained abstinence leads to rapid and full remission of Mental Health symptoms

Characteristics of Co-occurring Disorders

- More rapid progression from initial substance use to higher levels of severity
- Poor adherence to medication
- Decreased likelihood of treatment retention/completion
- Greater rates of hospitalization
- More frequent suicidal behavior
- Difficulties in social functioning
- Shorter time in remission of symptoms

Characteristics of Co-occurring Disorders (cont.)

- Difficulty comprehending or remembering important information (e.g., verbal memory)
- Does not recognize consequences of behavior
- Exhibits Poor judgment
- Disorganization
- Limited attention span
- Respond better to patient -centered approaches

Co-Occurring Conditions in Adolescence

- Ninety percent with lifetime co-occurring disorder had one MH disorder prior to onset of substance use
- Median onset MH disorder at age 11 years
- Onset substance use between 16 and 21 years

Evidence-Based Best Practices (continued)
Pharmacotherapy
Medication Assisted Therapy

Pharmacotherapy

- Detoxification/Withdrawal Management
- Cravings for Alcohol
- Replacement
- Aversive
- Antagonist
- Mixed (Agonist-antagonist)

Medicated Assisted Therapy

- Medicated-Assisted Treatment (MAT) is the use of **FDA-approved medications**, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

Medications for Alcohol Use Disorders

- Naltrexone
- Vivitrol (injectable form of Naltrexone), longer lasting)
- Disulfiram (Antabuse)
- Acamprosate (Campral)

Medications for Opioid Use Disorders

- Methadone (oral liquid)
- Naltrexone (oral)
- Vivitrol (injectable form of Naltrexone), longer lasting)
- Sublocade (injectable form of Buprenorphine)
- Suboxone/Zubzolv (Buprenorphine/Naloxone)
- Probuphine (Buprenorphine/ implant)

Opiate/Opioid : What’s the Difference?

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

- Opioid
    - A more general term that includes opiates as well as the synthetic drugs or medications, such as Buprenorphine, methadone, Meperidine (Demerol®), Fentanyl—that produce analgesia and other effects like morphine

Basic Opioid Facts

- Description: Opium-derived, or synthetics which relieve pain, produce euphoria and morphine-like addiction, and relieve withdrawal from opioids
- Medical Uses: Pain management, cough suppression
- Methods of Use: Intravenously injected, smoked, snorted, or orally administered
- Withdrawal: Prolonged and very unpleasant, but not life threatening

A Brief History of Opioid Treatment

- The Drug Abuse Treatment Act of 2000 and the approval of Buprenorphine by the U.S. Food and Drug Administration, in 2002, for the treatment of opioid addiction both allow for the expansion of traditional opioid treatment programs beyond the current structure to include treatment in office-based settings. With this expansion, more patients may be willing to access treatment, and the stigma associated with addiction may be reduced by broadening the definition and location of treatment

A Brief History of Opioid Treatment

- Opioid addiction continues to be a significant public health problem across the country. In 2007, approximately 12.5 million Americans ages 12 and older used prescription pain medications for non-medical purposes, according to the National Survey on Drug Use and Health administered by SAMHSA

- By 2019 full scale efforts to systemically decrease the access to prescribed opioids medications, over the previous decade, have created a continual surge in OD deaths, and the ongoing use of heroin and Fentanyl (acquired illicitly in order to manage the addiction to these opiate based-medications). Thus, creating the epidemic we see cycling through our healthcare/SUD treatment systems of care today.

A Brief History of Opioid Treatment (continued)

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

A Brief History of Opioid Treatment (continued)

- 2000: Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication-assisted opioid treatment
- 2002: Tablet formulations of Buprenorphine (Subutex®) and Buprenorphine/Naloxone (Suboxone®) were approved by the Food and Drug Administration (FDA)

Approval of Buprenorphine and Buprenorphine/Naloxone

- U.S. FDA approved Buprenorphine (marketed as Subutex®) and Buprenorphine/Naloxone (marketed as Suboxone®) for opioid addiction treatment on October 8, 2002
- Product launched in U.S. in March 2003
- Interim rule changes to federal regulation (42 CFR Part 8) on May 22, 2003 enabled OTP's (specialist clinics) to offer Buprenorphine

A Brief History of Opioid Treatment (continued)

- 2016 The First-Ever FDA-Approved Buprenorphine Implant For Opioid Dependence (Probuphine)
- 2017 FDA approves first once-monthly buprenorphine injection, a medication-assisted treatment option for opioid use disorder (Sublocade)

Buprenorphine
Treatment:
The Myths and The Facts

MYTH #1: Patients are still addicted

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

  ✓ Physical dependence on a medication for treatment of a medical problem does not mean the person is engaging in pathologic use

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

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

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

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

- **<u>FACT</u>:**
  - ✓ Buprenorphine is an important treatment option. However, the **complete** treatment package should include other elements as well (talk therapy, community support, etc.)
  - ✓ Combining pharmacotherapy with counseling and other ancillary services may increase the likelihood of success

MYTH #4: Patients are still getting high

- **FACT**:
  - ✓ When taken sublingually, Buprenorphine is slower acting and does not provide the same “rush” as heroin
  - ✓ Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses

Advantages of Buprenorphine in the Treatment of Opioid Addiction

1. Patient can participate fully in treatment activities and other activities of daily living easing their transition into the treatment environment
2. Limited potential for overdose *(Johnson et.al, 2003)*
3. Minimal subjective effects (e.g., sedation) following a dose
4. Available for use in an office setting
5. Lower level of physical dependence

Advantages of Buprenorphine/ Naloxone

- Discourages IV use
- Can prevent overdose deaths (Naloxone)

Training Summary

1. Evidence Based – Best Practice
2. Therapeutic Relationship and Treatment Alliance
3. Best Practices
4. Co-occurring Disorders
5. (some)Pharmacological Treatment options