Medications for Opioid Use Disorder

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

TREATMENT IMPROVEMENT PROTOCOL

TIP 63

SAMHSA
Substance Abuse and Mental Health Services Administration

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TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Treatment Improvement Protocol 63

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

This TIP reviews three Food and Drug Administration-approved medications for opioid use disorder treatment—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support people in recovery.

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TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Executive Summary

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

The Executive Summary of this **Treatment Improvement Protocol** provides an overview on the use of the three Food and Drug Administration-approved medications used to treat opioid use disorder—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery.

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SAMHSA
Substance Abuse and Mental Health Services Administration

EXECUTIVE SUMMARY

TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Part 4: Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals

For Healthcare and Addiction Professionals

Part 4 of this **Treatment Improvement Protocol (TIP)** is for addiction treatment professionals and peer recovery support specialists who work with individuals who take a Food and Drug Administration (FDA)-approved medication to treat opioid use disorder (OUD).

TIP Navigation

KEY MESSAGES

- Many patients taking OUD medication benefit from counseling as part of their treatment.
- Counselors play the same role for clients with OUD who take medication as for clients with any other SUD.
- Counselors help clients recover by addressing the challenges and consequences of addiction.
- OUD is often a chronic illness requiring ongoing communication among patients and providers to ensure that patients fully benefit from both pharmacotherapy and psychosocial treatment and support.
- OUD medications are safe and effective when prescribed and taken appropriately.
- Medication is integral to recovery for many people with OUD. Medication usually produces better treatment outcomes than outpatient treatment without medication.
- Supportive counseling environments for clients who take OUD medication can promote treatment and help build recovery capital.

SAMHSA
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PART 4: PARTNERING ADDICTION TREATMENT COUNSELORS WITH CLIENTS AND HEALTHCARE PROFESSIONALS

PART 4 of 5

Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals

Part 4 of this TIP is for addiction treatment professionals and peer recovery support specialists who work with individuals who take an FDA-approved medication for OUD—methadone, naltrexone, or buprenorphine. These providers have direct helping relationships with clients. They don't prescribe or administer OUD medications, but they interact with healthcare professionals who do. They also help people who take OUD medication access supportive services (e.g., transportation, child care, housing).

Overview and Context

Scope of the Problem

Opioid misuse has caused a growing nationwide epidemic of OUD and unintentional overdose deaths.[1] This epidemic affects people in all regions, of all ages, and from all walks of life. Opioid misuse devastates families, burdens emergency departments and first responders, fuels increases in hospital admissions, and strains criminal justice and child welfare systems.

Counselors can play an integral role in addressing this crisis. Counseling helps people with OUD and other substance use disorders (SUDs) change how they think, cope, react, and acquire the skills and confidence necessary for recovery. Counseling can provide support for people who take medication to treat their OUD. Patients may get counseling from prescribers or other staff members in the prescribers' practices or by referral to counselors at specialty addiction treatment programs or in private practice.

Counselors and peer recovery support specialists can work with patients who take OUD medication and refer patients with active OUD to healthcare professionals for an assessment for treatment with medication.

2.1 MILLION
people in the U.S., ages 12 and older, had OUD involving **PRESCRIPTION OPIOIDS, HEROIN,** or both in 2016.[2]

Part 4 uses "counselor" to refer to the range of professionals—including recovery coaches and other peer recovery support services specialists—who may counsel, coach, or mentor people who take OUD medication, although their titles, credentials, and range of responsibilities vary. At times, Part 4 refers to individuals as "clients." For other key terms, see Exhibit 4.1. Part 5 of this TIP provides a full glossary and other resources related to the treatment of OUD.

Counseling clients who take OUD medication requires understanding:

- Basic information about OUD.
- The role and function of OUD medications.
- Ways to create a supportive environment that helps clients work toward recovery.
- Counseling's role within a system of whole-person, recovery-oriented OUD care.

EXHIBIT 4.1. Key Terms

Addiction: As defined by the American Society of Addiction Medicine,[3] "a primary, chronic disease of brain reward, motivation, memory, and related circuitry" (p. 1). It is characterized by 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. Like other chronic diseases, addiction often involves cycles of **relapse** and **remission.** The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition[4] (DSM-5), does not use the term for diagnostic purposes, but it commonly describes the more severe forms of OUD.

Care provider: Encompasses both **healthcare professionals** and other professionals who do not provide medical services, such as counselors or providers of supportive services. Often shortened to "provider."

Healthcare professionals: Physicians, nurse practitioners, physician assistants, and other medical service professionals who are eligible to prescribe medications for and treat patients with OUD. The term **"prescribers"** also refers to these healthcare professionals.

Maintenance treatment: Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint (as is the typical standard of care in medical and psychiatric treatment of other chronic illnesses).

Mutual-help groups: Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most widespread and well-researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).

Opioid misuse: The use of prescription opioids in any way other than as directed by a doctor; the use of any opioid in a manner, situation, amount, or frequency that can cause harm to self or others.[5]

Opioid receptor agonist: A substance that has an affinity for and stimulates physiological activity at cell receptors in the central nervous system (CNS) that are normally stimulated by opioids. **Mu-opioid receptor full agonists** (e.g., methadone) bind to the mu-opioid receptor and produce actions similar to those produced by the endogenous opioid beta-endorphin. Increasing the dose increases the effect. **Mu-opioid receptor partial agonists** (e.g., buprenorphine) bind to the mu-opioid receptor. Unlike with full agonists, increasing their dose may not produce additional effects once they have reached their maximal effect. At low doses, partial agonists may produce effects similar to those of full agonists.

Opioid receptor antagonist: A substance that has an affinity for opioid receptors in the CNS without producing the physiological effects of opioid agonists. Mu-opioid receptor antagonists (e.g., naltrexone) can block the effects of exogenously administered opioids.

Opioids: All natural, synthetic, and semisynthetic substances that have effects similar to morphine. They can be used as medications having such effects (e.g., methadone, buprenorphine, oxycodone).

Opioid treatment program (OTP): An accredited treatment program with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and Drug Enforcement Administration registration to administer and dispense opioid agonist medications that are approved by FDA to treat opioid addiction. Currently, these include methadone and buprenorphine. Other pharmacotherapies, such as naltrexone, may be provided but are not subject to these regulations. OTPs must provide adequate medical, counseling, vocational, educational, and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement.[6]

EXHIBIT 4.1. Key Terms (continued)

Opioid use disorder (OUD): Per DSM-5,[7] a disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. Tolerance and withdrawal do not count toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision. OUD covers a range of severity and replaces what the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, termed "opioid abuse" and "opioid dependence." An OUD diagnosis is applicable to a person who uses opioids and experiences at least 2 of the 11 symptoms in a 12-month period. (See Exhibit 2.13 and the Appendix in Part 2 for full DSM-5 diagnostic criteria for OUD.)

Peer support: The use of peer support specialists in recovery to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.

Peer support specialist: Someone in recovery who has lived experience in addiction plus skills learned in formal training. Peer support specialists may be paid professionals or volunteers. They are distinguished from members of mutual-help groups because they maintain contact with treatment staff. They offer experiential knowledge that treatment staff often lack.

Prescribers: **Healthcare professionals** who are eligible to prescribe medications for OUD.

Psychosocial support: Ancillary services to enhance a patient's overall functioning and well-being, including recovery support services, case management, housing, employment, and educational services.

Psychosocial treatment: Interventions that seek to enhance a patient's social and mental functioning, including addiction counseling, contingency management, and mental health services.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their SUDs and regain health and social function. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature. Patients taking FDA-approved medication to treat OUD can be considered in recovery.

Recovery capital: The sum of the internal (e.g., motivation, self-efficacy, spirituality) and external (e.g., access to health care, employment, family support) resources that an individual can draw upon to begin and sustain recovery from SUDs.

Recovery-oriented care: A service orientation that supports individuals with behavioral health conditions in a process of change through which they can improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Relapse: A process in which a person with OUD who has been in **remission** experiences a return of symptoms or loss of remission. A relapse is different from a **return to opioid use** in that it involves more than a single incident of use. Relapses occur over a period of time and can be interrupted. Relapse need not be long lasting. The TIP uses relapse to describe relapse prevention, a common treatment modality.

Remission: A medical term meaning a disappearance of signs and symptoms of the disease.[8] DSM-5 defines remission as present in people who previously met OUD criteria but no longer meet any OUD criteria (with the possible exception of craving).[9] Remission is an essential element of **recovery.**

Return to opioid use: One or more instances of **opioid misuse** without a return of symptoms of OUD. A return to opioid use may lead to **relapse.**

Setting the Stage

Since the 1990s, dramatic increases in controlled medication prescriptions—particularly opioid pain relievers—have coincided with increases in their misuse.[10] Since the mid-2000s, heroin[11,12] and fentanyl (mainly illicit formulations)[13] consumption has also sharply increased. People who turn to illicit drugs after misusing opioid medications have driven greater use of heroin and fentanyl, which are cheaper and easier to obtain.

Approximately 1,500 OTPs currently dispense methadone, buprenorphine, or both.[14] They may also offer naltrexone. Historically, OTPs were the only source of OUD medication and offered only methadone.

Buprenorphine is increasingly available in general medical settings. Physicians, nurse practitioners, and physician assistants (whether or not they're addiction specialists) can get a federal waiver to prescribe buprenorphine. These healthcare professionals can also prescribe and administer naltrexone, which does not require a waiver or OTP program certification.

People with OUD should have access to the medication most appropriate for them. Medication helps establish and maintain OUD remission. By controlling withdrawal and cravings and blocking the euphoric effects of illicit opioids, OUD medication helps patients stop illicit opioid use and resolve OUD's psychosocial problems. For some people, OUD medication may be lifesaving. Ideally, patients with OUD should have access to all three FDA-approved pharmacotherapies. (See the "Quick Guide to Medications" section for an overview of each medication.)

Many patients taking OUD medication benefit from counseling as part of their treatment. Counseling helps people with OUD change how they think, cope, react, and acquire the skills and confidence needed for recovery. Patients may get counseling from medication prescribers or staff members in prescribers' practices or by referral to counselors at specialty addiction treatment programs or in private practice. Exhibit 4.2 discusses recommending versus requiring counseling as part of medication treatment for OUD.

> **The counselor's role with clients who take OUD medication is the same as it is with all clients who have SUDs: Help them achieve recovery by addressing addiction's challenges and consequences.**

Distinguishing OUD From Physical Dependence on Opioid Medications

According to DSM-5,[15] OUD falls under the general category of SUDs and is marked by:

- Compulsion and craving.
- Tolerance.
- Loss of control.
- Withdrawal when use stops.
- Continued opioid use despite adverse consequences.

Properly taken, some medications cause tolerance and physical dependence. Medications for some chronic illnesses (e.g., steroids for systemic lupus erythematosus) can make the body build tolerance to the medications over time. If people abruptly stop taking medications on which they've become physically dependent, they can experience withdrawal symptoms. This can be serious, even fatal.

Physical dependence on a prescribed, properly taken opioid medication is distinct from OUD and opioid addiction. OUD is a behavioral disorder associated with loss of control of opioid use, use despite adverse consequences, reduction in functioning, and compulsion to use. The professionals who revised DSM-5 diagnostic criteria for OUD made several significant changes. Among the most notable was differentiating physical dependence from OUD:

- Tolerance or withdrawal symptoms related to FDA-approved medications appropriately prescribed and taken to treat OUD (buprenorphine, methadone) don't count toward diagnostic criteria for OUD.

EXHIBIT 4.2. Recommending Versus Requiring Counseling

The TIP expert panel affirms that counseling and ancillary services greatly benefit many patients. However, such **counseling and ancillary services should target patients' needs and shouldn't be arbitrarily required as a condition for receiving OUD medication (although they are required by regulations in OTPs),** especially when the benefits of medication outweigh the risks of not receiving counseling.

The TIP expert panel recommends individualized treatment. Patients who choose to start medication and medication management with their prescriber without adjunctive counseling and don't adequately respond to such treatment should be referred to adjunctive counseling and more intensive services as needed.[16]

The law requires buprenorphine prescribers to be able to refer patients taking OUD medication to counseling and ancillary services. Buprenorphine prescribers may meet this requirement by keeping a list of referrals or by providing counseling themselves. **The law doesn't require naltrexone prescribers to refer patients to additional services.** However, FDA labels for both medications recommend counseling as part of treatment.

Some treatment environments require counseling by regulation or contractual obligation. In other cases, a healthcare professional may believe that a patient taking OUD medication would benefit from counseling. Some healthcare professionals may require counseling, particularly if patients aren't responding well to medication.

> **OUD is often a chronic medical illness.[17] Treatment isn't a cure.**

- If the individual is being treated with an OUD medication and meets no OUD criteria other than tolerance, withdrawal, or craving (but did meet OUD criteria in the past), he or she is considered in remission on pharmacotherapy.

Accepting this distinction is essential to working with clients taking OUD medication. One common question about patients taking medication for OUD is "Aren't they still addicted?" The new DSM-5 distinction makes the answer to this question "No, they're not still addicted." A person can require OUD medication and be physically dependent on it but still be in remission and recovery from OUD.

Understanding the Benefits of Medication for OUD

Medication is an effective treatment for OUD.[18,19,20] People with OUD should be referred for an assessment for pharmacotherapy unless they decline.[21] To be supportive and effective when counseling clients who could benefit from or who take medication for OUD, know that:

- **Treatment with methadone and buprenorphine is associated with lower likelihood of overdose death compared with not taking these medications.[22,23,24,25,26]**
- **Medication helps people reduce or stop opioid misuse.[27,28,29,30]** As Jessica's story in Exhibit 4.3 shows, even if people return to opioid use during treatment or don't achieve abstinence in the short term, medication lessens misuse and its health risks (e.g., overdose, injection-related infections).[31]
- **Patients taking FDA-approved medication used to treat OUD can join residential or outpatient treatment.** Decades of clinical experience in OTPs, which must provide counseling, suggest that patients taking OUD medication can fully participate in group and individual counseling, both cognitively and emotionally. Patients with concurrent SUDs (involving stimulants or alcohol) can benefit from residential treatment while continuing to take their OUD medication.

EXHIBIT 4.3. Jessica's Story About Medication

Jessica is a 32-year-old who unsuccessfully quit heroin dozens of times. She had been in and out of treatment but says, "It just never stuck. I'd always start using again when I left the program." Three years ago, her primary care doctor started prescribing her buprenorphine. Now Jessica says:

> **Some days I pinch myself. I can't believe I got my life back.** I tried quitting so many times but always got pulled back into the scene. Ever since I've been on buprenorphine, I haven't had any cravings. Even when I'm around triggers, they just don't set me off the same way. I've been able to get a job and I'm starting to build a community of friends who don't use. The hardest part about being on buprenorphine is that my emotions aren't masked anymore. I have to feel all of the sadness and fear that I was avoiding all these years. But it's good. I'm getting a chance to work through it.

- **Randomized clinical trials indicate that OUD medication improves treatment retention and reduces illicit opioid use.**[32,33,34] Retention in treatment increases the opportunity to provide counseling and supportive services that can help patients stabilize their lives and maintain recovery.
- **The longer patients take medication, the less likely they are to return to opioid use,** whereas short-term medically supervised withdrawal rarely prevents return to use:[35,36,37,38,39]
  - Conducting short-term medically supervised withdrawal may increase the risk of unintentional fatal overdose because of decreased tolerance after withdrawal completion.[40,41]
  - Providing short-term medical treatment for OUD is the same as treating a heart attack without managing the underlying coronary disease.
  - Providing longer courses of medication that extend beyond withdrawal can allow patients to stabilize.
  - Getting stabilized, which may take months or even years, allows patients to focus on building and maintaining a healthy lifestyle.
- **Patients taking OUD medication can achieve long-term recovery.** People who continue to take medication can be in remission from OUD and live healthy, productive lives.[42]

Reviewing the Evidence on Counseling in Support of Medication To Treat OUD

Dedicated counseling can help clients address the challenges of extended recovery. For clients who seek a self-directed, purposeful life, counseling can help them:

- Improve problem-solving and interpersonal skills.
- Find incentives for reduced use and abstinence.
- Build a set of techniques to resist drug use.
- Replace drug use with constructive, rewarding activities.

Moreover, evidence shows that counseling can be a useful part of OUD treatment for people who take OUD medication. Impact studies of counseling for people with SUDs show that:

- **Motivational enhancement/interviewing is generally beneficial.**[43] This approach helps get people into treatment. It also supports behavior change and, thus, recovery.

- **Cognitive–behavioral therapy (CBT) has demonstrated efficacy in the treatment of SUDs,** whether used alone or in combination with other strategies.[44] Clinical trials have not shown that CBT added to buprenorphine treatment with medical management is associated with significantly lower rates of illicit opioid use.[45,46] However, a secondary analysis of one of those trials found that CBT added to buprenorphine and medical management was associated with significantly greater reduction in any drug use among participants whose OUD was primarily linked to misuse of prescription opioids than among those whose OUD involved only heroin.[47] Thus, CBT may be helpful to those patients receiving buprenorphine treatment who have nonopioid drug use problems.
- **Case management helps establish the stability necessary for SUD remission.**[48,49,50] Case management helps some people in SUD treatment get or sustain access to services and necessities, such as:
  - Food.
  - Shelter.
  - Income support.
  - Legal aid.
  - Dental services.
  - Transportation.
  - Vocational services.
- **Family therapy can address SUDs and various other family problems** (e.g., family conflict, unemployment, conduct disorders). Several forms of family therapy are effective with adolescents[51] and can potentially address family members' biases about use of medication for OUD.[52]
- **There is more research on combined methadone treatment and various psychosocial treatments (e.g., different levels of counseling, contingency management) than on buprenorphine or naltrexone treatment in office-based settings.** More research is needed to identify the best interventions to use with specific medications, populations, and treatment phases in outpatient settings.[53]
- **Motivational intervention, case management, or both can improve likelihood of entry into medication treatment for OUD** among people who inject opioids, according to a systematic review of 13 studies plus data from a prior systematic review.[54]
- **Clinical trials have shown no differences in outcomes for buprenorphine with medical management between participants who get adjunctive counseling and those who don't** (i.e., prescriber-provided guidance focused specifically on use of the medication).[55,56,57,58]

RESOURCE ALERT

Principles of Effective Treatment

In its *Principles of Drug Addiction Treatment*, the National Institute on Drug Abuse lists 13 principles of effective treatment (p. 2).[59] Two principles that pertain to counseling are:

- **"No single treatment is effective for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society."
- **"Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture."

Yet those trials:

- Relied on well-structured medical management sessions that may not be typical in practice.
- Excluded patients with certain co-occurring disorders or factors that complicated treatment.

- **Benefits from counseling may depend on factors such as the number of sessions and adherence.[60]**

Using a Recovery-Oriented Approach to Treating Patients With OUD

Counseling for OUD gives patients tools to manage their illness, achieve and sustain better health, and improve their quality of life. There are limits to how much medication alone can accomplish. OUD medication will improve quality of life,[61] but many clients in addiction treatment have complex issues that may decrease quality of life, such as:

- Other SUDs (e.g., alcohol use disorder, cannabis use disorder).[62,63,64]
- Mental distress[65] (i.e., high levels of symptoms) and disorders[66,67,68] (e.g., major depressive disorder, posttraumatic stress disorder).
- Medical problems (e.g., hepatitis, diabetes).[69]
- History of trauma.[70,71]
- Poor diet, lack of physical activity, or both.[72]
- Lack of social support.[73]
- Unemployment.[74]

Acknowledge many pathways to recovery

Recovery occurs via many pathways.[75] OUD medication may play a role in the beginning, middle, or entire continuum of care.

Support clients in making their own informed decisions about treatment. Counselors don't need to agree with clients' decisions but must respect them. Educate new clients about:

- Addiction as a chronic disease influenced by genetics and environment.
- How medications for OUD work.

RESOURCE ALERT

Recovery-Oriented Treatment

Recovery-Oriented Methadone Maintenance: This guide by White and Mojer-Torres is the most thorough document on this topic currently available and is applicable to clients receiving other medications for OUD (www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph_RM_Methadone.pdf).

Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/MethadoneBestPracticeGuideline.pdf) and ***Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Buprenorphine and Suboxone*** (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/Community_Care_BP_Guidelines_for_Buprenorphine_and_Suboxone.pdf) outline phase-specific tasks and accompanying strategies for programs that provide services to clients who take these medications.

SAMHSA'S GUIDING PRINCIPLES OF RECOVERY[76]

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibilities.
- Recovery is based on respect.

- What occurs during dose stabilization.
- The benefits of longer term medication use and the risks of abruptly ending treatment.

Promote recovery for clients with OUD

Focus on addressing personal and practical problems of greatest concern to clients, which can improve their engagement in treatment.[77] Recovery supports can sustain the progress clients made in treatment and further improve their quality of life. Addressing the full range of client needs can improve clients' quality of life and lead to better long-term recovery outcomes. A recovery-oriented approach to traditional SUD counseling may help address client needs.[78,79]

Increasing recovery capital supports long-term abstinence and improved quality of life, especially for clients who decide to stop medication. Clients with substantial periods of abstinence from illicit drugs identify these strategies for increasing recovery capital as helpful:[80,81,82]

- Forging new relationships with friends/family
- Obtaining support from friends, family, partners, and communities
- Using positive coping strategies
- Finding meaning or a sense of purpose in life
- Engaging in a church or in spiritual practices
- Pursuing education, employment, or both
- Engaging in new interests or activities (e.g., joining a community group, exercising)
- Building confidence in ability to maintain abstinence (i.e., increasing abstinence-related self-efficacy)
- Finding ways to help other individuals who are new to recovery

Help clients further grow recovery capital by offering or connecting them to a range of services, such as:

- Ancillary services (e.g., vocational rehabilitation, supported housing).
- Additional counseling.
- Medical services.
- Mental health services.

Provide person-centered care

Clients' confidence in their ability to stay away from illicit substances, or self-efficacy, is an important factor in successful change. In person-centered care, also known as patient-centered care:

- Clients control the amount, duration, and scope of services they receive.
- They select the professionals they work with.
- Care is holistic; it respects and responds to clients' cultural, linguistic, and socioenvironmental needs.[83]
- Providers implement services that recognize patients as equal partners in planning, developing, and monitoring care to ensure that it meets each patient's unique needs.[84]

RESOURCE ALERT

Decision-Making Tool

Decisions in Recovery: Treatment for Opioid Use Disorders is a SAMHSA web-based tool (http://brsstacs.com/Default.aspx) and handbook (https://store.samhsa.gov/product/SMA16-4993) to help people with OUD make decisions about treatment and recovery.

RESOURCE ALERT

Relapse Prevention and Recovery Promotion TIP

Relapse Prevention and Recovery Promotion in Behavioral Health Services is a planned TIP, which will be available on the SAMHSA Publications Ordering webpage (https://store.samhsa.gov), that will cover the closely related topics of relapse prevention and recovery promotion for SUDs and many mental disorders.[85]

> The confrontational/expert model that characterized much of SUD treatment in the past may harm some patients and inhibit or prevent recovery.[86]

A person-centered approach to OUD treatment empowers clients in making decisions, such as:[87]

- Whether to take OUD medication.
- Which medication to take.
- Which counseling and ancillary services to receive.

Fragmented healthcare services are less likely to meet the full range of patients' needs. Integrated medical and behavioral healthcare delivery provides patient-focused, comprehensive treatment that meets the wide range of symptoms and service needs that patients with OUD may have. Significant demand remains for better integrated and coordinated SUD treatment (including OTP), medical, and mental health services.[88] Such improvements are particularly important for the many individuals with co-occurring substance use and mental disorders who receive OUD medication.[89,90] In a randomized trial of methadone patients with co-occurring mental disorders receiving onsite versus offsite mental health services, those receiving services onsite had less psychiatric distress at follow-up.[91]

Promote family and social support

Support from family and friends can be the most important factor in long-term recovery, according to many people who have achieved long-term recovery from OUD.[92,93] Support from intimate partners helps all clients, especially women, avoid return to opioid use.[94,95] But the more people in clients' social networks who use drugs, the more likely clients are to return to use.[96,97]

Most clients are willing to invite a substance-free family member or friend to support their recovery.[98] Most have at least one nearby family member who does not use illicit drugs.[99] A client's community may provide a cultural context for their recovery and culturally specific supports that may not otherwise be available in treatment.[100]

Help clients develop and support positive relations with their families by:

- Suggesting that clients invite family and friends to aid in the recovery planning process (Exhibit 4.4).
- Emphasizing the importance of relationships with family and friends who actively support recovery.
- Supporting clients in mending broken relationships with loved ones.
- Helping clients cut ties with individuals who still use drugs or enable clients' drug use.
- Encouraging clients to build new relationships that support recovery.

RESOURCE ALERT

Treatment Guidance for Co-Occurring Substance Use and Mental Disorders

TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, provides SUD treatment strategies for people with mental disorders (https://store.samhsa.gov/shin/content//SMA13-3992/SMA13-3992.pdf).

Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices KIT provides practical guidance for integrating mental health services and SUD treatment (https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367).

EXHIBIT 4.4. Engaging Reluctant Family Members in a Client's Treatment

If the client agrees and has signed the appropriate releases, help even reluctant family members engage in the client's treatment to offer support. To reach out to family members who hesitate to engage, try to:

- **Recognize that they have been harmed** by their family member's substance use and that their participation in his or her recovery can help them heal too.
- **Ask them to recall some positive experiences** they have had with the client.
- **Introduce them to mutual-help groups and other supports** for families (e.g., Nar-Anon, Learn to Cope, Parents of Addicted Loved Ones Group). Ensure that suggested groups don't have an antimedication bias.
- **Help them understand OUD, the treatment process, and medication's role in recovery.** This knowledge can keep family members from pressuring the client to taper medication prematurely.
- **Hold multifamily therapy groups or informal discussion sessions for families** (with or without clients present) so that family members can learn from one another and share their experiences.
- **Offer family or couples therapy** as an option for additional support.

Provide trauma-informed care

Trauma-informed service requires providers to realize the significance of trauma. According to SAMHSA,[101] trauma-informed counselors know what trauma is and also:

- Understand how trauma can affect clients, families, and communities.
- Apply knowledge of trauma extensively and consistently in both practice and policy.
- Know ways to promote recovery from trauma.
- Recognize the signs and symptoms of trauma in clients, families, staff members, and others.
- Resist things that may retraumatize or harm clients or staff.

Incorporate trauma-informed principles of care into recovery promotion efforts, because:

- Trauma histories and trauma-related disorders may increase clients' risk for various problems, including early drop-out from treatment[102] and greater problems with pain.[103]
- Childhood trauma is highly prevalent among people with OUD.[104,105]
- People often suffer multiple traumas during opioid misuse.[106]
- An intervention that integrated trauma treatment and standard care (which goes further than the trauma-informed care detailed here) had better outcomes than standard care alone in a diverse group of women treated in various settings, including an OTP.[107]

RESOURCE ALERT

Trauma-Informed Care TIP

TIP 57, *Trauma-Informed Care in Behavioral Health Services*, has more information on providing trauma-informed care in SUD treatment programs (https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816).

Quick Guide to Medications

This section introduces the neurochemistry and biology of OUD and the medications that treat it. Reading this section will familiarize counselors with terminology healthcare professionals may use in discussing patients who take OUD medication (see also Exhibit 4.1 and the comprehensive glossary in Part 5).

Understanding the Neurobiology of OUD

Opioid receptors are a part of the body's natural endorphin system. Endorphins are chemicals our bodies release to help reduce our experience of pain. They can also contribute to euphoric feelings like the "runner's high" that some people experience. When endorphins or opioids bind to opioid receptors, the receptors activate, causing a variety of effects.

After taking opioids, molecules bind to and activate the brain's opioid receptors and release dopamine in a brain area called the nucleus accumbens (NAc), causing euphoria. Like opioid receptors, the NAc has a natural, healthy function. For example, when a person eats, the NAc releases dopamine to reinforce this essential behavior. The NAc is a key part of the brain's reward system.

Opioid use leads to an above-normal release of dopamine, essentially swamping the natural reward pathway and turning the brain strongly toward continued use. The brain also learns environmental cues associated with this dopamine release. It associates specific people, places, and things (e.g., music, drug paraphernalia) with the euphoria; these environmental cues then become triggers for drug use.

Intermittent opioid use causes periods of euphoria followed by periods of withdrawal. The brain's strong draw toward euphoria drives repeated and continued use. Few people with OUD reexperience the euphoria they obtained early in their opioid use, yet they continue to seek it.

Changes in brain function that result from repeated drug use cause a person who once took the drug for euphoria to seek it out of habit, then compulsion. People with OUD use opioids to stave off withdrawal. Without opioids, the person feels dysphoric and physically ill, only feeling normal by taking opioids again. At the same time, other areas of the brain begin to change:[108]

- The amygdala, which is associated with feelings of danger, fear, and anger, becomes overactive.
- The frontal cortex, which is associated with planning and self-control, becomes underactive.
- The ability to control impulses diminishes, and drug use becomes compulsive.
- The need to escape the discomfort and intensely negative emotional states of withdrawal becomes the driving force of continued use.

Even after opioid use stops, brain changes linger. A person's ability to make plans and manage impulses stays underactive. That's why return to substance use is very common even after a period of abstinence.

Medications for OUD promote emotional, psychological, and behavioral stabilization. By acting directly on the same opioid receptors as misused opioids (**but in different ways**), medications can **stabilize** abnormal brain activity.

Learning How OUD Medications Work

The following sections describe how each of the OUD medications functions (Exhibit 4.5; see also Part 3 of this TIP for greater detail). Discuss questions or concerns about a patient's medication, side effects, or dosage with the patient's prescriber after getting the patient's consent.

EXHIBIT 4.5. FDA-Approved Medications Used To Treat OUD: Key Points

MEDICATION	HOW IT'S TAKEN	WHY IT WORKS	SIDE EFFECTS	NOTES
Bupre-norphine	Tablet dissolved under the tongue or film dissolved under the tongue or against the inside of the cheek. Taken once daily, every other day, or 3 times a week. It also comes as an implant that lasts 6 months or as an injection that lasts 1 month.	Partially activates the opioid receptor. Reduces craving and blocks the euphoric effect of opioids.	Can cause constipation, headache, nausea, insomnia, excessive sweating, or opioid withdrawal. Overdose is possible but less likely than with methadone. Overdose death risk is increased if buprenorphine is taken with alcohol or intravenously in combination with benzodiazepines or other CNS depressants. Neonatal abstinence syndrome (NAS)	Less sedating than methadone. Prescribers must have a special SAMHSA waiver but don't need to be part of a federally certified OTP. Can be prescribed through pharmacies or provided via OTPs.
Methadone	Liquid or tablet once daily. Dose may be divided for twice-daily dosing if medically necessary.	Fully activates the opioid receptor. Reduces craving and blocks the euphoric effect of opioids.	Can cause constipation, sleepiness, sweating, swelling of hands and feet, sexual dysfunction, heart arrhythmias, low blood pressure, fainting, and substance misuse. Can cause overdose death if increased too rapidly, taken in a much higher than usual dose, or taken concurrently with some substances and medications, particularly CNS depressants such as alcohol or benzodiazepines. NAS	Initially requires visits 6 to 7 times per week to an OTP. Patients can decrease attendance gradually based on time in treatment and clinical stability.
Naltrexone	Daily tablet (can also be taken 3 times a week) or monthly injection in buttock.	Occupies the opioid receptors. Reduces craving and blocks the euphoric effect of opioids.	Can cause nausea, headache, dizziness, fatigue, liver toxicity, depression and suicidality, muscle cramps, fainting, and loss of or decreased appetite or other appetite disorders; in the extended-release injectable formulation, can cause pain, swelling, and other complications at the injection site. Patient must complete withdrawal and stay opioid abstinent for at least 7 days before starting naltrexone and longer (e.g., 10 or more days) for long-acting opioids, such as methadone.	Tablets are rarely effective. Monthly injections are more effective than tablets.

Buprenorphine

Buprenorphine reduces opioid misuse, HIV risk behaviors, and risk of overdose death.[109,110,111,112] Buprenorphine only partially activates opioid receptors; it is a partial agonist. It binds to and activates receptors sufficiently to prevent craving and withdrawal and to block the effects of illicit opioids. Appropriate doses of buprenorphine shouldn't make patients feel euphoric, sleepy, or foggy headed.

Buprenorphine has the benefit of a ceiling effect. Its effectiveness and sedation or respiratory effects don't increase after a certain dosing level, even if more is taken. This lowers risk of overdose and misuse.[113] Groups at particular risk for buprenorphine overdose include children who accidentally ingest the medication[114] and patients who also use CNS depressants like benzodiazepines or alcohol.[115,116] (See Part 3 of this TIP for more information on concurrent use of CNS depressants and buprenorphine.)

Buprenorphine is available outside of OTPs, through non-OTP healthcare settings (e.g., physicians' offices, outpatient drug treatment programs). Healthcare professionals (including nurse practitioners and physician assistants, per the Comprehensive Addiction and Recovery Act of 2016) can prescribe it outside of an OTP provided they have a specific federal waiver. This is often referred to as "being waivered" to prescribe buprenorphine.

Buprenorphine can cause opioid withdrawal in patients who have recently taken a full opioid agonist (e.g., heroin, oxycodone). This occurs because buprenorphine pushes the full opioid activator molecules off the receptors and replaces them with its weaker, partially activating effect. For this reason, patients must be in opioid withdrawal when they take their first dose of buprenorphine.

The most common buprenorphine formulation contains naloxone to reduce misuse. Naloxone is an opioid antagonist. It blocks rather than activates receptors and lets no opioids sit on receptors to activate them. Naloxone is poorly absorbed under the tongue/against the cheek, so when taking the combined medication as directed, it has no effect. If injected, naloxone causes sudden opioid withdrawal.

Buprenorphine comes in two forms that melt on the inside of the cheek or under the tongue: films (combined with naloxone) or tablets (buprenorphine/naloxone or buprenorphine alone). For treatment of OUD, patients take the films or tablets once daily, every other day, or three times a week. Various companies manufacture these forms of the medication. Some are brand name, and some are generic. The different kinds vary in strength or number of milligrams, but they have been designed and tested to provide roughly the same amount of medication as the first approved product (Exhibit 3A.5 in Part 3).

Buprenorphine is also available in a long-acting implant that specially trained healthcare professionals place under the skin (subdermal implant) and an extended-release formulation that is administered under the skin (subcutaneous injection). The implant is appropriate for patients who have been stable on low doses of the films or tablets. It lasts for 6 months and can be replaced once after 6 months. The extended-release formulation lasts for 1 month and can be repeated monthly. It is appropriate for patients who have been stabilized on the films or tablets for at least 7 days.

Healthcare professionals with waivers can prescribe buprenorphine. Physicians who take an 8-hour training and get a waiver can prescribe buprenorphine. Nurse practitioners and physician assistants are eligible to apply for waivers after 24 hours of training. Providers who wish to deliver buprenorphine implants must receive special training on how to insert and remove them.

Buprenorphine can cause side effects including constipation, headache, nausea, and insomnia. These often improve over time and can be managed with dosage adjustments or other approaches.

Methadone

Methadone is highly effective. Many studies over decades of research show that it:[117,118,119]

- Increases treatment retention.
- Reduces opioid misuse.
- Reduces drug-related HIV risk behavior.
- Lowers risk of overdose death.

Methadone is slow in onset and long acting, avoiding the highs and lows of short-acting opioids. It is a full agonist. Patients who take the same appropriate dose of methadone daily as prescribed will neither feel euphoric from the medication nor experience opioid withdrawal.

Methadone is an oral medication that is taken daily under observation by a nurse or pharmacist and under the supervision of an OTP physician. Methadone is available as a liquid concentrate, a tablet, or an oral solution made from a dispersible tablet or powder.

Methadone blunts or blocks the euphoric effects of illicit opioids because it occupies the opioid receptors. This "opioid blockade" helps patients stop taking illicit opioids because they no longer feel euphoric if they use illicit opioids. When on a proper dose of methadone, patients can:

- Keep regular schedules.
- Lead productive, healthy lives.
- Meet obligations (family, social, work).

Methadone can lead to overdose death in people who use a dose that's considerably higher than usual, as methadone is a full agonist. People who don't usually take opioids or have abstained from them for a while could overdose on a fairly small amount of methadone. Thus, patients start on low doses of methadone and gradually adjust upward to identify the optimal maintenance dose level.

Patients must attend a clinic for dose administration 6 to 7 days per week during the start of treatment. Healthcare professionals can thus observe patients' response to medication and discourage diversion to others. Visit frequency can lessen after patients spend time in treatment and show evidence of progress.

Methadone can cause certain side effects. Common potential side effects of methadone include:

- Constipation.
- Sleepiness.
- Sweating.
- Sexual dysfunction.
- Swelling of the hands and feet.

Sleepiness can be a warning sign of potential overdose. Patients who are drowsy should receive prompt medical assessment to determine the cause and appropriate steps to take—which may require a reduction in methadone dose. Some patients may appear sleepy or have trouble staying awake when idle, even if there is no immediate danger of evolving overdose. These patients may need a lower dose or may be taking other prescribed or nonprescribed medications (e.g., benzodiazepines, clonidine) that are interacting with the methadone.

Naltrexone

Naltrexone stops opioids from reaching and activating receptors, preventing any reward from use. Naltrexone is an antagonist of the opioid receptors—it does not activate them at all. Instead, it sits on the receptors and blocks other opioids from activating them.

Naltrexone appears to reduce opioid craving[120] but not opioid withdrawal (unlike buprenorphine and methadone, which reduce both craving and withdrawal). Someone starting naltrexone must be abstinent from short-acting opioids for at least 7 days and from long-acting opioids for 10 to 14 days before taking the first dose. Otherwise, it will cause opioid withdrawal, which can be more severe than that caused by reducing or stopping opioid use.

Naltrexone comes in two forms: tablet and injection.

- Patients take naltrexone tablets daily or three times per week. Tablets are rarely effective, as patients typically stop taking them after a short time.[121,122,123]
- **Highly externally monitored populations in remission may do well with the tablet,**[124,125,126] such as physicians who have mandatory frequent urine drug testing and are at risk of losing their licenses.
- **The injected form is more effective than the tablet because it lasts for 1 month.** Patients can come to a clinic to receive an intramuscular injection in their buttock.

Naltrexone can produce certain side effects, which may include:

- Nausea.
- Headache.
- Dizziness.
- Fatigue.

For the extended-release injectable formulation, potential reactions at the injection site include:

- Pain.
- Bumps.
- Blistering.
- Skin lesions (may require surgery).

Knowing What Prescribers Do

The following sections will help explain the role healthcare professionals play in providing each OUD medication as part of collaborative care. Part 3 of this TIP offers more detailed clinical information.

Administer buprenorphine

Patients typically begin buprenorphine in opioid withdrawal. Patients may take their first dose in the prescriber's office so the prescriber can observe its initial effects. Increasingly often, patients take their first dose at home and follow up with prescribers by phone. Most people are stable on buprenorphine dosages between 8 mg and 24 mg each day.

Patients who take buprenorphine visit their prescriber regularly to allow monitoring of their response to treatment and side effects and to receive supportive counseling. The visits may result in specific actions, such as adjusting the dosage or making a referral for psychosocial services. Stable patients may obtain up to a 30-day prescription of this medication through community pharmacies. Visits may include urine drug testing. Early in treatment, patients typically see their prescribers at least weekly. Further along, they may visit prescribers every 1 to 2 weeks and then as infrequently as once a month or less.

The prescriber will make dosage adjustments as needed, reducing for side effects or increasing for unrelieved withdrawal or ongoing opioid misuse. OTPs that provide buprenorphine will typically follow a similar process, with the principal difference being that the program will administer or dispense the medication rather than the patient filling a prescription at a pharmacy.

Administer methadone

Only SAMHSA-certified OTPs may provide methadone by physician order for daily observed administration onsite or for self-administration at home by stable patients.[127] The physician will start patients on a low dose of methadone. People in early methadone treatment are required by federal regulation to visit the OTP six to seven times per week to take their medication under observation. The physician will monitor patients' initial response to the methadone and slowly increase the dose until withdrawal is completely relieved for 24 hours.

A prescriber can't predict at the start of treatment what daily methadone dose will work for a patient. An effective dose is one that eliminates withdrawal symptoms and most craving and blunts euphoria from self-administered illicit opioids without producing sedation. On average, higher dosages of methadone (60 mg to 100 mg daily) are associated with better outcomes than lower

dosages.[128,129] That said, an effective dose of methadone for a particular patient can be above or below that range.

The prescriber will continue to monitor the patient and adjust dosage slowly up or down to find the optimum dose level. The dose may need further adjustment if the patient returns to opioid use, experiences side effects such as sedation, starts new medications that may interact with methadone, or has a change in health that causes the previously effective dose to become inadequate or too strong.

If patients taking methadone drink heavily or take sedatives (e.g., benzodiazepines), **physicians may:**

- Treat the alcohol misuse.
- Refer to a higher level of care.
- Address comorbid anxiety or depression.
- Decrease dosage to prevent overdose.

Administer naltrexone

To avoid severe withdrawal, prescribers will ensure that patients are abstinent from opioids at least 7 to 10 days before initiating or resuming naltrexone. Prescribers may require longer periods of abstinence for patients transitioning from buprenorphine or methadone to naltrexone.

Prescribers typically take urine drug screens to confirm abstinence before giving naltrexone. Healthcare professionals can confirm abstinence through a "challenge test" with naloxone, a short-acting opioid antagonist.

Healthcare professionals manage withdrawal symptoms with nonopioid medication. Prescribers are prepared to handle withdrawal caused by naltrexone despite a period of abstinence.[130] Ideally, they administer the first injection before patients' release from residential treatment or other controlled settings (e.g., prison) so qualified individuals can monitor them for symptoms of withdrawal.

Healthcare professionals typically see patients at least monthly to give naltrexone injections. For those taking oral naltrexone, prescribers schedule visits at their discretion. Thus, urine drug testing may be less frequent for these patients than for patients taking buprenorphine. But periodic drug testing should occur.

There is only one dose level for injected naltrexone,[131] so prescribers cannot adjust the dose. However, they can slightly shorten the dosing interval if the medication's effectiveness decreases toward the end of the monthly dosing interval. If the patient is having side effects or intense cravings, the prescriber may recommend switching to a different medication.

Set expectations

Ideally, prescribers will collaborate with counselors and other care providers involved in patients' care to set reasonable patient expectations. Medications can effectively treat OUD, but they don't treat other SUDs (save naltrexone, also FDA-approved to treat alcohol use disorder). Patients may still need:

- Counseling for psychosocial issues.
- Social supports/treatment to get back on track.
- Medications, therapy, or both for co-occurring conditions.

Collaboration between all involved healthcare providers helps patients understand the OUD treatment timeline, which generally lasts months or years. Courses of medically supervised withdrawal or tapering are considerably less effective than longer term maintenance treatment with buprenorphine or methadone and are often associated with return to substance use and a heightened risk of overdose.[132,133,134,135]

> Patients may still benefit from the counseling you can offer in addition to care from other providers, even if you can't communicate with those providers directly.

Counselor–Prescriber Communications

OUD medication can support counselors' work with clients who have OUD, and counseling supports the work prescribers do with them. **Good communication facilitates mutually supportive work** (Exhibit 4.6). A counselor will probably:

- See patients more frequently than prescribers.
- Have a more complete sense of patients' issues.
- Offer providers valuable context and perspective.
- Help patients take medications appropriately.
- Ensure that patients receive high-quality care from their other providers.

Obtaining Consent

Get written consent from patients allowing communication directly with their providers (unless the counselor and the providers work in the same treatment program). The consent must explicitly state that the patient allows the counselor to discuss substance-use-related issues. It should also specify which kinds of information the counselor can share (e.g., medical records, diagnoses). Consent forms must comply with federal and state confidentiality laws that govern the sharing of information about patients with SUDs.[136,137]

Good communication with prescribers and other treatment team members allows everyone to work together to:

- **Assess patient progress.**
- **Change treatment plans if needed.**
- **Make informed decisions about OUD medication.**

Carefully protect any identifying information about patients and their medical and treatment information. Don't send such information through unsecured channels, such as:

- Text messaging.
- Unsecure, unencrypted emails.
- Faxes to unsecured machines.

EXHIBIT 4.6. Example of Counselor–Prescriber Communication

Counselor:	Dr. Smith, thank you for referring Jeff to my counseling practice. I'd like to review with you the elements of the treatment plan we've developed.
Prescriber:	That would be really helpful.
Counselor:	We agreed to meet weekly while he's getting stabilized on the buprenorphine. The initial focus of our sessions will be helping Jeff expand his recovery support network.
Prescriber:	I'm glad to hear that you're following up on that. My nurse reported that he's alone in the waiting room before his appointments, and he also mentioned to me that he doesn't have anybody to talk with.
Counselor:	I suggested a support group for people taking buprenorphine that's in his neighborhood. We've also begun talking about recreational activities that can help him fill the time he used to spend with drug-using friends.
Prescriber:	I'll reinforce your suggestions when he comes in this Friday.
Counselor:	Also, he seems confused about where the film goes in his mouth. I urged him to discuss that with you.
Prescriber:	I'll make a note to go over that with him again on Friday.

Phone calls are the most secure way to discuss patient cases, although it may be more convenient to reach out to healthcare professionals first through email.

Structuring Communications With Prescribers

Regular, structured communication can improve the flow of information between treatment teams. Some multidisciplinary programs produce regular reports for prescribers about patient progress. Exhibit 4.7 provides some strategies for discussing patient care with healthcare professionals.

Helping Clients Overcome Challenges in Accessing Resources

By collaborating with healthcare professionals in OUD care, counselors can help clients overcome challenges they face in obtaining treatment, such as:

- **Ability to pay for OUD medication.** Counselors are often already skilled in helping clients address treatment costs (e.g., facilitating Medicaid applications, linking them to insurance navigators). Try to refer clients who face difficulty meeting prescription costs or copays back to the agency's financial department for sliding scale adjustments and ability-to-pay assessments. Also try to help patients find and apply for relevant pharmaceutical company medication prescription plans.
- **Transportation.** Options to offer clients may include:
  - Providing vouchers for public transportation.
  - Providing information on other subsidized transportation options.
  - Linking clients to peer support specialists and case managers who can arrange transportation.
  - Assisting eligible clients in navigating Medicaid to obtain transportation services.
  - If available, arranging for telehealth services to overcome clients' transportation barriers.
- **Access to medication in disaster situations.** Counselors can review options with patients for obtaining prescription replacements and refills or daily medicine dosing under various scenarios. This could include if their usual clinic or primary pharmacy is closed or if they're relocated without notice because of an unforeseen emergency. Also advise patients on the items to take with them in such scenarios to facilitate refills from a new

EXHIBIT 4.7. Tips for Discussing Patient Care With Prescribers

- Identify the patient. Once the counselor has established secure communication through encrypted email or by phone, he or she should state the patient's name, date of birth, and medical record number (if obtained).
- Let prescribers know up front the purpose of the call. Begin by clearly describing the question or concern leading to the call. If it is simply to establish contact because of a shared patient, that's fine.
- Share any relevant information about the patient (if the patient has consented). If there is a concern about a side effect, for example, describe observed changes to the healthcare professional. If there is a concern about return to opioid use, describe which elements of the patient's behavior are worrisome.
- Work together to build a shared understanding of the patient's situation. The counselor likely has key information about the patient that the prescriber does not have, and vice versa.
- Discuss next steps with the healthcare provider before ending any communication to help coordinate patient care. Consider scheduling a check-in with each other to assess patient progress.

medication-dispensing facility. Key materials include:

- Photo identification.
- Medication containers of currently prescribed medications (even if empty).
- Written prescriptions.
- Packaging labels that contain dosage, prescriber, and refill information.
- Any payment receipts that contain medication information.

To overcome systemic barriers, help enact collaborative policies and procedures. Work with program management and the community at large to address the following issues:

- **Connection to treatment:** Counselors may be able to participate in community efforts to ensure that information on how to obtain treatment for OUD is available wherever people with OUD:
  - Gather (e.g., all-night diners, bars, free health clinics, injection equipment exchanges).
  - Seek help (e.g., emergency departments, houses of worship, social service agencies).
  - Reveal a need for help (e.g., encounters with law enforcement and child welfare agencies).

  Encourage buprenorphine prescribers to make known their availability if they are prepared to accept new patients. Help disseminate lists of addiction treatment providers and share their information via peer recovery specialists (see Part 5).
- **Rapid assessment and treatment initiation:** Try to help OUD pharmacotherapy providers, particularly in OTPs, streamline counseling intake processes to help patients receive medication efficiently. The expert panel of this TIP recognizes that same-day admission of patients with OUD may not be possible in all settings, but it's a worthwhile goal. Every program should streamline its intake processes and expedite admissions.
- **Return to treatment:** When patients discontinue treatment prematurely and return to use of opioids, it can be hard for them to reengage in treatment because of the shame they feel or because there is a waiting list for admission. The waitlist problem may not be solvable because of capacity limitations, but all collaborative care team members—including counselors and prescribers—should:
  - Inform patients from intake onward that the program will readmit them even if they drop out.
  - Encourage patients to seek readmission if they return to opioid use or feel that they are at risk for returning to opioid use.
  - **Inform patients of the importance of overdose prevention** (see the "Counseling Patients on Overdose Prevention and Treatment" section).
  - Provide continued monitoring if possible; it can range from informal quarterly check-ins to regularly scheduled remote counseling or peer support (e.g., from a recovery coach).
  - Offer an expedited reentry process to encourage patients to return if they need to.
  - Engage in active outreach and reengagement with OTP patients, which can be effective.[138,139] Try to contact patients who have dropped out to encourage them to return.

Creation of a Supportive Counseling Experience

Maintaining the Therapeutic Alliance

The therapeutic alliance is a counselor's most powerful tool for influencing outcomes.[140] It underlies all types and modalities of therapy and helping services. A strong alliance welcomes patients into treatment and creates a sense of safety.

COUNSELING PATIENTS WITH OUD WHO DON'T TAKE MEDICATION

Patients who don't take an OUD medication after withdrawal are at high risk of return to opioid use, which can be fatal given the loss of opioid tolerance. Provide these patients with overdose prevention education and the overdose-reversal medication naloxone, or educate them about naloxone and how they can obtain it in their community. Advise them to report a return to opioid use or a feeling that they are at risk of relapsing. Work with them and their care team to either resume medication for OUD or enter a more intensive level of behavioral care.

Certain counselor skills help build and maintain a therapeutic alliance, including:

- Projecting empathy and warmth.
- Making patients feel respected and understood.
- Not allowing personal opinions, anecdotes, or feelings to influence the counseling process (unless done deliberately and with therapeutic intention).[141]

These skills are relevant for working with all patients, including those taking medication for OUD. Apply them consistently from the very first interaction with a patient through the conclusion of services. For example, recognize and reconcile personal views about medication for OUD so that they don't influence counseling sessions.

Educating Patients About OUD and a Chronic Care Approach to Its Treatment

Help ensure that patients understand the chronic care approach to OUD and their:

- Diagnosis.
- Prognosis.
- Treatment options.
- Available recovery supports.
- Prescribed medications.
- Risk of overdose (and strategies to reduce it).

Seek to understand patients' preferences and goals. Doing so can help convey information meaningfully so patients understand the choices available to them. Also, help communicate patients' preferences and goals to healthcare professionals and family members.

Educate colleagues and other staff members so they can help create a supportive experience for patients with OUD:

- Provide basic education to colleagues about medications for OUD and how they work.
- Share evidence on how these medications reduce risky behavior, improve outcomes, and save lives.
- Note that major U.S. and international guidelines affirm use of medication to treat OUD.
- Ask about and address specific fears and concerns.
- Provide resources for additional information.

Counseling Patients on Overdose Prevention and Treatment

Know how to use naloxone to treat opioid overdose; share this information with patients and their family members and friends. Available by prescription (or without a prescription in some states), naloxone is an opioid antagonist that has successfully reversed many thousands of opioid overdoses. It comes in auto-injector and nasal spray formulations easy for laypeople to administer immediately on the scene of an overdose, before emergency responders arrive.

Ask patients if they have a naloxone prescription or help them get it without one if possible. Providers may prescribe naloxone in addition to OUD medication. Counselors should check state laws to learn their jurisdiction's naloxone prescription and dispensation policies (see "Resource Alert: Overdose Prevention/Treatment").

Inform clients and their friends and families of any Good Samaritan laws in the jurisdiction, which protect against drug offenses for people who call for medical help while experiencing or observing overdose.

Emphasize that a person given naloxone to reverse overdose must go to the emergency department, because overdose can start again when naloxone wears off.

Consider working with the program administrator to place a naloxone rescue kit in the office, if one is not already available. To be ready for an emergency, learn:

- The signs of overmedication (which may progress to overdose) and overdose itself.
- What to do if an overdose is suspected.
- How to administer naloxone.

Consider working with the program administrators to set up a program to distribute naloxone directly to patients. Many states allow organizations to do this under a standing order from a physician. Clients are more likely to access naloxone if their program provides it directly to them rather than sending them to another organization to get it. Learn more at Prescribe to Prevent (http://prescribetoprevent.org).

RESOURCE ALERT

Overdose Prevention/Treatment

SAMHSA Opioid Overdose Prevention Toolkit (https://store.samhsa.gov/product/SAMHSA-Opioid-Overdose-Prevention-Toolkit/SMA16-4742)

National Conference of State Legislatures' *Drug Overdose Immunity and Good Samaritan Laws* (www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx)

Project Lazarus' *Naloxone: The Overdose Antidote* (www.projectlazarus.org/naloxone)

Prescription Drug Abuse Policy System's: *Interactive Map of Naloxone Overdose Prevention Laws* (http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139)

Helping Patients Cope With Bias and Discrimination

Patients taking medication for OUD must deal with people—including family members, friends, colleagues, employers, and community members—who are misinformed or biased about the nature of OUD and effective treatments for it (Exhibit 4.8).

Wherever possible, such as in a counseling session or a community education forum, counter misunderstandings with accurate information. Emphasize the message that addiction is governed by more powerful brain forces than those that determine habits. As a result, having a lot of positive intent, wanting to quit, and working hard at it sometimes won't be enough.

Remind patients about building recovery capital and sticking with their treatment plan and goals. A particularly good opportunity to do so arises when patients ask how to "get off medication." Statements such as "The longer you take medication, the more of your life you can get back and the less likely you are to return to opioid use" and "We usually recommend continuing medication long term because it helps people maintain recovery" can help clients understand that they are following medical recommendations and doing a good job of caring for themselves (Exhibit 4.9).

> People may think that addiction is just a bad habit or willful self-destruction and that someone who has difficulty stopping opioid misuse is lazy. They may view OUD medication as "just another drug" and urge patients to stop taking it.

EXHIBIT 4.8. Conversation: Addressing Misinformation

Mother of Patient:	They want to put my son on methadone, but it's going to rot his teeth.
Father of Patient:	Yeah. I don't want him to look like he's on drugs when he's finally off them.
Counselor:	You have the impression that people who use drugs have bad teeth. And in many cases, that's true. But there are a lot of reasons why people with a substance use disorder develop teeth and gum problems—such as a high-sugar diet, co-occurring depression that prevents them from taking good care of themselves, poor health that allows oral disease to develop, and lack of access to preventive dental care or treatment. But if your son practices good oral hygiene, his mouth will stay healthy while he takes methadone.
Mother of Patient:	What do you mean by "oral hygiene"?
Counselor:	Like all of us, he'll have to limit his sweets and brush and floss regularly. Methadone can reduce the flow of saliva, which means that not as much of the bacteria on his teeth will get washed away. So, he'll want to get good dental advice on how to address dry mouth if that's a problem for him. Regular dental checkups will be really important, too.
Father of Patient:	So, he won't trade his teeth for his recovery. Thanks—that's one less thing to worry about!

Review a client's motivation for tapering or quitting medication (Exhibit 4.10) and have a conversation about the best timing for such a change (Exhibit 4.11). If the client has consented to communication with other providers, inform the client's prescriber about the client's desires or intent so that shared decision making can take place.

Be proactive in dispelling myths and providing facts about medications for OUD when countering misconceptions and judgmental attitudes. Point out that multiple organizations consider individuals to be in recovery if they take OUD medication as prescribed, including:

- The American Medical Association.[142]
- The American Society of Addiction Medicine.[143]
- The National Institute on Drug Abuse.[144]
- The Office of the Surgeon General.[145]
- SAMHSA.[146]
- The World Health Organization.[147]

Explain that alcohol and opioids are different substances with different effects on the body and brain. This counters the mistaken belief that people receiving buprenorphine or methadone are always "high" and as impaired as if they drank alcohol all day. People acquire tolerance to impairments that drinking causes in motor control and cognition. But this tolerance is partial; alcohol consumption always results in some deficits. Opioids don't have the same motor or cognitive effects. Complete tolerance develops to the psychoactive effects and related motor impairments opioids cause.

If a person takes a therapeutic dose of opioid agonist medication as prescribed, he or she may be as capable as anyone else of driving, being emotionally open, and working productively. Some people worry that OUD medication causes a "high" because they've seen patients taking OUD medication whose behavior was affected by other substances (e.g., benzodiazepines). Others may assume that someone is high

EXHIBIT 4.9. Addressing the Misconception That an Opioid Medication Is "Just Another Drug"

Concerned Colleague:	These patients are just replacing one drug with another. Instead of heroin, they're using buprenorphine or methadone.
Counselor:	Actually, there's substantial research that medication for opioid use disorder helps patients stop feeling withdrawal and craving and allows them to get their life back on track. These medications keep patients in treatment and reduce crime and HIV risk behavior.
Concerned Colleague:	Yeah, but aren't they still addicted?
Counselor:	Physically dependent, yes; but addicted, no. There's an important difference. Someone addicted to heroin has to take the drug several times a day to avoid withdrawal. This usually leads to craving, loss of control, and taking more than intended. Drug-seeking behavior causes loss of family and friends. It makes the person unable to perform daily roles and meet obligations.
Concerned Colleague:	Yes, I know how addiction works. But isn't taking methadone an addiction, too?
Counselor:	Patients only take methadone once a day, and its makeup is different from heroin. Daily methadone lets the body stabilize so patients don't have the highs and lows that come from heroin use. If patients use heroin, the methadone blocks its effects; they don't get high. Methadone is taken orally, so there isn't the same danger of infection that comes with injection drug use. Taking methadone as part of a treatment program lets patients feel normal and focus on changing the other aspects of their lives that led to drug use.
Concerned Colleague:	But you just said they take methadone every day.
Counselor:	Yes. That is true of most medications for any disease, if you think about it. Patients have a physical dependence on the medication but are in remission from addiction.

on a medication for OUD who isn't taking any such medication at all.

Point out that many thousands of people are prescribed medication for OUD every year, are receiving appropriate treatment, and are indistinguishable from other people. People taking OUD medication rely on it to maintain daily function, like people with diabetes rely on insulin. Nevertheless, some people think that individuals taking buprenorphine or methadone are still addicted to opioids (Exhibit 4.9), even if they don't use illicit drugs. For people with OUD, the medication addresses the compulsion and craving to use. It also blocks the euphoric effects of illicit opioids, which over time helps people stop attempting to use. For people with

EXHIBIT 4.10. When a Patient Wants To Taper Medication or Stop Altogether

- Review the decision with the patient to determine the motivation for tapering or quitting medication and the best timing for such a change.
- Tell the prescriber that the patient wants to taper; shared decision making should guide the patient's decision.
- Avoid encouraging tapering, which can imply that recovery can only truly occur off of the medication.

EXHIBIT 4.11. Responding to a Patient's Desire To Taper Medication for OUD

Patient:	I want to taper off the buprenorphine.
Counselor:	You'd like to taper—can you tell me why?
Patient:	I'm getting married. I want a fresh start.
Counselor:	You're saying you'd like to have this all behind you for the new phase in your life.
Patient:	Yeah, that's it.
Counselor:	Would it be alright if I share my concerns about that?
Patient:	Okay.
Counselor:	A big change—whether it's having a baby, getting a new job, or getting married like you're about to do—can be very exciting. But it can also be surprisingly stressful. You may want to consider staying on the medication during this transition to make sure you maintain your recovery. I'm just suggesting postponing a taper decision until you start getting settled into married life.
Patient:	I hear you. The last thing I want to do is mess up my marriage right away by using again.

> It would be inappropriate for a medical team to refuse radiation for cancer patients because the team believes chemotherapy is always needed, or to refuse chemotherapy because they believe that radiation is always needed, regardless of each patient's diagnosis and condition. It would be just as **inappropriate to refuse evidence-based treatment with medication for a patient with OUD, when that may be the most clinically appropriate course of treatment.**

diabetes, medication addresses the problems caused by inadequate production of insulin by the pancreas. Medication allows both populations to live life more fully.

Focus on common ground—all patients want a healthy recovery, and judging or isolating someone for return to use doesn't aid anyone's recovery. A divide may occur between patients in a group setting over return to opioid use. People in the OUD community typically are forgiving of return to opioid use and recognize that it can occur on the path to long-term recovery. However, some people in mutual-help communities judge those who return to use (see the "Helping Clients Find Accepting Mutual-Help Groups" section). Address judgmental attitudes through this analogy: People with diabetes whose blood sugar spikes aren't condemned and ejected from treatment.

Dispel the myth that OUD medications make people sick. In fact, methadone and buprenorphine relieve opioid withdrawal, even if patients don't feel complete relief in the first few days. Taking naltrexone too soon after opioid use can cause opioid withdrawal, but withdrawal symptoms can generally be managed successfully. Point out that people taking medication for OUD sometimes get colds, the flu, or other illnesses, like everyone else. A similar misconception is that OUD medications make all patients sleepy. Exhibit 4.12 offers a sample dialog for responding to this misconception.

EXHIBIT 4.12. Conversation: Redirecting a Concern to the Prescriber

Concerned Colleague:	A patient in my group was falling asleep. I think his methadone dose is too high.
Counselor:	That's an important observation. That certainly is possible, although there are many other possible explanations. What makes you think it's the medication and not lack of sleep or some other reason?
Concerned Colleague:	Because everyone taking methadone falls asleep in group.
Counselor:	Our medical staff members work hard to make sure that each patient is on the right dose. If a patient is falling asleep in group, you should alert the patient's physician right away, regardless of what medication they're taking. But I'm wondering if anything besides medication could be causing this issue.
Concerned Colleague:	Well, this patient is struggling with having an all-night job.
Counselor:	It may be helpful to talk to the patient about moving to a group that meets at a time when he can be more rested. In any case, to be safe, you should call the patient's prescriber about reassessing him.

When return to opioid use comes up in a group counseling setting, messages about getting back on track and avoiding shaming and blaming apply just as much to the patients taking OUD medication as to other participants. This topic is an opportunity to **address the dangers of overdose, especially the dangers of using an opioid after a period of abstinence or together with other CNS depressants.**

Helping Patients Advocate for Themselves

Educate clients so they can advocate for their treatment and personal needs. Key topics include:

- Addiction as a chronic disease influenced by genetics and environment.
- The ways that medications for OUD work.
- The process of dose stabilization.
- The benefits of longer term medication use and risks of abrupt treatment termination.
- The role of recovery supports (e.g., mutual-help groups) in helping achieve goals.

Offer clients' family and friends education on these topics as well so that they can advocate for their loved ones. Encourage patients to let family and friends know how important they are and how valuable their support is. Also urge patients to ask loved ones to help them express concerns or fears.

Role-playing can help patients self-advocate. It allows them to practice what to say, what reactions to expect, and ways to respond. Coach patients in active listening and in focusing on solutions rather than problems. Exhibit 4.13 gives an example of a counselor helping a client self-advocate.

Urge patients to advocate for themselves beyond one-on-one conversations. Options include sharing educational pamphlets, inviting loved ones to a counseling session, or referring them to websites.

Addressing Discrimination Against Clients Who Take OUD Medication

Patients can face discriminatory actions when dealing with individuals, organizations, or systems that make decisions based on mis-information about, or biases against, the use of medication for OUD. The following sections highlight issues patients taking OUD medication may face and how counselors can help.

EXHIBIT 4.13. Conversation: Helping a Client Self-Advocate

Patient:	My mom is driving me to my back surgery. I'm worried that she'll find out I'm taking buprenorphine.
Counselor:	It sounds like you're worried she'll reject you and be upset if she knows you're taking medication.
Patient:	I think she'll be disappointed in me. She thinks people who take addiction medication are still on drugs.
Counselor:	What would you think about finding a time before your surgery to tell your mother that you're taking buprenorphine? You can explain how it works and remind her how well you've been doing maintaining your job, regaining custody of your children, and living a balanced and healthy life. That may help ease her fears.
Patient:	Thanks. I'll give that a try.
Counselor:	If you want, you could invite her to one of our sessions so that I can answer any questions she has.
Patient:	Yeah, she may hear it better from you. I like the idea of having her come in after I've told her.
Counselor:	When would be a good time to bring up this topic?
Patient:	She's driving me to my pre-op appointment on Friday. Maybe I'll suggest we go for coffee after.
Counselor:	That's a good idea. How about we practice that conversation? I'll play the role of your mom.

Help clients address employment-related issues

Under the Americans With Disabilities Act, employers cannot discriminate against patients taking medication for OUD.[148] However, the law doesn't always stop employers from taking such action. For example, some employers conduct workplace urine drug testing, either before offering employment or randomly during employment. The OUD medication they test for most frequently is methadone, but it's possible to test for buprenorphine. Naltrexone is generally not tested for. The TIP expert panel concludes, based on multiple patient experiences, that patients who take OUD medication find it intimidating to explain to their employers why their urine test results are positive for opioids. Yet if they offer no explanation, they don't get the callback for the job or are let go from the job they have.

Direct patients to legal resources and help them consider how to respond to discrimination at work based on misinterpreted drug tests. Offer to speak with their prospective/current employers to address concerns and misperceptions about OUD medication and its effect on their ability to do work tasks.

RESOURCE ALERT

Becoming a Certified Medication-Assisted Treatment Advocate

The National Alliance for Medication Assisted Recovery has a training and credentialing program for interested people—not just those who receive medication for OUD—to become Certified Medication-Assisted Treatment Advocates (www.methadone.org/certification/faq.html).

Understand potential legal issues

This section describes issues that can affect access to care for patients involved in the justice system who take buprenorphine or methadone for OUD. These issues usually don't apply for naltrexone.

Many jails (short term) and prisons (long term) restrict or disallow access to OUD medication despite the federal mandate that people who are incarcerated have access to medical care.[149,150] For example:

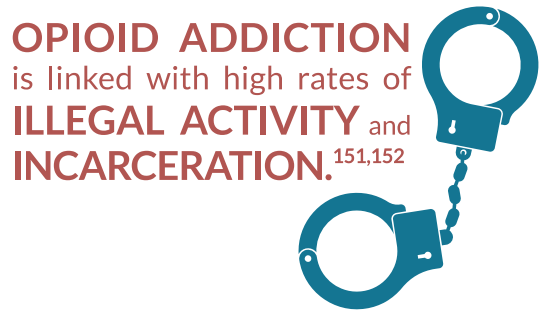
- A jail may not continue methadone treatment or allow methadone delivery by patients' OTPs.
- Patients' medication may be seized upon arrest.
- Jail health officials may deny patients' buprenorphine prescriptions.

Help negotiate patient access to OUD medication during incarceration. Negotiating access to OUD medication can be problematic and often requires multiple meetings between care providers and jail staff members to resolve successfully. Patients taking OUD medication may be forced to go without medication during incarceration. This increases their risk for opioid overdose if they return to use after reentering the community, given the decreased tolerance that results from interrupted treatment.

Encourage patients to reengage in treatment as soon as they're released. People with OUD released from prison or jail who don't take OUD medication have higher risk of overdose death during their first few weeks in the community. Early after release, they are at very high risk of overdose, given possible:

- Decrease in opioid tolerance while incarcerated.
- Lack of appropriate OUD therapy while incarcerated.
- OUD medication initiation right before release.
- Release without coordination or a slot for community-based treatment.

Patients who aren't opioid tolerant need a lower starting dose that prescribers will increase more slowly than usual. Extended-release injectable naltrexone can be an effective alternative for these patients.



Support patients in getting legal advice or counsel via their OUD medication prescribers' healthcare organization. Members of the TIP expert panel have observed situations in which law enforcement personnel arrested patients leaving methadone clinics and charged them with driving under the influence or arrested them after finding buprenorphine prescription bottles in their cars. Discussions among treatment organizations and local law enforcement leadership can help address such situations.

Address concerns and advocate for addiction specialists to select treatments best suited for each patient. Sometimes, authorities insist that patients enter a particular kind of treatment or follow particular rules related to their OUD. To ensure a patient-centered focus, help involve addiction specialists in determining what kind of treatment best meets patients' needs. This kind of advocacy works best when counselors and the programs for which they work have preexisting relationships with personnel in local employment, law enforcement, drug court, and child welfare facilities.

Address issues in dealing with healthcare providers

Misunderstandings about OUD and its treatment aren't rare among healthcare providers:

- Patients admitted to the hospital for medical issues may face prejudice from hospital staff members.
- Providers may not know how to manage patients' OUD medication during their hospital stay.
- Some providers don't know how to manage pain in someone taking medication for OUD.

Help communicate issues to patients' prescribers, who can advocate for proper handling of OUD medication. It is also possible to help hospital staff members see the patient as a whole person who deserves respect and to provide them with essential information about treatment for OUD.

Inpatient SUD treatment facilities may refuse admission until patients are off buprenorphine or methadone. Sometimes, patients taking OUD medication seek admission to inpatient facilities for treatment of an additional SUD, a mental disorder, or both. If a facility won't accept someone on OUD medication, call on local or state regulatory authorities (e.g., the State Opioid Treatment Authority) and patients' healthcare professionals to intervene with the facility's professional staff and management.

Demonstrate awareness of pregnancy and parenting issues

Healthcare professionals may be unaware of current guidelines for treating pregnant women with OUD (Exhibit 4.14). As a result, they may inappropriately:

- Deny OUD medication to pregnant women.
- Discourage breastfeeding by mothers taking OUD medication.
- Direct women who become pregnant while taking OUD medication to undergo withdrawal from their medication and attempt abstinence.

Hospital policies on screening infants for prenatal substance exposure vary considerably. A positive screen may trigger involvement of Child Protective Services. This may occur even when the positive screen results from treatment with OUD medication under a physician's care rather than opioid misuse.

Help pregnant and postnatal clients in these situations by:

- **Educating them** and encouraging them to share pertinent information and resources with healthcare professionals involved in their care.
- **Coordinating with their prescribers** to help them get prenatal and postnatal care from well-informed healthcare professionals.
- **Getting involved in efforts to educate the local healthcare community** about best practices for the care of pregnant and postnatal women with OUD.

Legal problems can arise if Child Protective Services or legal personnel don't understand that parents receiving OUD medication are fully capable of caring for children and contributing to their families. Judges, probation or parole officers, or Child Protective Services workers may inappropriately request that patients discontinue medication as a condition of family reunification. Such orders are medically inappropriate and should be challenged. Possible ways to help:

RESOURCE ALERT

Treatment of Pain in Patients With OUD

SAMHSA's TIP 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671)

RESOURCE ALERT

Pregnancy- and Parenting-Related Issues

SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (https://store.samhsa.gov/product/SMA18-5054)

EXHIBIT 4.14. Summary of Current Guidance for the Treatment of Pregnant Women With OUD

- An obstetrician and an addiction treatment provider should comanage care, and the woman should receive counseling and supportive services as needed to assist her in achieving a stable life.
- Treatment with methadone or buprenorphine without naloxone during pregnancy is recommended. Treatment with naltrexone is not recommended during pregnancy.
- Medically supervised withdrawal during pregnancy is typically not advisable. If not done with great care in a controlled setting, it can cause premature labor, fetal distress, and miscarriage. Attempts at abstinence from opioids without the support of medication are generally not advised because of the risk of return to opioid use, which can adversely affect both mother and fetus.
- Newborns of women who take OUD medication often show symptoms of NAS, which is treatable. NAS from opioid agonist treatment is not as harmful to the fetus as continued use of illicit opioids during pregnancy.
- Mothers stabilized on medication for OUD are encouraged to breastfeed.

Summarized from SAMHSA's publication *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders* (https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978).[153]

- **Write letters to judges and lawyers** explaining how effective OUD medication can be.
- **Send judges and lawyers literature** about current medical recommendations (including this TIP).
- **Testify in court,** if necessary.

Helping Clients Find Accepting Mutual-Help Groups

Voluntary participation in 12-Step groups can improve abstinence and recovery-related skills and behaviors for some people with SUDs. Greater involvement (e.g., being a 12-Step sponsor) can increase these benefits.[154,155,156,157] However, not much research has explored less widespread types of groups (e.g., groups that follow a given religion's principles, secular groups that downplay the spiritual aspects of 12-Step groups). Research exploring longitudinal outcomes for people with OUD who attend NA is limited, but findings link more frequent attendance with abstinence.[158,159,160]

Clients taking medication for OUD may face challenges in attending mutual-help groups. For example:

- NA, the most widely available program, treats illicit opioids and OUD medications equally in gauging abstinence and recovery. NA doesn't consider people taking OUD medication "clean and sober."[161]
- Local chapters of NA may decide not to allow people taking OUD medication to participate at meetings or may limit their participation (e.g., not allowing service work).
- Clients attending some NA meetings may encounter hostile attitudes toward the use of medication.
- AA's official policy is more accepting of the use of prescribed medication, but clients may still encounter negative attitudes toward their use of medications for OUD.
- Other groups, such as some religious mutual-help programs, SMART Recovery, and LifeRing Secular Recovery, also have policies that could challenge clients for taking medication for OUD.

RESOURCE ALERT

Addressing Bias and Discrimination

Are You in Recovery From Alcohol or Drug Problems? Know Your Rights: Rights for Individuals on Medication-Assisted Treatment: SAMHSA publication explaining patient rights and federal laws that protect people receiving OUD medication. Describes whom these laws protect and what they cover, including employment, housing, services, and public accommodations (http://store.samhsa.gov/product/Rights-for-Individuals-on-Medication-Assisted-Treatment/SMA09-4449)

Know Your Rights: Employment Discrimination Against People With Alcohol/Drug Histories: Legal Action Center webinar (http://lac.org/resources/substance-use-resources/employment-education-housing-resources/webinar-know-rights-employment-discrimination-people-alcoholdrug-histories)

Medication-Assisted Treatment for Opioid Addiction: Myths and Facts: Legal Action Center publication that dispels myths and provides facts about OUD medication (http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf)

Methadone Maintenance Myths and Resources: Missouri Department of Mental Health factsheet (http://dmh.mo.gov/docs/ada/methadonemyths.pdf)

Prepare clients who take medication for OUD to attend mutual-help meetings

Clients will be better able to find supportive mutual-help groups if their counselor and program:

- **Evaluate attitudes** toward medication for OUD among local mutual-help groups.
- **Keep on hand information** about all mutual-help options available in the clients' area.
- **Recruit volunteers from mutual-help groups** to help clients find and attend meetings (e.g., by providing transportation, serving as "sponsors," introducing clients).
- **Do not mandate meeting attendance.** Recommending participation is just as effective.[162]
- **Keep track of clients' experiences at different groups** to ensure that meetings remain welcoming.
- **Help clients start onsite mutual-help groups.**
- **Ask staff members to evaluate their own feelings and beliefs** about mutual-help groups.[163]

Facilitate positive mutual-help group experiences

- **Educate clients about mutual-help groups.** Explore group types, risks and benefits of participation, and limitations of research in support of those risks and benefits.
- **Suggest buddying up.** Clients can attend meetings with other people who take medication for OUD.
- **Review with clients their understanding of and prior experience with mutual help.**
- **Explore clients' understanding of the benefits and risks of disclosure** about taking OUD medication.
- **Develop a risk-reduction plan** for disclosure if clients want to share their use of OUD medication (e.g., talking with an individual group member instead of disclosing to the entire group).

- **Help clients anticipate and learn to handle negative responses:**
  - Develop sample scripts clients can use when questioned about their medication.
  - Role-play scenarios in which clients respond to questions about their use of medication.
- **Respect the privacy of clients' participation** in mutual-help groups and recognize that some groups ask that participants not discuss what occurs in meetings.
- **Make sure clients know they can talk about their experiences** in mutual-help groups but don't pressure them to disclose in these groups that they take OUD medication.
- **Consider mutual-help participation using groups more open to OUD medication** (e.g., attending AA even if the client has no alcohol use disorder; attending groups for co-occurring substance use and mental disorders, such as Dual Recovery Anonymous or Double Trouble in Recovery). Clients with OUD who attend AA and not NA have similar recovery-related outcomes and retention rates.[164]

RESOURCE ALERT

How To Use Technology-Based Tools in Behavioral Health Services

SAMHSA's TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services*, is available from the SAMHSA Store (https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924). In addition to discussing online mutual-help groups, this TIP can help counselors implement technology-assisted care for patients with OUD. It highlights the importance of using technology-based assessments and interventions and discusses how technology reduces barriers to treatment.

Online mutual-help groups

Before recommending an online group, check its content and tone on the use of medication. Mutual help using the Internet (either through real-time chat rooms or discussion boards where one posts and waits for responses) has been growing in popularity. This is an especially valuable resource for clients living in rural and remote areas. Groups range from general meetings for people with a particular SUD (e.g., online AA meetings) to those that are very specific (e.g., Moms on Methadone). Moderated groups are preferable to unmoderated groups. TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services*, addresses many of the pros and cons of online support groups.[165] Part 5 of this TIP gives links for several groups that the TIP expert panel has identified as helpful.

RESOURCE ALERT

Mutual Help for Clients With OUD

William White's *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States:* Publication that gives more information on the pros and cons of 12-Step groups for people receiving medication for OUD and how to prepare them for meetings[166] (http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf)

White, Galanter, Humphreys, and Kelly's "The Paucity of Attention to Narcotics Anonymous in Current Public, Professional, and Policy Responses to Rising Opioid Addiction": Peer-reviewed journal article on the benefits of NA and the need to include it among the options offered to people receiving medication for OUD[167] (www.tandfonline.com/doi/abs/10.1080/07347324.2016.1217712)

Mutual-help groups specific to OTPs

Although these meetings occur mostly on the premises of OTPs, it may be possible to use the models developed by OTPs in more general SUD treatment settings. Because they serve only patients receiving medication to treat OUD, OTPs can create and sustain onsite mutual-help groups specific to this population. Such groups include Methadone Anonymous (MA),[168] other variations on a 12-Step model,[169,170] and the mutual-help component of Medication-Assisted Recovery Services (MARS). MARS is a recovery community organization, not just a mutual-help program. MARS members design, implement, and evaluate a variety of peer-delivered recovery support services in addition to providing meetings. More information on these programs is in the articles cited and online resources presented in Part 5.

Facilitating Groups That Include Patients Taking OUD Medication

Foster acceptance via attitude and behavior when facilitating groups that include patients taking OUD medication:

- **Establish ground rules** about being respectful, avoiding negative comments about group members, and keeping statements made in the group confidential—as with any group.
- **Be proactive.** State up front that ground rules apply to everyone, regardless of a given person's decisions about whether to include OUD medication in his or her path to recovery.
- **Ask members to discuss how to address any negative comments,** should they occur. This is especially important for mixed groups.
- **Ask group members to affirm that they will abide by the rules.**
- **Provide consistent reminders** throughout each session about the ground rules.

Group members may still make negative comments about medication for OUD. Avoid feeding the negativity with attention, which can worsen the situation. **Reframe negative comments to express underlying motivations, often based on fear or misunderstanding.** Remain positive; model expected behavior, which can benefit the person who made the negative remark (Exhibit 4.15).

Additional tips for leading mixed groups include the following:

- **Treat patients taking OUD medication the same as other patients in the group.** Patients taking medication can participate in and benefit from individual and group counseling just like other patients. There is no need to have separate counseling tracks

EXHIBIT 4.15. Redirecting Negative Comments

Petra:	How can you say Joni is in recovery when she's still taking a drug every day? I struggled every day and never took anything for 10 years.
Counselor:	I hear your concern for Joni. You want her recovery to follow the same path you took in yours.
Petra:	Right! And she's taking methadone, which is an opioid. People use opioids to get high.
Counselor:	In this treatment program, we see addiction as a brain disease. Methadone treats the brain disease part of addiction. It stabilizes the brain and allows the person to focus on learning new ways of thinking and reacting. It works by blocking the effects of other opioids. Patients on a proper dose can't get high even if they try to use. This helps discourage future drug use. Joni, would you like to add anything?
Joni:	Petra, it's great that you stopped using opioids and stayed in recovery without medication—but everyone has a different path to recovery. For me, medication helps me hold a job, take care of my kids, stay focused in my counseling sessions, and feel normal.

based on OUD medication status, nor should that status limit a participant's responsibilities, leadership role, or level of participation.

- **Meet with patients taking OUD medication in advance to prepare them for mixed-group settings.** Advise them that they don't have to disclose their medication status to the group, just as they don't have to disclose any other health issues. Counsel them that if they choose to talk about their medication status, it helps to talk about how medication has helped shape their personal recovery.
- **Don't single out patients taking OUD medication.** Let participants decide whether to tell the group about any issue they want to share, including medication status. If a patient chooses to disclose that status, follow up after the session to ensure that he or she is in a positive space and feels supported.
- **Keep the session's focus on the topic and not on the pros and cons of medication for OUD.** If the person receiving medication for OUD or other group members have specific questions about such medications, have them ask their healthcare professionals.
- **Reinforce messages of acceptance.** During the wrap-up discussion at the end of a session, members may comment on points that stood out for them. This is a chance to restate information accurately and model respect for each patient's road to recovery, whether it includes OUD medication or not.
- **Review confidentiality rules.** Affirm that patients' OUD medication status will not be shared with other group members. Remind participants to think carefully before sharing personal details such as their medication status with the group, because other participants may not respect confidentiality even if they have agreed to do so as part of the group guidelines.

Other Common Counseling Concerns

Patients must sign releases to permit ongoing conversations between care providers in accordance with federal regulations on confidentiality of medical records for patients in treatment for an SUD (42 CFR Part 2). When patients' primary care providers, prescribers of medication for OUD, and addiction-specific counselors don't work for the same entity, patients must consent for them to share information.

It can be challenging when a patient refuses to consent to collaborative communication among his or her healthcare team members. In these cases, the professionals involved must decide whether they will continue to provide either medication or counseling services without permission to collaborate. In other words, is cross-communication among all providers required for collaborative care? The answer to this complicated question depends on each patient's circumstances.

> **The TIP expert panel recommends communication among providers as the standard of care for OUD treatment and recovery support.** Carefully consider deviations from this standard, which should occur only rarely. That said, individualize decisions about collaborative communication among providers to each patient's unique preferences, needs, and circumstances.

Patients may not consent to communication among providers if they:

- **Have experienced discrimination in health-care systems.**
- **Have developed OUD after taking opioid pain medication.**
- **Have legitimate cause not to trust providers** (e.g., perceiving themselves as having been abused by a healthcare professional).[171]
- **Are not ready to make primary care providers aware of their disorder,** even (or especially) if those providers have been prescribing opioid pain medication.
- **Encounter problems in making progress toward recovery.** After typically consenting to communication among providers, a patient's sudden revocation may signal trouble in recovery.

Exhibit 4.16 lists common collaborative care issues and responses counselors can consider. Suggested responses assume that patients have consented to open exchange of information among all providers.

EXHIBIT 4.16. Common Collaborative Care Issues and Possible Counselor Responses

POTENTIAL MEDICATION-RELATED ISSUE	COUNSELOR RESPONSE
The patient complains of continued cravings.	Talk with the patient about his or her medication adherence. Review with the patient strategies for overcoming cravings using a CBT model. Communicate with the prescriber to see whether dosage can be adjusted to subdue the cravings.
A patient taking methadone does not appear engaged in counseling sessions and seems drowsy during conversations.	Ask the patient whether drowsiness is caused by lack of sleep, disturbed sleep, substance use, or overmedication. Consider obtaining a spot urine test (if available). In all cases of drowsiness, alert the prescriber immediately so that the cause can be determined. This is particularly important during the first few weeks of treatment.
The patient is at risk for return to opioid use.	Inform the prescriber if the patient appears at risk for return to use given cravings, life stressors, changes in social circumstances, new triggers, or the like. This alerts the prescriber to monitor the patient more closely and consider medication changes to reduce likelihood of return to use.
The patient has recently returned to opioid misuse after a period of abstinence.	Gather details about circumstances surrounding the incident of use and, in collaboration with the prescriber and the patient, adjust the treatment plan accordingly. Reinforce the patient's understanding of the increased risk of opioid overdose given altered levels of tolerance.

Continued on next page

EXHIBIT 4.16. Common Collaborative Care Issues and Possible Counselor Responses (continued)

POTENTIAL MEDICATION-RELATED ISSUE	COUNSELOR RESPONSE
The patient is discussing chronic pain with the counselor.	Direct the patient to a healthcare professional for assessment of pain and medical treatment as necessary. If indicated as appropriate by a healthcare professional, provide CBT for dealing with pain or instruct the patient in adjunct methods for pain relief (e.g., meditation, exercise, physical therapy).
The patient is asking the counselor for medical advice on what dose to take, side effects, how long to stay on the medication, and the like.	Answer questions based on your knowledge of medications for treatment of OUD but don't provide medical advice. Refer the patient to the prescriber for that. As appropriate, contact the prescriber with the patient to have a three-way discussion.
The counselor or patient is concerned that the prescriber is not giving quality care.	As appropriate, advocate for the patient with the prescribing medical team.
The patient discloses use of other drugs.	Use motivational interviewing techniques to have a collaborative conversation about the details of this drug use. For example, give a response like "Tell me more about this," followed by questions about the specific drugs used, why they were used, and what the patient's thoughts are about changing that drug use.
The patient discloses that she is pregnant.	Advise the patient to contact her prescriber immediately no matter what medication she is taking. Work with her to help her get access to prenatal care (if she doesn't have it already) and other health services related to pregnancy as needed.
The patient has a positive urine screen.	Using motivational interviewing tools, discuss with the patient the context of the substance use and what implications this use may have for the treatment plan. If the patient denies the substance use, reconsider the patient's readiness to change and how it affects the treatment plan.

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TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Part 5: Resources Related to Medications for Opioid Use Disorder

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

Part 5 of this **Treatment Improvement Protocol (TIP)** provides a collection of resources by audience and a glossary of key terms to help readers better understand how Food and Drug Administration (FDA)-approved medications can be used to treat opioid use disorder (OUD).

TIP Navigation

KEY MESSAGES

- Practice guidelines and decision-making tools can help healthcare professionals with OUD screening, assessment, diagnosis, treatment planning, and referral.
- Patient- and family-oriented resources provide information about opioid addiction in general; the role of medication, behavioral and supportive services, and mutual-help groups in the treatment of OUD; how-tos for identifying recovery support services; and how-tos for locating medical and behavioral health service providers who specialize in treating OUD or other substance use disorders (SUDs).

SAMHSA
Substance Abuse and Mental Health Services Administration

PART 5: RESOURCES RELATED TO MEDICATIONS FOR OPIOID USE DISORDER

PART 5 of 5

Resources Related to Medications for Opioid Use Disorder

There are numerous resources to help healthcare professionals and behavioral health service providers better understand the use of FDA-approved medications for OUD. Many other resources are available to help patients, their families and friends, and the general public better understand OUD and the medications available to treat it and support recovery from it. Part 5 of this TIP provides an audience-segmented collection of resources and a glossary of key terms related to OUD. It is of use to all interested readers.

General Resources

Facts and Figures

American Association for the Treatment of Opioid Dependence (AATOD), Frequently Asked Questions (www.aatod.org/resources/frequently-asked-questions).

Centers for Disease Control and Prevention (CDC), Smoking & Tobacco Use (www.cdc.gov/tobacco/index.htm).

Legal Action Center (LAC), Medication-Assisted Treatment for Opioid Addiction: Myths and Facts (http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf).

Missouri Department of Mental Health, Methadone Maintenance Myths and Resources (https://dmh.mo.gov/docs/ada/methadonemyths.pdf).

National Institute on Drug Abuse (NIDA) (www.drugabuse.gov):

- Addiction Science (www.drugabuse.gov/related-topics/addiction-science). Provides two short videos that explain the nature of addiction. These are useful in educating people in primary care who suffer from addiction. This site has links to publications for professionals that explain the nature of addiction.
- NIDAMED, Medical and Health Professionals (www.drugabuse.gov/nidamed-medical-health-professionals). Disseminates science-based resources to healthcare professionals on the causes and consequences of drug use and addiction and advances in pain management.

Office of National Drug Control Policy, Medication-Assisted Treatment for Opioid Addiction (https://online.ndbh.com/docs/providers/SubstanceUseCenter/Medication-Assisted-Treatment-Edited.pdf): Offers a factsheet with a useful summary of pharmacotherapy for OUD and its effectiveness.

Partnership for Drug-Free Kids, Commentary: Countering the Myths About Methadone (www.drugfree.org/news-service/commentary-countering-the-myths-about-methadone).

Substance Abuse and Mental Health Services Administration (SAMHSA):

- Addiction Technology Transfer Center **(ATTC)** (http://attcnetwork.org/home). Network with 10 regional centers across the country that provide training and information on evidence-based practices to practitioners. The ATTC website's section on OUD medication has many resources for clinicians, patients, and family members (www.attcnetwork.org/explore/priorityareas/wfd/mat/mat.pubs.asp).
- State Opioid Treatment Authorities (SOTAs) (https://dpt2.samhsa.gov/regulations/smalist.aspx).

United States Surgeon General's Report, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (https://addiction.surgeongeneral.gov).

Groups and Organizations

AATOD (www.aatod.org): Works with federal and state agencies on opioid treatment policy throughout the United States. Convenes conferences every 18 months on evidence-based clinical practice, current research, and organizational developments related to OUD treatment. AATOD develops publications that serve as resources for addiction counselors and peer support providers.

American Academy of Addiction Psychiatry (AAAP) (www.aaap.org): Offers education and training materials on addiction psychiatry (e.g., webinars, continuing medical education courses).

American Society of Addiction Medicine (ASAM) (www.asam.org): Provides medical education and resources on the treatment of SUDs, including OUD.

LAC (https://lac.org): Offers information about the rights of people with criminal records, HIV/AIDS, and SUDs.

Medical Assisted Treatment of America (www.medicalassistedtreatment.org): Raises awareness and understanding of substance misuse, the problems it creates, and ways to address these problems.

National Alliance for Medication Assisted Recovery (NAMA Recovery) (www.methadone.org): Supports quality opioid agonist treatment through its many U.S. chapters and its international network of affiliate chapters. Thousands of methadone clients and healthcare professionals belong to the organization.

National Alliance of Advocates for Buprenorphine Treatment (www.naabt.org): Aims to educate the public about opioid addiction and buprenorphine as a treatment option, to reduce prejudice and discrimination against clients who have SUDs, and to connect clients in need to qualified treatment providers.

SAMHSA (www.samhsa.gov):

- Buprenorphine Practitioner Verification for Pharmacists (www.samhsa.gov/bupe/lookup-form)
- National Recovery Month (https://recoverymonth.gov)
- Opioid Treatment Program (OTP) Directory (https://dpt2.samhsa.gov/treatment)
- SOTAs (https://dpt2.samhsa.gov/regulations/smalist.aspx)

SAMHSA Publications

All publications listed in this section are available for free from SAMHSA's publications ordering webpage (https://store.samhsa.gov) or by calling 1-877-SAMHSA-7 (1-877-726-4727):

- TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992)
- TIP 54: *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671)
- TIP 57: *Trauma-Informed Care in Behavioral Health Services* (https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816)
- *Advisory:* An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence (https://store.samhsa.gov/product/An-Introduction-to-Extended-Release-Injectable-Naltrexone-for-the-Treatment-of-People-with-Opioid-Dependence/SMA12-4682)
- *Advisory:* Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update (https://store.samhsa.gov/product/Advisory-Sublingual-and-Transmucosal-Buprenorphine-for-Opioid-Use-Disorder-Review-and-Update/SMA16-4938)
- *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/All-New-Products/SMA18-5054)
- *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorders: A Brief Guide* (https://store.samhsa.gov/shin/content//SMA14-4892/SMA14-4892.pdf)
- *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders* (https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978)
- *Decisions in Recovery: Treatment for Opioid Use Disorders, Handbook* (https://store.samhsa.gov/product/SMA16-4993)
- Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit (https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367)
- Technical Assistance Publication 32: *Clinical Drug Testing in Primary Care* (https://store.samhsa.gov/shin/content//SMA12-4668/SMA12-4668.pdf)
- *What Are Peer Recovery Support Services?* (https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf)

General Information

Agency for Healthcare Research and Quality:

- *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings* (www.ncbi.nlm.nih.gov/books/NBK402352)
- Academy for Integrating Behavioral Health and Primary Care (https://integrationacademy.ahrq.gov)

American Academy of Family Physicians:

- Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper) (www.aafp.org/about/policies/all/pain-management-opioid.html)
- Pain Management and Opioid Use Resources (www.aafp.org/patient-care/public-health/pain-opioids/resources.html)

ATTC Network (http://attcnetwork.org/home): This nationwide network of SAMHSA-sponsored regional centers is a multidisciplinary resource for professionals in the addiction treatment and recovery services fields. The network has many valuable resources and projects of interest to people involved in treating SUDs. Of particular interest to readers of this TIP are the training programs produced as part of the NIDA/SAMHSA-ATTC Blending Initiative:

- Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals (www.attcnetwork.org/projects/buptx.aspx)
- Buprenorphine Treatment for Young Adults (www.attcnetwork.org/projects/bupyoung.aspx)
- Prescription Opioid Addiction Treatment Study (POATS) (www.attcnetwork.org/projects/poats.aspx)

BupPractice.com Federal Recordkeeping Requirements for Buprenorphine Treatment (www.buppractice.com/node/12246): Provides information about federal recordkeeping requirements.

CDC Smoking & Tobacco Use (www.cdc.gov/tobacco/index.htm): Includes resource links for clinicians on smoking and the treatment of tobacco use.

Centers for Medicare & Medicaid Services (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html): Gives guidance on the delivery of telehealth.

Department of Health and Human Services (HHS):

- Centers for Medicare & Medicaid Services Clinical Laboratory Improvement Amendments Application for Certification (www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms116.pdf)
- Medication Assisted Treatment for Opioid Use Disorders: Final Rule (www.federalregister.gov/documents/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders)

Drug Enforcement Administration (DEA):

- DEA Requirements for DATA Waived Physicians (www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm). Lists DEA requirements for Drug Addiction Treatment Act of 2000 (DATA 2000)-waivered healthcare professionals.
- Form DEA-106, Report of Theft or Loss of Controlled Substances (https://apps.deadiversion.usdoj.gov/webforms/dtlLogin.jsp). Provides instructions for completing form DEA-106, which must be filed when stored buprenorphine is lost or stolen.
- *Practitioner's Manual* (www.deadiversion.usdoj.gov/pubs/manuals/pract). Provides guidance on how to comply with federal requirements on recordkeeping for ordering, storing, and dispensing buprenorphine in the office. This manual is from the DEA's Office of Diversion Control.

Drugs.com:

- Buprenorphine Drug Interactions (www.drugs.com/drug-interactions/buprenorphine-index.html?filter=3&generic_only=)
- Drug Interactions Checker (www.drugs.com/drug_interactions.php)

FDA:

- Approved Risk Evaluation and Mitigation Strategy (REMS): Buprenorphine Transmucosal Products for Opioid Dependence (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=9)
- REMS: Probuphine (buprenorphine hydrochloride) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=356)
- REMS: Sublocade (extended-release injectable buprenorphine) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=376)
- REMS: Suboxone/Subutex (buprenorphine and naloxone/buprenorphine) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=352)
- REMS: Vivitrol (extended-release naltrexone [XR-NTX]) (www.vivitrolrems.com)

LAC (https://lac.org): LAC attorneys provide legal advice by phone to service providers and government agencies. They assist dozens of agencies annually with questions about confidentiality of treatment records, discrimination, and other issues. LAC's confidentiality hotline provides information about the federal law protecting the confidentiality of drug and alcohol treatment and prevention records (42 CFR Part 2). The hotline is free to New York treatment providers and government agencies. Outside New York, the hotline is accessible if the state alcohol/drug oversight agency subscribes to LAC's Actionline service. To speak with a hotline attorney, call LAC Monday through Friday 1–5 p.m. (Eastern Time Zone) at 1-212-243-1313, or toll-free at 1-800-223-4044.

National Alliance of Advocates for Buprenorphine Treatment 30–100 Patient Limit (www.naabt.org/30_patient_limit.cfm): Summarizes the DATA 2000 law.

National Association of State Controlled Substances Authorities State Profiles (www.nascsa.org/stateprofiles.htm): Contains a directory of each state's prescription drug monitoring program (PDMP).

National Conference of State Legislatures Drug Overdose Immunity and Good Samaritan Laws (www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx): Provides information about naloxone and Good Samaritan immunity.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Professional Education Materials (www.niaaa.nih.gov/publications/clinical-guides-and-manuals): Provides professional education materials; offers links to screening, treatment planning, and general information for clinicians in outpatient programs.

National Library of Medicine's DailyMed:

- FDA label information for methadone (https://dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=all&query=METHADONE)
- FDA label information for naltrexone (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd11c435-b0f0-4bb9-ae78-60f101f3703f)

NIDA:

- Available Treatments for Marijuana Use Disorders (www.drugabuse.gov/publications/research-reports/marijuana/available-treatments-marijuana-use-disorders). Provides information about treatment options for individuals with marijuana use disorder.
- Opioid Overdose Reversal With Naloxone (Narcan, Evzio) (www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio). Contains naloxone information for providers.

- NIDAMED, Medical and Health Professionals (www.drugabuse.gov/nidamed-medical-health-professionals). Provides practice-related and professional education-related resources.
- Medications To Treat Opioid Addiction (www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview). Provides an overview of the need for and efficacy of OUD medications and discusses common misconceptions, impacts on outcome, and use of OUD medications with certain specific populations.
- *Effective Treatments for Opioid Addiction* (https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction).
- Therapeutic Communities (www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-are-therapeutic-communities). Gives a brief overview of OUD medications and links to additional information.
- *Principles of Drug Addiction Treatment: A Research-Based Guide* (www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface). Discusses how OUD affects the brain and covers the state of addiction treatment in the United States, principles of effective treatment, frequently asked questions about OUD medication, evidence-based approaches to treatment, and additional resources.
- *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide* (www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction). Discusses principles of SUDs in adolescents, addresses frequently asked questions, summarizes treatment settings and evidence-based treatment approaches, and provides treatment referral resources.
- *Treating Opioid Use Disorder During Pregnancy* (www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy). Addresses the risks of OUD to the pregnant woman and the fetus, briefly summarizes OUD pharmacotherapies for use during pregnancy, and provides links to additional information.

North American Syringe Exchange Program (https://nasen.org/directory): Provides a national directory of syringe exchange programs in the United States.

Prescription Drug Abuse Policy System's Naloxone Overdose Prevention Laws (http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139): Provides a map with a link to each state's naloxone overdose prevention laws, including policies on prescribing, dispensing, and civil and criminal immunity.

Project Lazarus's Naloxone: The Overdose Antidote (www.projectlazarus.org/naloxone): Provides guidance on administering naloxone.

Providers' Clinical Support System's (PCSS's) How To Prepare for a Visit From the Drug Enforcement Agency Regarding Buprenorphine Prescribing (http://pcssmat.org/wp-content/uploads/2014/02/FINAL-How-to-Prepare-for-a-DEA-Inspection.pdf): Provides a description of the DEA inspection process and how to comply with its requirements.

SAMHSA:

- Dear Colleague Letters for Medication-Assisted Treatment Providers (www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/dear-colleague-letters). Offers regular communications to the opioid treatment community regarding clinical and regulatory issues related to opioid treatment. Regulations, policies, and best practices for OTPs and office-based

opioid treatment (OBOT) clinics can change, and Dear Colleague Letters help providers stay up to date.

- Understanding the Final Rule for a Patient Limit of 275 (www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/understanding-patient-limit275.pdf). Provides information about the final rule and how to use it to increase patient access to medication for OUD and associated reporting requirements.
- Buprenorphine Waiver Management (www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management). Provides information on the buprenorphine waiver, including links to the buprenorphine waiver application and an explanation of the processes, requirements, and recordkeeping strategies associated with prescribing buprenorphine.
- Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver (www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers). Provides information for NPs and PAs about the buprenorphine waiver training, with links to trainings and the application process.
- Buprenorphine Training for Physicians (www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training). Offers links to organizations that provide buprenorphine training for physicians.
- *SAMHSA Opioid Overdose Prevention Toolkit* (https://store.samhsa.gov/product/SAMHSA-Opioid-Overdose-Prevention-Toolkit/SMA16-4742). Prepares healthcare professionals, communities, and local governments with material to develop practices and policies to help prevent opioid-related overdoses and deaths. It addresses issues for healthcare professionals, first responders, treatment providers, and those recovering from opioid overdose.
- *Federal Guidelines for Opioid Treatment Programs* (https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP). Provides updated guidelines for how OTPs can satisfy the federal regulations.
- Form SMA-168 Opioid Treatment Exception Request (www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/submit-exception-request). Provides instructions for physicians on how to request exceptions to federal standards for opioid treatment.
- Laws and Regulations (www.samhsa.gov/about-us/who-we-are/laws-regulations). Provides an overview and summary of the most frequent questions about disclosure and patient records pertaining to substance use treatment that federal programs maintain.
- *Substance Abuse in Brief Fact Sheet:* Introduction to Mutual-Support Groups for Alcohol and Drug Abuse (https://store.samhsa.gov/shin/content/SMA08-4336/SMA08-4336.pdf). Provides information to help medical and behavioral health service providers understand mutual-help groups and how to make referrals to such groups.
- SAMHSA has developed several resources to guide healthcare professionals in their use of telehealth and telemedicine approaches for OUD:
  - *In Brief:* Rural Behavioral Health: Telehealth Challenges and Opportunities (https://store.samhsa.gov/shin/content/SMA16-4989/SMA16-4989.pdf)
  - Certified Community Behavioral Health Clinics (CCBHCs) Using Telehealth or Telemedicine (www.samhsa.gov/section-223/care-coordination/telehealth-telemedicine)

Practice Guidelines and Decision-Support Tools

ASAM:

- *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (http://download.lww.com/wolterskluwer_vitalstream_com/PermaLink/JAM/A/JAM_11_3_2017_06_02_SAFARIAN_JAM-D-17-00020_SDC1.pdf). Details the ASAM consensus statement on drug testing in addiction treatment.
- The ASAM Criteria (www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Provides criteria and a comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions.
- *The ASAM National Practice Guidelines: For the Use of Medication in the Treatment of Addiction Involving Opioid Use* (www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf). Provides information on prescribing methadone, buprenorphine, naltrexone, and naloxone. The document also discusses the needs of special populations, including women during pregnancy, patients with chronic pain, adolescents, individuals in the criminal justice system, and patients with co-occurring psychiatric conditions.

CDC:

- CDC Guideline for Prescribing Opioids for Chronic Pain (www.cdc.gov/drugoverdose/prescribing/guideline.html).
- Guideline Resources: Clinical Tools (www.cdc.gov/drugoverdose/prescribing/clinical-tools.html). Provides links and tools to help clinicians prevent opioid overdose deaths.

Credible Meds (www.crediblemeds.org): Maintains a list of medications that may increase QTc intervals. Free registration is required to access the most up-to-date list.

HHS:

- BeTobaccoFree.gov News and Resources (https://betobaccofree.hhs.gov/quit-now/index.html#professionals). Offers links for clinicians that provide guidance on the care for patients with nicotine addiction. The Resources section is at the bottom of the page linked here.
- BeTobaccoFree.gov Nicotine Addiction and Your Health (https://betobaccofree.hhs.gov/health-effects/nicotine-health). Provides information on nicotine addiction and its health effects.

Institute for Research, Evaluation, and Training in Addictions' Management of Benzodiazepines in Medication-Assisted Treatment (http://ireta.org/wp-content/uploads/2014/12/BP_Guidelines_for_Benzodiazepines.pdf): Provides information on managing benzodiazepine use in patients taking medications for OUD.

PCSS for Medication Assisted Treatment (https://pcssmat.org): Provides buprenorphine waiver training for clinicians (physicians, NPs, and PAs).

PCSS Mentoring Program (https://pcssmat.org/mentoring): Gives providers guidance on prescribing OUD medications. This national network of experienced providers is available at no cost. Mentors provide support by telephone, email, or in person if possible.

PCSS Models of Buprenorphine Induction (http://pcssmat.org/wp-content/uploads/2015/02/Buprenorphine-Induction-Online-Module.pdf): Provides information about various buprenorphine induction approaches including in-office, non-OTP, and at-home dosing.

Prescribe To Prevent (http://prescribetoprevent.org): Provides information about naloxone prescribing for overdose prevention, including educational patient handouts and videos.

SAMHSA:

- MATx Mobile App To Support Medication-Assisted Treatment of Opioid Use Disorder (https://store.samhsa.gov/apps/mat). Provides information on FDA-approved treatment approaches and medications used to treat OUD. It includes a buprenorphine prescribing guide with information on the DATA 2000 waiver process and patient limits. Clinical support tools (e.g., treatment guidelines; *International Classification of Diseases,* 10th Edition, coding; guidance on working with special populations), help lines, and SAMHSA's treatment locators are also included.
- *Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder* (https://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf).
- Buprenorphine (www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine).
- Naltrexone (www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone).
- Decisions in Recovery: Treatment for Opioid Use Disorder (https://media.samhsa.gov/MAT-Decisions-in-Recovery). Provides information on shared decision making in pharmacotherapy for OUD.
- Decisions in Recovery: Treatment for Opioid Use Disorder, Planning for Success (https://media.samhsa.gov/MAT-Decisions-in-Recovery/section/how/planning_for_success.aspx). Provides assistance in developing a recovery plan.
- Bringing Recovery Supports to Scale Technical Assistance Center Strategy (www.samhsa.gov/brss-tacs) and Shared Decision-Making Tools (www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making). Offers training and technical assistance on many topics related to medication for OUD, including recovery-oriented systems of care, mutual-support groups, capacity building, leadership by people in recovery and family members, certification requirements for peer specialists and mutual-support group coaches, and core competencies for recovery-oriented behavioral health workers.
- *Pharmacologic Guidelines for Treating Individuals With Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders* (https://store.samhsa.gov/shin/content/SMA12-4688/SMA12-4688.pdf).
- *General Principles for the Use of Pharmacological Agents To Treat Individuals With Co-Occurring Mental and Substance Use Disorders* (https://store.samhsa.gov/shin/content/SMA12-4689/SMA12-4689.pdf).

Veterans Administration (VA)/Department of Defense (DoD) *Clinical Practice Guideline for the Management of Substance Use Disorders* (www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf): Provides information on screening, assessment, and treatment of OUD as well as other SUDs. It is primarily for VA and DoD healthcare providers and others involved in the care of service members or veterans with an SUD.

Assessment Scales and Screening Tools

AAAP, Education & Training (www.aaap.org/education-training/cme-opportunities): Provides Performance-in-Practice Clinical Modules for alcohol use disorder and tobacco use disorder.

American Psychiatric Nurses Association, Tobacco & Nicotine Use Screening Tools & Assessments (www.apna.org/i4a/pages/index.cfm?pageID=6150): Provides the Fagerström screening tools for nicotine dependence and smokeless tobacco and a screening checklist for adolescent tobacco use.

ASAM *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (www.asam.org/quality-practice/guidelines-and-consensus-documents/drug-testing): Gives information on the appropriate use of drug testing in identifying, diagnosing, and treating people with or at risk for SUDs.

Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms (www.ncpoep.org/wp-content/uploads/2015/02/Appendix_7_Clinical_Institute_Narcotic_Assessment_CINA_Scale_for_Withdrawal_Symptoms.pdf).

NIDA, Screening, Assessment, and Drug Testing Resources (www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/additional-screening-resources): Gives resources such as an evidence-based screening tool chart for adolescents and adults and drug use screening tool supports; also has a clinician resource and quick reference guide for drug screening in general medical settings.

World Health Organization *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (www.ncbi.nlm.nih.gov/books/NBK143183): Includes links to the Clinical Opiate Withdrawal Scale (www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf) and other opioid withdrawal scales from Annex 10 of the guidelines.

Resources for Counselors and Peer Providers

Organizations

Community Care Behavioral Health Organization (www.ccbh.com): A provider network focused on recovery that has published *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance* (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/MethadoneBestPracticeGuideline.pdf), a set of recovery-oriented practice implementation guidelines for methadone programs.

Faces & Voices of Recovery (https://facesandvoicesofrecovery.org): Dedicated to organizing and mobilizing the millions of Americans in recovery from addiction to alcohol and drugs, their families and friends, and other allies into recovery community organizations and networks. Faces & Voices of Recovery promotes the right resources to recover through advocacy, education, and demonstration of the power and proof of long-term recovery.

International Association of Peer Supporters (https://inaops.org): An organization for mental health and addiction peer recovery support specialists, recovery coaches, recovery educators and trainers, administrators of consumer-operated or peer-run organizations, and others.

Medication-Assisted Recovery Services (MARS) Project (www.marsproject.org): A peer-initiated, peer-based recovery support project sponsored by NAMA Recovery that offers, among other resources, an educational video about the MARS peer support program and an online network for MARS peer support personnel:

- MARS Project Video (www.marsproject.org).
- New York State Peer Recovery Network, Peers Organizing for Results Through Advocacy and Leadership (PORTAL) (http://advocacy.marsproject.org). Created to help peers in recovery more effectively organize their communities, communicate with each other, and create a stronger voice for advocacy efforts.

Pillars of Peer Support Services (www.pillarsofpeersupport.org): Develops and fosters the use of Medicaid funding to support peer recovery services in state mental health systems of care.

Recovery Community Services Program—Statewide Network (www.samhsa.gov/grants/grant-announcements/ti-14-001): A SAMHSA grant program for peer-to-peer recovery support services that help people initiate and sustain recovery from SUDs.

Publications and Other Resources

ATTC's Recovery-Oriented Methadone Maintenance (www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph_RM_Methadone.pdf): This guide is the most thorough document on this topic currently available and is applicable to clients receiving other medications for OUD.

Community Care Behavioral Health Organization: These publications outline phase-specific tasks and accompanying strategies for programs that serve clients who take methadone or buprenorphine:

- *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance* (www.williamwhitepapers.com/pr/Recovery-oriented%20Methadone%20Maintenance%20Best%20Practice%20Guidelines%202014%20-%20CCBHO.pdf)
- *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Buprenorphine and Suboxone* (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/Community_Care_BP_Guidelines_for_Buprenorphine_and_Suboxone.pdf)

Narcotics Anonymous (NA) (www.na.org): The organization's most recent statement on medications for treating OUD—*Narcotics Anonymous and Persons Receiving Medication-Assisted Treatment*—is available online (www.na.org/admin/include/spaw2/uploads/pdf/pr/2306_NA_PRMAT_1021.pdf).

SAMHSA (https://store.samhsa.gov): This agency oversees medications to treat opioid addiction, including methadone, buprenorphine, and naltrexone; sets regulations; guides policy; and offers information and resources for the field. SAMHSA has many recovery-oriented publications for providers:

- *Dear Colleague Letters for Medication-Assisted Treatment Providers* (www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/dear-colleague-letters). Regulations, policies, and best practices for OTPs can change; these regular communications help providers stay up to date on clinical and regulatory issues related to opioid treatment.
- *Medication-Assisted Recovery: Medication Assisted Peer Recovery Support Services Meeting Report* (www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2015-prss-summary-report.pdf).
- *Financing Recovery Support Services: Review and Analysis of Funding Recovery Support Services and Policy Recommendations* (www.samhsa.gov/sites/default/files/partnersforrecovery/docs/RSS_financing_report.pdf).
- SAMHSA's *Working Definition of Recovery* (https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf).
- *Access to Recovery Approaches to Recovery-Oriented Systems of Care* (https://store.samhsa.gov/product/Access-to-Recovery-ATR-Approaches-to-Recovery-Oriented-Systems-of-Care/SMA09-4440).
- *Building Bridges—Co-Occurring Mental Illness and Addiction: Consumers and Service Providers, Policymakers, and Researchers in Dialogue* (https://store.samhsa.gov/shin/content//SMA04-3892/SMA04-3892.pdf).

Selected Papers of William L. White (www.williamwhitepapers.com): Contains papers, monographs, and presentations on recovery, including recovery-oriented methadone maintenance, methadone and anti-medication bias, discrimination and methadone, NA and the pharmacotherapeutic treatment of OUD, and co-participation in 12-Step mutual-support groups and methadone maintenance.

Resources for Clients and Families

Organizations

AAOTD (www.aatod.org): Offers a variety of resources, news releases about medication for the treatment of OUD, and information about its national conferences.

Al-Anon Family Groups (www.al-anon.org): Describes group meetings where friends and family members of people with substance use issues share their experiences and learn how to apply the principles of the Al-Anon program to their individual situations. Sponsorship gives members the chance to get personal support from more experienced individuals in the program.

Alcoholics Anonymous (AA) (www.aa.org): Offers group meetings for people who have problems relating to drinking and wish to stop. AA sponsors provide members with more personal support from experienced individuals. Many people who are taking medication to treat OUD find AA increasingly receptive to their decisions about medication, and AA meetings are more widely available to these individuals.

ASAM: Provides patient and family education tools about addiction in general and OUD specifically:

- Patient Resources (www.asam.org/resources/patientresources)
- *Opioid Addiction Treatment: A Guide for Patients, Families, and Friends* (http://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece/0?)

Double Trouble in Recovery (www.hazelden.org/HAZ_MEDIA/3818_doubletroubleinrecovery.pdf): Describes a fellowship of people who support each other in recovering from substance use and mental disorders.

Dual Recovery Anonymous (www.draonline.org): Presents information on mutual-help organization that follows 12-Step principles in supporting people recovering from addiction and emotional or mental illness. Focuses on preventing relapse and actively improving members' quality of life through a community of mutual support.

Faces & Voices of Recovery (https://facesandvoicesofrecovery.org): Offers recovery stories, news, events information, publications, and webinars.

Heroin Anonymous (http://heroinanonymous.org): Describes a nonprofit fellowship of individuals in recovery from heroin addiction committed to helping each other stay sober. This organization holds local support meetings, a directory of which can be found on its website.

LAC (https://lac.org): Offers information about the rights of people with criminal records, HIV/AIDS, and SUDs.

Learn to Cope (www.learn2cope.org): Describes a secular mutual-help group that offers education, resources, and peer support for the families of people with SUDs (although the focus is primarily on OUD). The organization maintains an online forum, but groups are only available in a few states.

NA (www.na.org): Provides a global, community-based organization with a multilingual, multicultural membership that supports addiction recovery via a 12-Step program, including regular group meeting attendance. Members hold nearly 67,000 meetings weekly in 139 countries. NA is an ongoing support network for maintaining a drug-free lifestyle. NA doesn't focus on a particular addictive substance.

NAMA Recovery (www.methadone.org): Offers an education series, provides training and certification for Certified MAT Advocates, and has local chapters and international affiliates that act to advocate for methadone patients. It has a helpful webpage titled FAQs About Advocate Training and Certification (www.methadone.org/certification/faq.html).

Nar-Anon Family Groups (www.nar-anon.org): Provides group meetings where friends and family of people with drug use problems can share their experiences and learn to apply the 12-Step Nar-Anon program to their lives. Nar-Anon groups also offer more individualized support from experienced individuals in the program who act as sponsors.

National Alliance on Mental Illness (NAMI) (www.nami.org): Describes the largest grassroots educational, peer support, and mental health advocacy organization in the United States. Founded in 1979 by a group of family members of people with mental disorders, NAMI has developed into an association of hundreds of local affiliates, state organizations, and volunteers.

Parents of Addicted Loved Ones (https://palgroup.org): Presents a secular support group for parents who have a child with an SUD. The organization has meetings in only some states but also hosts telephone meetings.

Pills Anonymous (www.pillsanonymous.org): Offers a 12-Step mutual-support group that holds regular meetings in which individuals in recovery from addiction to pills share their experiences, build their strengths, and offer hope for recovery to one another.

Secular Organizations for Sobriety (www.sossobriety.org): Describes a nonprofit, nonreligious network of autonomous, nonprofessional local groups that support people in achieving and maintaining abstinence from alcohol and drug addiction.

Self-Management for Addiction Recovery (SMART Recovery) (www.smartrecovery.org): Is a self-empowering addiction recovery support group; participants learn science-based tools for addiction recovery and have access to an international recovery community of mutual-help groups.

Stop Stigma Now (www.stopstigmanow.org): Describes an advocacy organization that works to eradicate prejudice associated with taking medication to treat OUD and offers resources and a media library.

Women for Sobriety (https://womenforsobriety.org/beta2): Offers an abstinence-based mutual-help group that helps women find their individual paths to recovery by acknowledging the unique needs women have in recovery. This organization is not affiliated with any other recovery organization. It offers recovery tools to help women in recovery develop coping skills focused on emotional growth, spiritual growth, self-esteem, and a healthy lifestyle.

Publications and Other Resources

AAAP Patient Resources (www.aaap.org/patient-resources/helpful-links): Offers resources and publications for patients and their families.

Addiction Treatment Forum, *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States* (http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf): Presents William White's publication for people receiving medication for OUD that gives information on the pros and cons of 12-Step groups and how to prepare for meetings.

ASAM, Opioid Addiction Treatment: A Guide for Patients, Families, and Friends (http://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece): Provides a guide about the treatment of OUD for patients, families, and friends.

HHS:

- Smokefree.gov (https://smokefree.gov). Provides useful information that helps individuals in planning and maintaining tobacco cessation.
- BeTobaccoFree.gov (https://betobaccofree.hhs.gov/health-effects/nicotine-health). Provides information for individuals struggling with nicotine addiction and links for clinicians that provide guidance on the care for patients with nicotine addiction.

LAC (https://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources). Maintains a library of documents related to medication for the treatment of OUD and other resources, including an advocacy toolkit, sample support letter form, training materials, and webinars:

- *Driving on Methadone or Buprenorphine (Suboxone): DUI?* (http://lac.org/wp-content/uploads/2014/07/Driving-on-Methadone-or-Suboxone-DUI.pdf) factsheet.
- *Know Your Rights: Employment Discrimination Against People With Alcohol/Drug Histories* (https://lac.org/resources/substance-use-resources/employment-education-housing-resources/webinar-know-rights-employment-discrimination-people-alcoholdrug-histories) webinar.
- *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment* (https://lac.org/wp-content/uploads/2014/12/Know_Your_Rts_-_MAT_final_9.28.10.pdf) publication.
- *Medication-Assisted Treatment for Opioid Addiction: Myths and Facts* (http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf) factsheet.

NAMA Recovery (www.methadone.org): Offers many resources and training opportunities to become a certified advocate for pharmacotherapy for OUD and provides links to resources related to medication for the treatment of OUD.

National Council on Alcoholism and Drug Dependence's *Consumer Guide to Medication-Assisted Recovery* (www.ncadd.org/images/stories/PDF/Consumer-Guide-Medication-Assisted-Recovery.pdf).

NIAAA's Rethinking Drinking (www.rethinkingdrinking.niaaa.nih.gov/help-links): Provides links to patient and family education, help lines, and other recovery resources.

SAMHSA (https://store.samhsa.gov): Provides patient and family educational tools about OUD and medication treatment for OUD treatment. The resources below are available in several languages, including Spanish and Russian:

- *Decisions in Recovery: Treatment for Opioid Use Disorders* (https://store.samhsa.gov/product/Decisions-in-Recovery-Treatment-for-Opioid-Use-Disorders/SMA16-4993). Helps clients identify an appropriate path of recovery from OUD.
- *The Facts About Buprenorphine for Treatment of Opioid Addiction* (https://store.samhsa.gov/shin/content//SMA14-4442/SMA14-4442.pdf).
- *The Facts About Naltrexone for Treatment of Opioid Addiction* (https://store.samhsa.gov/shin/content/SMA09-4444/SMA09-4444.pdf).
- *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment* (https://store.samhsa.gov/product/Rights-for-Individuals-on-Medication-Assisted-Treatment/SMA09-4449).
- *Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends* (www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfoFamilyFriends.pdf).
- *What Every Individual Needs To Know About Methadone Maintenance* (https://store.samhsa.gov/product/What-Every-Individual-Needs-to-Know-About-Methadone-Maintenance/SMA06-4123).
- *What Is Substance Abuse Treatment? A Booklet for Families* (https://store.samhsa.gov/shin/content/SMA14-4126/SMA14-4126.pdf).

Treatment Locators

Faces & Voices of Recovery Guide to Mutual Aid Resources (http://facesandvoicesofrecovery.org/resources/mutual-aid-resources): Offers a comprehensive list of 12-Step and non-12-Step recovery support groups throughout the United States and online.

National Alliance of Advocates for Buprenorphine Treatment (www.treatmentmatch.org/TM_index.php): Offers a free, 24/7 anonymous treatment-matching service for patients and providers.

Probuphine Healthcare Provider Locator (https://probuphinerems.com/probuphine-locator): Offers a list of healthcare professionals who prescribe, insert, and/or remove buprenorphine implants.

SAMHSA:

- Behavioral Health Treatment Services Locator is a directory of inpatient treatment providers (https://findtreatment.samhsa.gov).
- Behavioral Health Treatment Services Locator: Self-Help, Peer Support, and Consumer Groups (Addiction) provides a directory for consumers (https://findtreatment.samhsa.gov/locator/link-focSelfGP).
- Buprenorphine Treatment Practitioner Locator provides an interactive treatment locator of providers who prescribe buprenorphine (www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).
- Opioid Treatment Program Directory provides an interactive SAMHSA OTP treatment locator (https://dpt2.samhsa.gov/treatment/directory.aspx).

VA Substance Use Disorder Program Locator (www.va.gov/directory/guide/SUD.asp): Provides an interactive treatment locator for VA SUD treatment programs.

Patient Success Stories

Patients' success stories highlight the powerful ways in which medication for the treatment of OUD can help people achieve remission and recovery. Examples of patient success stories include the following:

- Carol (https://vimeo.com/105287902)
- Brandon (https://vimeo.com/105078010)
- Archie (www.youtube/iHJ6K4VQvrw?list=PLGV_2NAg58zkUOZRupfKc6_Z7jaBf7h-V)
- MARS Project Video (www.marsproject.org)

Online Boards and Chat Rooms

12-Step Forums: A variety of NA and AA meetings are available online, each with its own perspective on medication:

- The AA online intergroup directory lists numerous online AA meetings, which occur at specific times (https://aa-intergroup.org/directory_venue.php?code=CH).
- The NA chatroom asks that participants not talk about medication (www.nachatroom.net).

Facebook Forums and Groups: Many medication-assisted recovery organizations maintain a presence on Facebook because of the ease of creating online mutual-support and chat groups:

- A.T. Watchdog: A Pro Methadone Maintenance Support Group (www.facebook.com/groups/1599996730222196)
- Clean & Sober Today (www.facebook.com/groups/1822841161286327)
- Heroin Anonymous (www.facebook.com/HeroinAnonymous)
- Medication-Assisted Treatment Miracles (www.facebook.com/groups/MATMiracles)
- Methadone Discussion (www.facebook.com/groups/MethadoneSupport)

- NAMA Recovery:
  - NAMA-R (www.facebook.com/groups/NAMARecoveryTN)
  - Boston Methadone & Bupe Patient Discussion (www.facebook.com/groups/833560336673414)
  - NAMA Recovery of Washington (www.facebook.com/groups/398175280306632)
- Secular Organizations for Sobriety (www.facebook.com/groups/251215211975)
- Social Media 4Recovery (www.facebook.com/groups/748016625286020)
- Stop Stigma Now (www.facebook.com/Stop-Stigma-Now-1482990085299885)
- Suboxone/Buprenorphine Treatment and Support—Detox/Maintenance (www.facebook.com/groups/Fightingthestigmaofaddiction)

Heroin Addiction & Recovery Forum (http://killtheheroinepidemicnationwide.org/forum): An online discussion forum for both people who are addicted to heroin and their friends and families.

Moms on Methadone (www.circleofmoms.com/moms-on-methadone): An online support group for pregnant women or women with children who are taking medication to treat OUD.

SMART Recovery Online Forum (www.smartrecovery.org/community/forum.php): An online group that welcomes new members.

We Speak Methadone (and Buprenorphine) (www.methadone.org/wespeakmethadone): A discussion forum for medication-assisted treatment patients, their families, and advocates.

Provider Tools and Sample Forms

Provider Screening and Assessment Tools and Aids

Alcohol Use Disorders Identification Test (AUDIT)

1. How often do you have a drink containing alcohol?

(0) Never *[Skip to Questions 9–10]*
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Questions 9 and 10 if total score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Note: Add up the points associated with answers. A score of 8 or more is considered a positive test for unhealthy drinking.

Adapted from material in the public domain.[3] Available online (http://auditscreen.org).

Stable Resource Toolkit

Audit-C – Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, **b** = 1 point, **c** = 2 points, **d** = 3 points, **e** = 4 points

- **In men,** a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women,** a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	MEN[1]	WOMEN[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

	MEN[1]	WOMEN[2]
≥3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. *Arch Internal Med. 1998* (3): 1789-1795.
2. Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. *Arch Internal Med Vol 165,* April 2003: 821-829.
3. Frequently Asked Questions guide to using the AUDIT-C can be found via the website: https://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs-print.cfm

Continued on next page

AUDIT-C Questionnaire

Patient Name: _____ **Dates of Visit:** _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

Reprinted from material in the public domain.[4] Available online (https://www.integration.samhsa.gov/images/res/tool_auditc.pdf).

Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (i.e., marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have trouble with a question, then choose the response that is mostly right.

Segment: _____ Visit Number: _____ Date of Assessment: _____/_____/_____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1.	**Have you used drugs other than those required for medical reasons?**	☐ No	☐ Yes
2.	**Do you use more than one drug at a time?**	☐ No	☐ Yes
3.	**Are you always able to stop using drugs when you want to?**	☐ No	☐ Yes
4.	**Have you had "blackouts" or "flashbacks" as a result of drug use?**	☐ No	☐ Yes
5.	**Do you ever feel bad or guilty about your drug use?**	☐ No	☐ Yes
6.	**Does your spouse (or parents) ever complain about your involvement with drugs?**	☐ No	☐ Yes
7.	**Have you neglected your family because of your use of drugs?**	☐ No	☐ Yes
8.	**Have you engaged in illegal activities to obtain drugs?**	☐ No	☐ Yes
9.	**Have you ever experienced withdrawal symptoms (i.e., felt sick) when you stopped taking drugs?**	☐ No	☐ Yes
10.	**Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?**	☐ No	☐ Yes

Comments:

Scoring

Score 1 point for each "Yes," except for question 3, for which a "No" receives 1 point.

DAST Score: _____

Interpretation of Score:

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1–2	Low level	Monitor, reassess at a later date
3–5	Moderate level	Further investigation
6–8	Substantial level	Intensive assessment
9–10	Severe level	Intensive assessment

Adapted with permission.[5,6]

DSM-5 Opioid Use Disorder Checklist[7]

Patient's Name: _____ **Date of Birth:** _____

Worksheet for DSM-5 Criteria for Diagnosis of Opioid Use Disorder

DIAGNOSTIC CRITERIA (Opioid use disorder requires that at least 2 criteria be met within a 12-month period.)	MEETS CRITERIA? Yes OR No	NOTES/SUPPORTING INFORMATION
1. Opioids are often taken in larger amounts or over a longer period of time than intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.		
3. A lot of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.		
4. Craving, or a strong desire to use opioids.		
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home.		
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.		
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.		
8. Recurrent opioid use in situations in which it is physically hazardous.		
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.		
10. Tolerance,* as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid		
11. Withdrawal,* as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms		

*This criterion is not met for individuals taking opioids solely under appropriate medical supervision.

Severity: mild = 2–3 symptoms; moderate = 4–5 symptoms; severe = 6 or more symptoms

Signed: _____ Date: _____

Heaviness of Smoking Index

Ask these two questions of current or recent smokers:

1. How soon after waking do you smoke your first cigarette?
   - Within 5 minutes (3 points)
   - 5–30 minutes (2 points)
   - 31–60 minutes (1 point)
   - 61 or more minutes (no points)
2. How many cigarettes a day do you smoke?
   - 10 or less (no points)
   - 11–20 (1 point)
   - 21–30 (2 points)
   - 31 or more (3 points)

Total score: 1 to 2 points = very low dependence; 3 points = low to moderate dependence; 4 points = moderate dependence; 5 or more points = high dependence

Adapted with permission.[8]

NIAAA Single-Item Screener

How many times in the past year have you had five or more drinks in a day (four drinks for women and all adults older than age 65)?

A response of one or more times is considered a positive screen. Patients who screen positive should have an assessment for alcohol use disorder.

Adapted with permission.[9]

Opioid Overdose: Risk, Prevention, Identification, and Response

Overdose Risk

- Using heroin (possibly mixed with illicitly manufactured fentanyl or fentanyl analogs)
- Using prescription opioids that were not prescribed
- Using prescription opioids more frequently or at higher doses than prescribed
- Using opioids after a period of abstinence or reduced use (e.g., after medically supervised withdrawal or incarceration)
- Using opioids with alcohol, benzodiazepines, or both

Overdose Prevention

- Don't use opioids that were not prescribed.
- Take medications only as prescribed.
- Don't use drugs when you are alone.
- Don't use multiple substances at once.
- Have naloxone available and make sure others know where it is and how to use it.
- Use a small "test dose" if returning to opioid use after a period of abstinence, if the substance appears altered or has been acquired from an unfamiliar source. Beware: This doesn't guarantee safety; illicitly manufactured fentanyl or other substances may be present in the drug, and **any use may be fatal.**

Overdose Identification

- Fingernails or lips are blue or purple.
- Breathing or heartbeat is slow or stopped.
- The person is vomiting or making gurgling noises.
- The person can't be awakened or is unable to speak.

Overdose Response

- Call 9-1-1.
- Administer naloxone (more than one dose may be needed to restore adequate spontaneous breathing).
- Perform rescue breathing. If certified to provide cardiopulmonary resuscitation, perform chest compressions if there is no pulse.
- Put the person in the "recovery position," on his or her side and with the mouth facing to the side to prevent aspiration of vomit, if he or she is breathing independently.
- Stay with the person until emergency services arrive. Naloxone's duration of action is 30–90 minutes. The person should be observed after this time for a return of opioid overdose symptoms.

Adapted from material in the public domain.[10]

Physical Signs of Opioid Withdrawal and Time to Onset

STAGE	GRADE	PHYSICAL SIGNS/SYMPTOMS
Early Withdrawal Short-acting opioids: 8–24 hours after last use Long-acting opioids: Up to 36 hours after last use	Grade 1	Lacrimation, rhinorrhea, or both Diaphoresis Yawning Restlessness Insomnia
Early Withdrawal Short-acting opioids: 8–24 hours after last use Long-acting opioids: Up to 36 hours after last use	Grade 2	Dilated pupils Piloerection Muscle twitching Myalgia Arthralgia Abdominal pain
Fully Developed Withdrawal Short-acting opioids: 1–3 days after last use Long-acting opioids: 72–96 hours after last use	Grade 3	Tachycardia Hypertension Tachypnea Fever Anorexia or nausea Extreme restlessness
Fully Developed Withdrawal Short-acting opioids: 1–3 days after last use Long-acting opioids: 72–96 hours after last use	Grade 4	Diarrhea, vomiting, or both Dehydration Hyperglycemia Hypotension Curled-up position

Total duration of withdrawal:

- Short-acting opioids: 7–10 days.
- Long-acting opioids: 14 days or more.

Signs of Opioid Intoxication

Physical Findings

Drowsy but arousable
Sleeping intermittently ("nodding off")
Constricted pupils

Mental Status Findings

Slurred speech
Impaired memory or concentration
Normal to euphoric mood

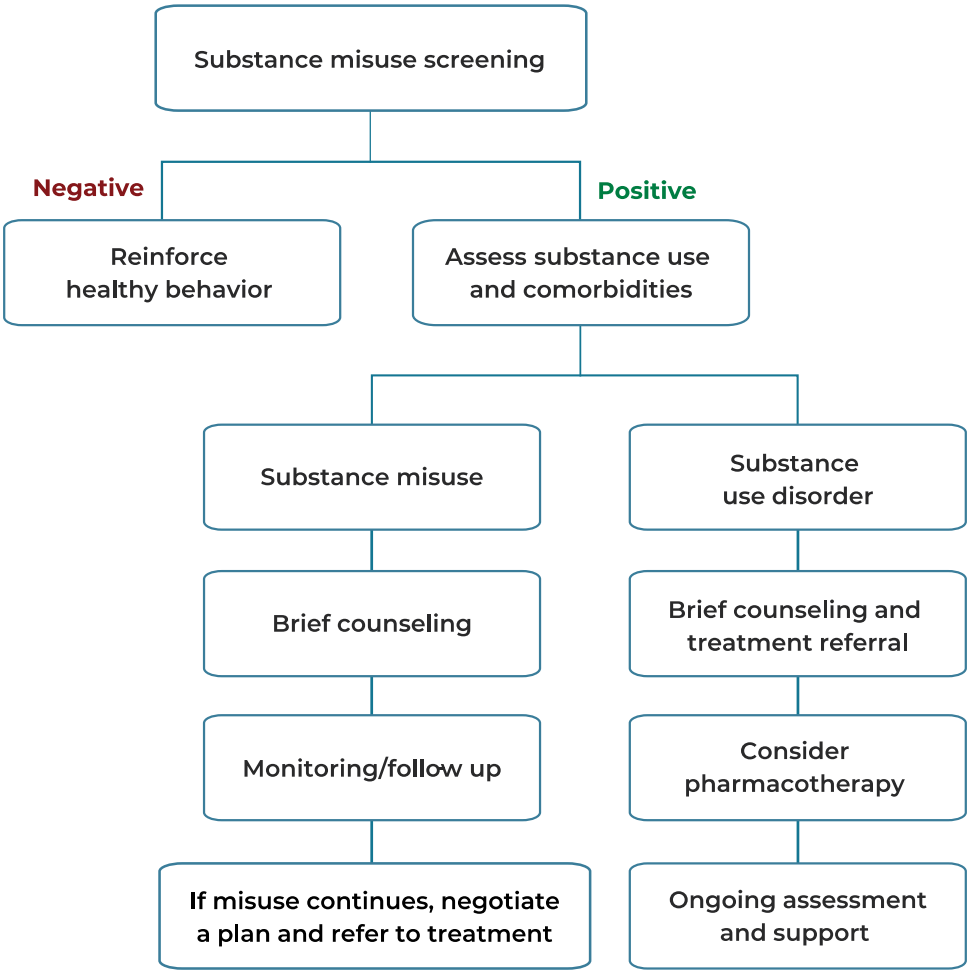
Single-Item Drug Screener

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

(A positive screen is 1 or more days.)

Reprinted with permission.[11]

Substance Misuse and SUD Screening



Adapted with permission.[12]

TAPS Tool Part I

Directions: The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the PAST YEAR. Question 2 should be answered by males, and Question 3 should be answered by females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

In the PAST 12 MONTHS:

1. How often have you used any tobacco product (for example, cigarettes, ecigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

2. How often have you had 5 or more drinks containing alcohol in 1 day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. *(Note: This question should only be answered by males.)*

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

3. How often have you had 4 or more drinks containing alcohol in 1 day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. *(Note: This question should only be answered by females.)*

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4. How often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, or ecstasy/MDMA?

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5. How often have you used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? Prescription medications that may be used this way include opiate pain relievers (for example, OxyContin, Vicodin, Percocet, or methadone), medications for anxiety or sleeping (for example, Xanax, Ativan, or Klonopin), or medications for ADHD (for example, Adderall or Ritalin).

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

TAPS Tool Part 2

Directions: The TAPS Tool Part 2 is a brief assessment for tobacco use, alcohol use, illicit substance use, and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answers, yes or no. Check the box to select your answer.

In the PAST 3 MONTHS:

1. **Did you smoke a cigarette containing tobacco?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No
   - Did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. **Did you have a drink containing alcohol?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you have 4 or more drinks containing alcohol in a day?* ☐ Yes ☐ No
     (Note: This question should only be answered by females.)
   - Did you have 5 or more drinks containing alcohol in a day?* ☐ Yes ☐ No
     (Note: This question should only be answered by males.)
   - Have you tried and failed to control, cut down, or stop drinking? ☐ Yes ☐ No
   - Has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. **Did you use marijuana (hash, weed)?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. **Did you use cocaine, crack, or methamphetamine (crystal meth)?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. **Did you use heroin?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you tried and failed to control, cut down, or stop using heroin? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. **Did you use a prescription opiate pain reliever (for example Percocet or Vicodin) not as prescribed or that was not prescribed for you?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you tried and failed to control, cut down, or stop using an opiate pain reliever? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

Continued on next page

7.	**Did you use medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you?**	☐ **Yes**	☐ **No**
	If "Yes," answer the following questions:		
	• Have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often?	☐ Yes	☐ No
	• Has anyone expressed concern about your use of medication for anxiety or sleep?	☐ Yes	☐ No
8.	**Did you use medication for ADHD (for example, Adderall or Ritalin) not as prescribed or that was not prescribed for you?**	☐ **Yes**	☐ **No**
	If "Yes," answer the following questions:		
	• Did you use a medication for ADHD (for example, Adderall or Ritalin) at least once a week or more often?	☐ Yes	☐ No
	• Has anyone expressed concern about your use of medication for ADHD (for example, Adderall or Ritalin)?	☐ Yes	☐ No
9.	**Did you use any other illegal or recreational drugs (for example, ecstasy, molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ["spice"], whip-its)?**	☐ **Yes**	☐ **No**
	If "Yes," answer the following question:		
	• What were the other drug(s) you used? (write in response)		

The complete tool is available online (https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f).
Adapted from material in the public domain.[13]

Two-Item Drug Use Disorder Screener for Primary Care Clinics Serving U.S. Veterans

Question 1: How many days in the past 12 months have you used drugs other than alcohol? (A positive screen is 7 or more days.) If <7, proceed with Question 2.

Question 2: How many days in the past 12 months have you used drugs more than you meant to? (A positive screen is 2 or more days.)

Adapted with permission.[14]

Urine Drug Testing Window of Detection[15,16]

DRUG	POSITIVE TEST	WINDOW OF DETECTION*	COMMENTS
Amphetamine; methamphetamine; 3,4-methylenedioxy-methamphetamine	Amphetamine	1–2 days	False positives w/ bupropion, chlorpromazine, desipramine, fluoxetine, labetalol, promethazine, ranitidine, pseudoephedrine, trazadone, and other common medications. Confirm unexpected positive results with the laboratory.
Barbiturates	Barbiturates	Up to 6 weeks	N/A
Benzodiazepines	Benzodiazepines	1–3 days; up to 6 weeks with heavy use of long-acting benzodiazepines	Immunoassays may not be sensitive to therapeutic doses, and most immunoassays have low sensitivity to clonazepam and lorazepam. Check with your laboratory regarding sensitivity and cutoffs. False positives with sertraline or oxaprozin.
Buprenorphine	Buprenorphine	3–4 days	Will screen negative on opiate screen. Tramadol can cause false positives. Can be tested for specifically.
Cocaine	Cocaine, benzoylecgonine	2–4 days; 10–22 days with heavy use	N/A
Codeine	Morphine, codeine, high-dose hydrocodone	1–2 days	Will screen positive on opiate immunoassay.
Fentanyl	Fentanyl	1–2 days	Will screen negative on opiate screen. Can be tested for specifically. May not detect all fentanyl-like substances.[17]
Heroin	Morphine, codeine	1–2 days	Will screen positive on opiate immunoassay. 6-monoacetylmorphine, a unique metabolite of heroin, is present in urine for about 6 hours. Can be tested for specifically to distinguish morphine from heroin, but this is rarely clinically useful.
Hydrocodone	Hydrocodone, hydromorphone	2 days	May screen negative on opiate immunoassay. Can be tested for specifically.
Hydromorphone	May not be detected	1–2 days	May screen negative on opiate immunoassay. Can be tested for specifically.

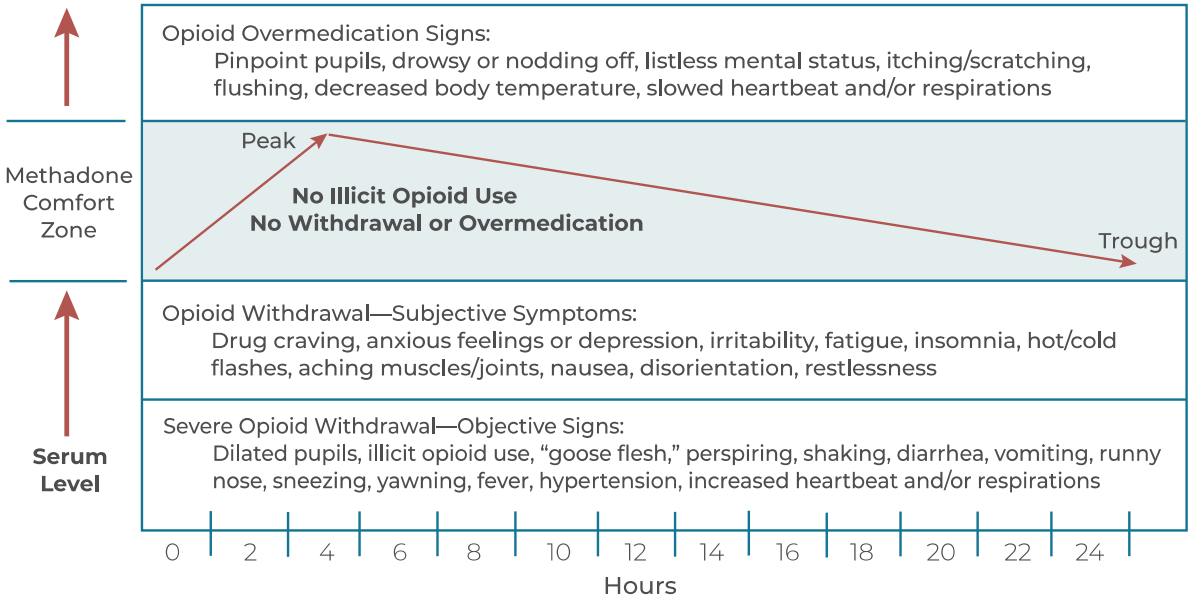
Continued on next page

Urine Drug Testing Window of Detection (continued)

DRUG	POSITIVE TEST	WINDOW OF DETECTION*	COMMENTS
Marijuana	Tetrahydrocannabinol	Infrequent use of 1–3 days; chronic use of up to 30 days	False positives possible with efavirenz, ibuprofen, and pantoprazole.
Methadone	Methadone	2–11 days	Will screen negative on opiate screen. Can be tested for specifically.
Morphine	Morphine, hydromorphone	1–2 days	Will screen positive on opiate immunoassay. Ingestion of poppy plant/seed may screen positive.
Oxycodone	Oxymorphone	1–1.5 days	Typically screens negative on opiate immunoassay. Can be tested for specifically.

*Detection time may vary depending on the cutoff.

Using Signs and Symptoms To Determine Optimal Methadone Level



Adapted with permission.[18]

Provider Informational, Educational, and Decision-Making Tools

Key Elements of an OBOT Clinic Diversion Control Plan[19]

New Patients

Check the state's PDMP before admission to determine whether patients are receiving opioids or benzodiazepine prescriptions from other providers.

Ask patients to sign a release of information to speak with the other prescribers. Patients who are unwilling to sign a release of information are poor candidates for outpatient treatment.

Review the clinic diversion control policy with new patients. This should include counseling patients to:

- Keep buprenorphine locked up and out of children's reach.
- Never share medication with anyone.
- Never sell medication to anyone.
- Acknowledge giving or selling medication to others as illegal.
- Take medication only as prescribed.
- Review, understand, and agree to the practice's buprenorphine treatment agreement before they start.

Prescribe buprenorphine/naloxone when possible, rather than monoproduct. Exceptions would include prescribing the monoproduct for pregnant women with OUD.

Prescribe an adequate but not excessive dose. Most patients respond to doses at or below 24 mg per day. Carefully evaluate requests for higher doses and confirm, document, and assess medication adherence continuously.

Ongoing Patients

Periodically check the state's PDMP.

Conduct random urine tests that include a wide spectrum of opioids—including morphine, oxycodone, and buprenorphine—and periodically include buprenorphine metabolites. This will help monitor response to treatment and determine whether patients are taking at least some of their prescribed buprenorphine.

Use **unobserved** specimen collection to preserve patient privacy and dignity:

- Do not let patients bring backpacks, jackets, or other items into the bathroom.
- Do not let others enter bathrooms with patients.
- Temperature test the urine sample.

Use **observed** specimen collection (obtained by a staff member of the same gender) or oral fluid testing if there is reason to suspect tampering or falsification.

Contact patients at random; ask them to bring in their medication within a reasonable period (24 to 48 hours) to count the tablets/films to ensure that all medication is accounted for.

Provide a limited number of days of medication per prescription without refills (e.g., several days or 1 week per prescription) until the patient has demonstrated stability and lowered diversion risk.

Key Points of Patient Education for Buprenorphine

Before starting OUD treatment with buprenorphine, patients should:

- Tell providers the prescribed and over-the-counter medications they take, to allow drug interaction assessment.
- Understand the goal of the first week of treatment: To improve withdrawal symptoms without oversedation.
- Tell providers if they feel sedated or euphoric within 1 to 4 hours after their dose.
- Be given the appropriate buprenorphine medication guide.
- Know possible side effects, including:
  - Headache.
  - Dizziness.
  - Nausea.
  - Vomiting.
  - Sweating.
  - Constipation.
  - Sexual dysfunction.
- Agree to store medication securely and out of the reach of others.
- Alert providers if they discontinue medications, start new ones, or change their medication dose.
- Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.
- Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.
- Understand the importance of informing providers if they become pregnant.
- Tell providers if they are having a procedure that may require pain medication.
- Be aware of resources through which to obtain further education for:
  - Themselves (https://store.samhsa.gov/product/SMA16-4993).
  - Their families and friends (http://www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfoFamilyFriends.pdf).

Key Points of Patient Education for Methadone

Before starting OUD treatment with methadone, patients should:

- Be told that the methadone dose is started low and increased slowly over days and weeks with monitoring, because it takes 4 or more days for the body to adjust to a dose change. This is necessary to avoid the risk of overdose.
- Understand that the goal of the first weeks of treatment is to improve withdrawal symptoms without oversedation. Patients should tell providers if they feel sedated or high within the first 4 hours after their dose.
- Learn the symptoms of methadone intoxication and how to seek emergency care. The first 2 weeks of treatment have the highest risk of overdose.
- Be aware that rescue naloxone does not last very long, so they should remain in emergency care for observation if they are treated for opioid overdose.
- Know that concurrent alcohol, benzodiazepine, or other sedative use with methadone increases the risk of overdose and death.
- Inform OTP nursing/medical staff about prescribed and over-the-counter medications and herbs (e.g., St. John's wort) they are taking, stopping, or changing doses of to allow assessment of potential drug–drug interactions.
- Inform other treating healthcare professionals that they are receiving methadone treatment.
- Plan to avoid driving or operating heavy machinery until their dose is stabilized.
- Learn about other possible side effects of methadone, including dizziness, nausea, vomiting, sweating, constipation, edema, and sexual dysfunction.
- Agree to keep take-home doses locked up and out of the reach of others. Understand that giving methadone, even small amounts, to others may be fatal.
- Inform providers if they become pregnant.
- Understand that stopping methadone increases their risk of overdose death if they return to illicit opioid use.

Key Points of Patient Education for Naltrexone

- Do not use any opioids in the 7 to 10 days (for short acting) or 10 to 14 days (for long acting) before starting XR-NTX, to avoid potentially serious opioid withdrawal symptoms. Opioids include:
  - Heroin.
  - Prescription opioid analgesics (including tramadol).
  - Cough, diarrhea, or other medications that contain codeine or other opioids.
  - Methadone.
  - Buprenorphine.
- Seek immediate medical help if symptoms of allergic reaction or anaphylaxis occur, such as:
  - Itching.
  - Swelling.
  - Hives.
  - Shortness of breath.
  - Throat tightness.
- Do not try to override the opioid blockade with large amounts of opioids, which could result in overdose.
- Understand the risk of overdose from using opioids near the time of the next injection, after missing a dose, or after stopping medications.
- Report injection site reactions including:
  - Pain.
  - Hardening.
  - Lumps.
  - Blisters.
  - Blackening.
  - Scabs.
  - An open wound.

  Some of these reactions could require surgery to repair (rarely).
- Report signs and symptoms of hepatitis.
- Report depression or suicidal thoughts. Seek immediate medical attention if these symptoms appear.
- Seek medical help if symptoms of pneumonia appear (e.g., shortness of breath, fever).
- Tell providers of naltrexone treatment, as treatment differs for various types of pneumonia.
- Inform all healthcare professionals of XR-NTX treatment.
- Report pregnancy.
- Inform providers of any upcoming medical procedures that may require pain medication.
- Understand that taking naltrexone may result in difficulty achieving adequate pain control if acute medical illness or trauma causes severe acute pain.
- Wear medical alert jewelry and carry a medical alert card indicating you are taking XR-NTX. A patient wallet card or medical alert bracelet can be ordered at 1-800-848-4876.

Medication Management for Patients With Respiratory or Hepatic Impairment Who Take Buprenorphine

CONTRAINDICATION/CAUTION	MANAGEMENT
Compromised respiratory function (e.g., chronic obstructive pulmonary disease, decreased respiratory reserve, hypoxia, hypercapnia [abnormally elevated blood levels of carbon dioxide], preexisting respiratory depression).	• Prescribe with caution; monitor closely. • Warn patients about the risk of using benzodiazepines or other depressants while taking buprenorphine.[20] • Support patients in their attempts to discontinue tobacco use.
Hepatic impairment Buprenorphine and naloxone are extensively metabolized by the liver. Moderate to severe impairment results in decreased clearance, increased overall exposure to both medications, and higher risk of buprenorphine toxicity and precipitated withdrawal from naloxone. These effects have not been observed in patients with mild hepatic impairment.[21,22]	• Mild impairment (Child-Pugh score of 5–6):[23] No dose adjustment needed. • Moderate impairment (Child-Pugh score of 7–9):[24] Combination products are not recommended; they may precipitate withdrawal. *Use combination products cautiously for maintenance treatment in patients who've been inducted with a monoproduct;[25,26] monitor for signs and symptoms of buprenorphine toxicity or overdose.[27] Naloxone may interfere with buprenorphine's efficacy.[28,29] • Severe impairment (Child-Pugh score of 10–15):[30] Do not use the combination product.[31] For monoproduct, consider halving the starting and titration doses used in patients with normal liver function; monitor for signs and symptoms of toxicity or overdose caused by increased buprenorphine levels.[32]

*Moderate to severe impairment results in much more reduced clearance of naloxone than of buprenorphine. Nasser et al.[33] found that moderate impairment doubled or tripled exposure (compared with subjects with no or mild impairment) for both medications. In subjects with severe impairment, buprenorphine exposure was two to three times higher; naloxone exposure increased more than tenfold.

Adapted from material in the public domain.[34]

Monitoring Recovery Activities

At medical management visits, do not simply ask about attendance at recovery support meetings; explore the level of participation and engagement in those activities. Some activities include:

- Finding and working closely with a sponsor.
- "Working" the 12 Steps at 12-Step meetings and with a sponsor.
- Doing service at meetings (e.g., setting up chairs, making coffee, going on a "commitment" to speak at a meeting in a jail or an inpatient drug and alcohol program).
- Having and frequently attending a regular "home" group.[35]

Remember this statement from recovery experts A. Thomas McLellan and William White: "Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of such treatment by itself constitutes recovery. Recovery status instead hinges on broader achievements in health and social functioning—with or without medication support."[36]

OUD Medications: An Overview[37,38]

CATEGORY	BUPRENORPHINE*	METHADONE	XR-NTX**
Appropriate patients	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	**Opioid receptor partial agonist** Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.	**Opioid receptor agonist** Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.	**Opioid receptor antagonist** Blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy. Causes no opioid effects.
Patient Education	**Tell patients:** • 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.	**Tell patients:** • 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.	**Tell patients:** • That they will need to be opioid free for at least 7–10 days for short-acting and at least 10–14 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.
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 from dispersible tablet or powder (unless patients can take some home).	Every 4 weeks or once-per-month intramuscular injection.
Prescribing	Physicians, NPs, and 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.

*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 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.

OUD Medications: Comparison To Guide Shared Decision Making

CATEGORY	BUPRENORPHINE	METHADONE	NALTREXONE
Appropriate patients	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 are abstinent from short-acting opioids for 7 days and long-acting opioids for 10–14 days
Outcome: Retention in treatment	Higher than treatment without medication and treatment with placebo[39]	Higher than treatment without OUD medication and treatment with placebo[40]	Treatment retention with oral naltrexone is no better than with placebo or no medication;[41] for XR-NTX, treatment retention is higher than for treatment without OUD medication and treatment with placebo;[42,43] treatment retention is lower than with opioid receptor agonist treatment
Outcome: Suppression of illicit opioid use	Effective	Effective	Effective
Outcome: Overdose mortality	Lower for people in treatment than for those not in it	Lower for people in treatment than for those not in it	Unknown
Location/ frequency of office visits	**Office/clinic:** Begins daily to weekly, then tailored to patient's needs **OTP:** Can treat with buprenorphine 6–7 days/ week initially; take-homes are allowed without the time-in-treatment requirements of methadone	**OTP only:** 6–7 days/week initially; take-homes are allowed based on time in treatment and patient progress	**Office/clinic:** Varies from weekly to monthly
Who can prescribe/order?	Physicians, NPs,* and PAs* possessing federal waiver can prescribe and dispense; can be dispensed by a community pharmacy or an OTP	OTP physicians order the medication; nurses and pharmacists administer and dispense it	Physicians, NPs,* and PAs*

*NPs and PAs should check with their state to determine whether prescribing buprenorphine, naltrexone, or both is within their allowable scope of practice.

Continued on next page

OUD Medications: Comparison To Guide Shared Decision Making (continued)

CATEGORY	BUPRENORPHINE	METHADONE	NALTREXONE
Administration	Sublingual/buccal; implant by specially trained provider, and only for stabilized patients	Oral	Oral or intramuscular (Note: Oral naltrexone is less effective than the other OUD medications.)
Misuse/diversion potential	Low in OTPs or other settings with observed dose administration; moderate for take-home doses; risk can be mitigated by providing take-homes to stable patients and a diversion control plan	Low in OTPs with directly observed therapy; moderate for take-home doses; risk can be mitigated by a diversion control plan	None
Sedation	Low unless concurrent substances are present (e.g., alcohol, benzodiazepines)	Low unless dose titration is too quick or dose is not adjusted for the presence of concurrent substances (e.g., alcohol, benzodiazepines)	None
Risk of medication-induced respiratory depression	Very rare; lower than methadone	Rare, although higher than buprenorphine; may be elevated during the first 2 weeks of treatment or in combination with other sedating substances	None
Risk of precipitated withdrawal when starting medication	Can occur if started too prematurely after recent use of other opioids	None	Severe withdrawal is possible if period of abstinence is inadequate before starting medication
Withdrawal symptoms on discontinuation	Present; lower than methadone if abruptly discontinued	Present; higher than buprenorphine if abruptly discontinued	None
Most common side effects	Constipation, vomiting, headache, sweating, insomnia, blurred vision	Constipation, vomiting, sweating, dizziness, sedation	Difficulty sleeping, anxiety, nausea, vomiting, low energy, joint and muscle pain, headache, liver enzyme elevation XR-NTX: Injection site pain, nasopharyngitis, insomnia, toothache

D. Coffa, December 2017 (personal communication). Adapted with permission.

OUD Medications: Formulations[44,45]

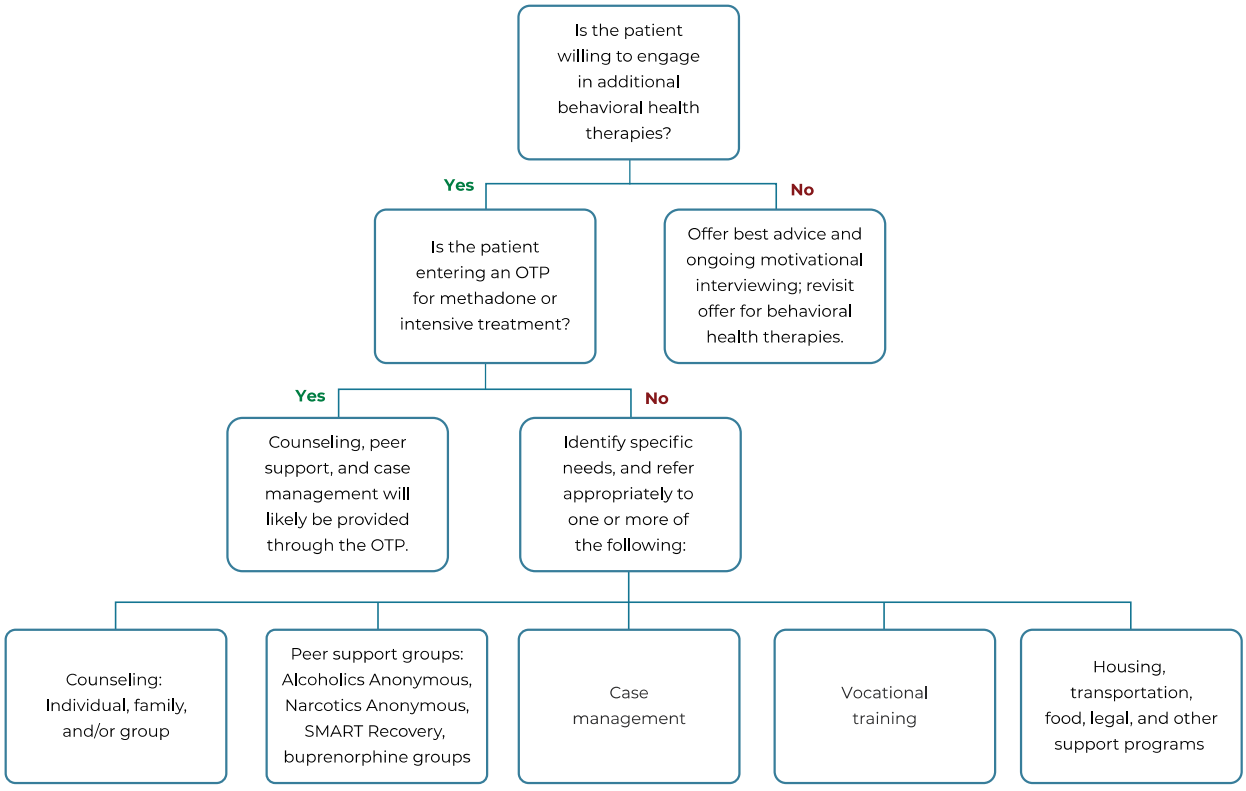
GENERIC/ TRADE NAME	FORMULATIONS	ACTION AT THE RECEPTOR	FDA INDICATIONS	DOSING REGIMEN
Methadone (Methadose, Dolophine)	Orally as liquid concentrate, tablet, or oral solution of powder or dispersible tablet	Mu-opioid receptor full agonist	Medically supervised withdrawal and maintenance treatment of opioid dependence; additional formulations FDA-approved for pain are not a focus of this TIP	Once daily (also off-label dosing regimens if appropriate, such as split dose twice daily)
Generic buprenorphine monoproduct	Sublingual tablet	Mu-opioid receptor partial agonist	Treatment of opioid dependence; additional formulations FDA-approved for pain are not a focus of this TIP	Once daily (also alternative off-label regimens)
Generic combination product (buprenorphine/ naloxone)	Sublingual tablet	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Zubsolv)	Sublingual tablet	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Bunavail)	Buccal film	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Suboxone)	Sublingual film; may also be administered buccally	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)

Continued on next page

OUD Medications: Formulations (continued)

GENERIC/ TRADE NAME	FORMULATIONS	ACTION AT THE RECEPTOR	FDA INDICATIONS	DOSING REGIMEN
Buprenorphine (Probuphine)	Implants	Mu-opioid receptor partial agonist	Maintenance treatment of opioid dependence in clinically stable patients taking 8 mg/ day or less of Suboxone equivalents	Implants last for 6 months and are then removed, after which a second set can be inserted
Extended-release injection buprenorphine (Sublocade)	Subcutaneous injection in the abdominal region	Mu-opioid receptor partial agonist	Treatment of moderate-to-severe OUD among patients initiated and taking transmucosal buprenorphine for at least 7 days	Monthly
Oral naltrexone (Revia)	Oral tablet	Mu-opioid receptor antagonist	Block the effects of administered opioid agonists	Once daily (also alternative off-label regimens)
XR-NTX (Vivitrol)	Intramuscular injection	Mu-opioid receptor antagonist	Prevent return to opioid dependence after medically supervised opioid withdrawal	Once monthly by injection

Referring Patients Who Receive OUD Pharmacotherapy to Behavioral Health Therapies



Strategies for Managing Benzodiazepine Use by Patients in OUD Treatment

- **Carefully assess the patient's benzodiazepine use,** including:
  - Intent of use.
  - Source (check the state's PDMP).
  - Amount and route of use.
  - Binge use.
  - Prior overdoses.
  - Harms (e.g., car crashes, criminal acts, sleep trouble).
  - Co-use with other substances that further increase risk for respiratory depression and overdose.
  - Withdrawal history (e.g., seizures, delirium).
- **Also assess the following:**
  - Psychiatric and medical comorbidity
  - Motivation for change
  - Psychosocial support system (obtain history from a significant other if the patient permits)
- **Gauge level of care and setting needed** (e.g., residential, outpatient). Inpatient treatment may be best for patients with poor motivation, limited psychosocial support, serious or complicated comorbidity, or injection or binge use.
- **Coordinate with other prescribers.** Some patients may have taken appropriately prescribed benzodiazepines for years with limited or no evidence of misuse. For such patients, tapering benzodiazepines may be contraindicated and unrealistic.
- **Address comorbid mental disorders (e.g., anxiety, depression)** with other medications or psychosocial treatments, when feasible.
- **Provide medically supervised withdrawal** from benzodiazepines or refer to specialty care for same.
- **Create a treatment plan with built-in conditions** (e.g., urine testing, more frequent visits, short medication supply).
- **Frequently review patient progress and objective outcomes,** such as:
  - Urine drug testing.
  - PDMP reports.
  - Psychosocial functioning.
  - Reports from significant others.
- **Revise treatment plans** as needed, and document the rationale for treatment decisions.

Adapted with permission.[46]

Sample Provider Forms

General forms

Goal-Setting Form

Patient's Name: _____ **Date:** _____

GOAL CATEGORY	CURRENT SITUATION SCORE 10 = major problems and 0 = no problems	What would need to change to decrease this score?	PRIORITY SCORE 10 = highest priority ("I really want to work on this") and 1 = lowest priority ("I really do not want to work on this")
Opioid use			
Other illicit drug use: _____			
Alcohol use			
Tobacco use			
Physical health			
Mental health			
Legal/court issues			
Finances			
Job/employment			
Hobbies			
Family relations			
Partner relations			
Supportive drug-free network			
Education			
Keeping medication safe (e.g., not giving it away, selling it, having it stolen)			
Other			
Other			

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Goal Sheet and Coping Strategies Form

Goals are things you would like to accomplish.

Patient's Name: _____ **Date:** _____

3-MONTH GOALS

1 _____

2 _____

3 _____

6-MONTH GOALS

1 _____

2 _____

3 _____

1-YEAR GOALS

1 _____

2 _____

3 _____

List of Triggers to Using Drugs

People To Stay Away From

Places To Stay Away From

Ways To Cope or Manage Stress Without Using Drugs

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Medical Management Visit Form

Patient's Name: _____ **ID#**_____

Date: _____ **Week#:** _____ **Dose:** _____ mg ☐ No Show

Heroin/cocaine or other illicit drug use since last visit?

_____

Symptoms or signs that might indicate return to use (e.g., changes in mood, physical appearance)?

_____

Since the last visit, are there any problems with the following:

			If yes, explain
Drug Use	☐ Yes	☐ No	_____
Alcohol Use	☐ Yes	☐ No	_____
Psychiatric	☐ Yes	☐ No	_____
Medical	☐ Yes	☐ No	_____
Employment	☐ Yes	☐ No	_____
Social/Family	☐ Yes	☐ No	_____
Legal	☐ Yes	☐ No	_____

Any new problem to add to Treatment Plan Review? ☐ Yes ☐ No

_____

Plan to address any new problem _____

_____

Participation in Narcotics Anonymous or Alcoholics Anonymous since last visit? ☐ Yes ☐ No

Length of Session: _____ Healthcare Professional Signature: _____

D. Fiellin, December 3, 2016 (personal communication). Adapted with permission.

Patient Urine Drug Screen and Medication Count Monitoring Form

Patient's Name: _____ **Dates To Be Called:** _____

Called for:

☐ Urine Drug Screen

☐ Medication Count at ☐ Office or ☐ Pharmacy FOR: _____

☐ Buprenorphine/Naloxone

☐ Other (list drug: _____, _____, _____)

Documentation of Phone Call to Patient

Patient was called at _____ (insert phone #) on _____ (date) at _____:_____ (time) and informed of monitoring required (described above) within the next _____ hours.

Check One:

☐ I spoke with patient

☐ Message left on answering machine/voicemail

☐ Message left with _____

☐ Other _____

Signature of Staff Member Making Phone Call: _____

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Pharmacy Tablet/Film Count Form

(Note: Before sending this form, discuss with the pharmacist first to explain goals and procedures and to ensure agreement and understanding.)

Date: _____

To: Pharmacists @ _____ Pharmacy

From: Healthcare Provider: _____

Clinic Address: _____

Phone Number: _____

My patient, _____, is starting office-based buprenorphine treatment for opioid dependence.

As part of monitoring this treatment, we ask the patient to do buprenorphine tablet/film counts at random times (we call the patient when it's time for a pill/film count).

The above-named patient lives much closer to your pharmacy than to our treatment clinic. It would be a big help to me and this patient if you would be able to perform periodic tablet/film counts on his/her buprenorphine and then fax this form to us.

On the days we call the patient for a random tablet/film count, the patient would come to your pharmacy with his or her pill bottle. When we call the patient to go for a random tablet/film count, we will fax this form to you. We would appreciate if you could record the tablet/film count results on this form and fax it back to us the same day. This would be a real help to me in monitoring my patient's treatment and also a great service to the patient.

Thank you very much for your help with this! Sincerely,

_____
Signature

Buprenorphine/naloxone formulation: _____

Dose per tablet/film: _____

Total # of tablets/films remaining in bottle: _____ Fill date on bottle: _____

Total # of tablets/films dispensed on fill date: _____ Tablet/film count correct? ☐Yes ☐No

Please fax this back to: _____

Thank You!

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Standard Consent to Opioid Maintenance Treatment Form for OTPs

CONSENT TO PARTICIPATE IN METHADONE OR BUPRENORPHINE TREATMENT

Patient's Name: _____ **Date:** _____

I authorize and give voluntary consent to _____ [insert name of program] to dispense and administer medications—including methadone or buprenorphine—to treat my opioid use disorder. Treatment procedures have been explained to me, and I understand that I should take my medication at the schedule determined by the program physician, or his/her designee, in accordance with federal and state regulations.

I understand that, like all other medications, methadone or buprenorphine can be harmful if not taken as prescribed. It has been explained to me that I must safeguard these medications and not share them with anyone because they can be fatal to children and adults if taken without medical supervision.

I also understand that methadone and buprenorphine produce physical opioid dependence.

Like all medications, they may have side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical and psychiatric provider who may treat me that I am enrolled in an opioid treatment program. In this way, the provider will be aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my treatment with methadone or buprenorphine or my recovery.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of these medications at any time. If I choose this option, I understand I will be offered medically supervised withdrawal.

For women of childbearing age: Pregnant women treated with methadone or buprenorphine have better outcomes than pregnant women not in treatment who continue to use opioid drugs. Newborns of mothers who are receiving methadone or buprenorphine treatment may have opioid withdrawal symptoms (i.e., neonatal abstinence syndrome). The delivery hospital may require babies who are exposed to opioids before birth to spend a number of days in the hospital for monitoring of withdrawal symptoms. Some babies may also need medication to stop withdrawal. If I am or become pregnant, I understand that I should tell the medical staff of the OTP right away so I can receive or be referred to prenatal care. I understand that there are ways to maximize the healthy course of my pregnancy while I am taking methadone or buprenorphine.

Signature of Patient: _____ **Date of Birth:** _____

Date: _____ **Witness:** _____

Adapted from material in the public domain.[47]

Buprenorphine Forms

Buprenorphine Diversion Control Policy

XYZ Medical Practice
Office-Based Opioid Use Disorder Policy and Procedure Manual

Policy Title: Diversion Control for Patients Prescribed Transmucosal (Sublingual) Buprenorphine

Effective Date: _____ (Month, Day, Year)

This Diversion Control Policy is provided for educational and informational purposes only. It is intended to offer healthcare professionals guiding principles and policies regarding best practices in diversion control for patients who are prescribed buprenorphine. This policy is not intended to establish a legal or medical standard of care. Healthcare professionals should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual patients and practice arrangements. The information provided in this Policy is provided "as is" with no guarantee as to its accuracy or completeness.

Preamble: Healthcare professionals can now treat up to 275 patients with buprenorphine. This increased access may contribute to increased diversion, misuse, and related harms. Signs that a patient is misusing or diverting buprenorphine include (1) missed appointments; (2) requests for early refills because pills were lost, stolen, or other reasons; (3) urine screens negative for buprenorphine, positive for opioids; (4) claims of being allergic or intolerant to naloxone and requesting monotherapy; (5) nonhealing or fresh track marks; or (5) police reports of selling on the streets. Likewise, there are a range of reasons for diversion and misuse (e.g., diverting to family/friends with untreated opioid addiction with the intent of trying to "help" convince them to also get treatment; diverting to family/friends on a treatment waiting list; selling some or all of the medication to pay off old drug debts/purchase preferred opioid of misuse/pay for treatment in places where there are inadequate addiction treatment professionals taking private insurance or Medicaid for such reasons as inadequate reimbursement/no reimbursement/burdensome prior authorization process).

The safety and health of patients and others in the community could be at risk if misuse and diversion are not addressed proactively throughout treatment. The reputation of XYZ Medical Practice may also be put at risk.

Definitions: *Diversion* is defined as the unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended (including sharing or selling a prescribed medication); *misuse* includes taking medication in a manner, by route or by dose, other than prescribed.[48]

Purpose: Misuse and diversion should be defined and discussed with patients at the time of treatment entry; periodically throughout treatment, particularly when there have been returns to illicit drug use; and when suspected (e.g., incorrect buprenorphine pill/film count) or confirmed. These procedures will establish the steps to be taken to prevent, monitor, and respond to misuse and diversion of buprenorphine. The response should be therapeutic and matched to the patients' needs, as untreated opioid use disorder and treatment dropout/administrative discharges may lead to increased patient morbidity and mortality and further use of diverted medications or illicit opioids associated with overdose death.

Procedures for Prevention:

- Use buprenorphine/naloxone combination products when medically indicated and cost is not an issue. Reserve the daily buprenorphine monoproducts for pregnant patients and patients who could not afford treatment if the combination product were required, who have a history of stability in treatment and low diversion risk, or who have arrangements for observed dosing. Buprenorphine monoproducts are recommended for pregnant women.
- Counsel patients on safe storage of, and nonsharing of, medications. Patients must agree to safe storage of their medication. This is even more critical if there are children in the home where the patient lives. Counsel patients about acquiring locked devices and avoiding storage in parts of the home frequented by visitors (e.g., do not recommend storage in the kitchen or common bathrooms). Proactively discuss how medication should be stored and transported when traveling to minimize risk of unintended loss.
- Counsel patients on taking medication as instructed and not sharing medication. Explicitly explain to patients the definitions of diversion and misuse, with examples. Patients are required to take medication as instructed by the healthcare professional; for example, they may not crush or inject the medication.
- Check the prescription drug monitoring program for new patients and check regularly thereafter. Prescription drug monitoring program reports can be a useful resource when there is little history available or when there is a concern based on observation. Check for prescriptions that interact with buprenorphine and for other buprenorphine prescribers.

- Prescribe a therapeutic dose that is tailored to the patient's needs. Do not routinely provide an additional supply "just in case." Question patients who say they need a significantly higher dose, particularly when they are already at 24 mg per day of buprenorphine equivalents.
- Make sure the patient understands the practice's treatment agreement and prescription policies. The XYZ Medical Practice's treatment agreement and other documentation are clear about policies regarding number of doses in each prescription, refills, and rules on "lost" prescriptions. Review the policies in person with the patient. Offer an opportunity for questions. Patient and provider must sign the agreement. Review the policies again with the patient at subsequent appointments. See Sample Buprenorphine Treatment Agreement or Sample XR-NTX Treatment Agreement as needed.

Procedures for Monitoring:

- Request random urine tests. The presence of buprenorphine in the urine indicates that the patient has taken some portion of the prescribed dose. Absence of buprenorphine in the urine supports nonadherence. Testing for buprenorphine metabolites (which are present only if buprenorphine is metabolized) should periodically be included to minimize the possibility that buprenorphine is added directly to the urine sample. Dipstick tests can be subverted or replaced. A range of strategies can be used to minimize falsified urine collections, including (1) observed collection; (2) disallowing carry-in items (e.g., purses, backpacks) in the bathroom; (3) turning off running water and coloring toilet water to eliminate the possibility of dilution; (4) monitoring the bathroom door so that only one person can go in; and (5) testing the temperature of the urine immediately after voiding.
- Schedule unannounced pill/film counts. Periodically ask patients who are at high risk at initial or subsequent appointments to bring in their medication containers for a pill/film count.
- With unannounced monitoring (both pill/film counts and urine tests), the patient is contacted and must appear within a specified time period (e.g., 24 hours) after the phone call. If the patient doesn't show, then the provider should consider this as a positive indicator of misuse or diversion.
- Directly observe ingestion. Patients take medication in front of the healthcare professional or another qualified clinician and are observed until the medication dissolves in the mouth (transmucosal [sublingual or buccal] absorption). Patients who are having difficulty adhering to their buprenorphine can have their medication provided under direct observation in the office for a designated frequency (e.g., three times/week).
- Limit medication supply. When directly observed doses in the office are not practical, short prescription time spans can be used (e.g., weekly, 3 days at a time).

Procedures To Respond to Misuse or Diversion: Misuse or diversion doesn't mean automatic discharge from the practice. However, it will require consideration of one or more of the following procedures:

- Evaluate the misuse and diversion. For instance, describe the incident of misuse (e.g., "the patient took the prescribed dose on three or more occasions by intravenous route immediately after starting treatment, stating that she believed the dose would not be adequate by sublingual route; she has just initiated treatment") or diversion ("the patient gave half of dose to his wife, who is still using heroin and was withdrawing, because he did not want her to have to buy heroin off the street; she is on a waiting list for treatment") and tailor the response to the behavior (e.g., reeducation of the patient on buprenorphine pharmacology in the first example above; assistance with treatment entry for the spouse in the second example). Reassess the treatment plan and patient progress. Strongly consider smaller supplies of medication and supervised dosing for any patient who is taking medication intravenously or intranasally or diverting, regardless of reason. Treatment structure may need to be increased, including more frequent appointments, supervised administration, and increased psychosocial support.
- Intensify treatment or level of care, if needed. Some patients may require an alternative treatment setting or pharmacotherapy such as methadone. The clinician will discuss these alternatives with the patient to ensure optimal patient outcome. This should be discussed at treatment onset so the patient is aware of the consequences of misuse and diversion.
- Document and describe the misuse and diversion incident. Also document the clinical thinking that supports the clinical response, which should be aimed at minimizing risk of diversion and misuse and treating the patient's opioid use disorder at the level of care needed.

Policy adapted from ASAM's *Office-Based Opioid Use Disorder Policy and Procedure Manual*, which is updated periodically; the most current version is available online (https://www.asam.org/docs/default-source/advocacy/sample-diversion-policy.pdf?sfvrsn=6).

Adapted with permission.[49]

Buprenorphine Induction and Maintenance Appropriate Use Checklists

Patient Name: _____

BTOD|REMS

APPROPRIATE USE CHECKLIST:
BUPRENORPHINE-CONTAINING TRANSMUCOSAL PRODUCTS FOR OPIOID DEPENDENCE

This checklist is a useful reminder of the safe use conditions and monitoring requirements for prescribing buprenorphine-containing transmucosal products for opioid dependence.

Requirements to address during each patient's appointment include:

- understanding and reinforcement of safe use conditions
- the importance of psychosocial counseling
- screening and monitoring patients to determine progress towards treatment goals

If a patient continues to abuse various drugs or is unresponsive to treatment, including psychosocial intervention, it is important that you assess the need to refer the patient to a specialist and/or a more intensive behavioral treatment environment.

Additional resource: Physician Clinical Support System: http://pcssb.org/

This checklist may be used during the induction period and filed in patient's medical record to document safe use conditions. Once a maintenance dose has been established, use the maintenance checklist.

MEASUREMENT TO ENSURE APPROPRIATE USE	NOTES
Date:	
INDUCTION	
☐ Verified patient meets appropriate diagnostic criteria for opioid dependence	
☐ Discussed risks described in professional labeling and Medication Guide with patient	
☐ Explained or reviewed conditions of safe storage of medication, including keeping it out of the sight and reach of children	
☐ Provided induction doses under appropriate supervision	
☐ Prescribed limited amount of medication at first visit	
☐ Scheduled next visit at interval commensurate with patient stability • Weekly, or more frequent visits recommended for the first month	

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Continued on next page

Patient Name: _____

BTOD|REMS

APPROPRIATE USE CHECKLIST:

BUPRENORPHINE-CONTAINING TRANSMUCOSAL PRODUCTS FOR OPIOID DEPENDENCE

This checklist may be used for visits following the induction period and filed in patient's medical record to document safe use conditions.

MEASUREMENT TO ENSURE APPROPRIATE USE	NOTES
Date: **Visit #**	
MAINTENANCE	
☐ **Assessed and encouraged patient to take medication as prescribed** • Consider pill/film count/dose reconciliation	

☐ **Assessed appropriateness of dosage**
• Buprenorphine combined with naloxone is recommended for maintenance:
  • Buprenorphine/Naloxone SL tablet and film (Suboxone®): doses ranging from 12 mg to 16 mg of buprenorphine are recommended for maintenance
  • Buprenorphine/Naloxone SL tablet (Zubsolv®): a target dose of 11.4 mg buprenorphine is recommended for maintenance
  • Buprenorphine/Naloxone Buccal Film (Bunavail®): a target dose of 8.4 mg of buprenorphine is recommended for maintenance
• Doses higher than this should be an exception
• The need for higher dose should be carefully evaluated	

☐ **Conduct urine drug screens as appropriate to assess use of illicit substances**	
☐ **Assessed participation in professional counseling and support services**	
☐ **Assessed whether benefits of treatment with buprenorphine-containing products outweigh risks associated with buprenorphine-containing products**	
☐ **Assessed whether patient is making adequate progress toward treatment goals** • Considered results of urine drug screens as part of the evidence of the patient complying with the treatment program • Consider referral to more intensive forms of treatment for patients not making progress	
☐ **Scheduled next visit at interval commensurate with patient stability** • Weekly, or more frequent visits are recommended for the first month	

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Available online (www.accessdata.fda.gov/drugsatfda_docs/rems/BTOD_2017-01-23_Appropriate_Use_Checklist.pdf). *Reprinted from material in the public domain.*[50]

Buprenorphine Treatment Agreement

This form is for educational/informational purposes only. It doesn't establish a legal or medical standard of care. Healthcare professionals should use their judgment in interpreting this form and applying it in the circumstances of their individual patients and practice arrangements. The information provided in this form is provided "as is" with no guarantee as to its accuracy or completeness.

TREATMENT AGREEMENT

I agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. The risks and benefits of buprenorphine treatment have been explained to me.
2. The risks and benefits of other treatment for opioid use disorder (including methadone, naltrexone, and nonmedication treatments) have been explained to me.
3. I will keep my medication in a safe, secure place away from children (for example, in a lockbox). My plan is to store it [describe where and how _____].
4. I will take the medication exactly as my healthcare provider prescribes. If I want to change my medication dose, I will speak with my healthcare provider first. Taking more medication than my healthcare provider prescribes or taking it more than once daily as my healthcare provider prescribes is medication misuse and may result in supervised dosing at the clinic. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on my healthcare provider's evaluation.
5. I will be on time to my appointments and respectful to the office staff and other patients.
6. I will keep my healthcare provider informed of all my medications (including herbs and vitamins) and medical problems.
7. I agree not to obtain or take prescription opioid medications prescribed by any other healthcare provider without consulting my buprenorphine prescriber.
8. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.
9. If I miss an appointment or lose my medication, I understand that I will not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.
10. If I come to the office intoxicated, I understand that my healthcare provider will not see me, and I will not receive more medication until the next office visit. I may also have to start having supervised buprenorphine dosing.
11. I understand that it's illegal to give away or sell my medication; this is diversion. If I do this, my treatment will no longer include unsupervised buprenorphine dosing and may require referral to a higher level of care, supervised dosing at the clinic, and/or a change in medication based on my healthcare provider's evaluation.
12. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from the clinic.
13. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.
14. I understand that I will be called at random times to bring my medication container into the office for a pill or film count. Missing medication doses could result in supervised dosing or referral to a higher level of care at this clinic or potentially at another treatment provider based on my individual needs.
15. I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit.
16. I can be seen every 2 weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row. I will then get a prescription for 14 days of medication at each visit.
17. I will go back to weekly visits if I have a positive drug test. I can go back to visits every 2 weeks when I have two negative drug tests in a row again.
18. I may be seen less than every 2 weeks based on goals made by my healthcare provider and me.
19. I understand that people have died by mixing buprenorphine with alcohol and other drugs like benzodiazepines (drugs like Valium, Klonopin, and Xanax).

Continued on next page

20. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to comply with my healthcare provider's recommendations for additional counseling and/or for help with other problems.
21. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
22. I understand that I may experience opioid withdrawal symptoms when I stop taking buprenorphine.
23. I have been educated about the other two FDA-approved medications used for opioid dependence treatment, methadone and naltrexone.
24. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and been informed about methods for preventing pregnancy.

Other specific items unique to my treatment include:

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

This form is adapted from the American Society of Addiction Medicine's Sample Treatment Agreement, which is updated periodically; the most current version of the agreement is available online (https://www.asam.org/docs/default-source/advocacy/sample-treatment-agreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn=bd4675c2_0).

Adapted with permission.[51]

Naltrexone forms

Key Techniques for Reducing Injection Site Reactions[52]

To reduce severe injection site reactions when administering XR-NTX via intramuscular injection, use the following techniques:

- **Use one of the administration needles provided with the XR-NTX kit to ensure that the injection reaches the gluteal muscle.** Use the 2-inch needle for patients who have more subcutaneous adipose tissue. Use the 1.5-inch needle for patients with less subcutaneous adipose tissue. Either needle is appropriate for use with patients who have average amounts of subcutaneous adipose tissue.
- **Use aseptic technique when administering intramuscularly.** Using a circular motion, clean the injection site with an alcohol swab. Let the area dry before administering the injection. Do not touch this area again before administration.
- **Use proper deep intramuscular injection technique into the gluteal muscle.** XR-NTX must not be injected intravenously, subcutaneously, or into adipose tissue. Accidental subcutaneous injection may increase the risk of severe injection site reactions.
  - **Administer the suspension by deep intramuscular injection into the upper outer quadrant of gluteal muscle,** alternating buttocks per monthly injection.
  - **Remember to aspirate for blood before injection.** If blood aspirates or the needle clogs, do not inject. Change to the spare needle provided in the package and administer into an adjacent site in the same gluteal region, again aspirating for blood before injection.
  - **Inject the suspension in a smooth, continuous motion.**

A patient counseling tool is available to help you counsel your patients before administration about the serious risks associated with XR-NTX.

The above information is a selection of key safety information about the XR-NTX injection. For complete safety information, refer to the directions for use and the prescribing information provided in the medication kit. You can also obtain this information online (www.vivitrolrems.com) or by calling 1-800-VIVITROL.

Available online (www.vivitrolrems.com/content/pdf/patinfo-injection-poster.pdf).

Patient Counseling Tool for XR-NTX

Patient Counseling Tool

VIVITROL® (naltrexone for extended-release injectable suspension)

Risk of sudden opioid withdrawal during initiation and re-initiation of VIVITROL

Using any type of opioid including street drugs, prescription pain medicines, cough, cold or diarrhea medicines that contain opioids, or opioid dependence treatments buprenorphine or methadone, in the 7 to 14 days before starting VIVITROL may cause severe and potentially dangerous sudden opioid withdrawal.

Risk of opioid overdose

Patients may be more sensitive to the effects of lower amounts of opioids:

- After stopping opioids (detoxification)
- When the next VIVITROL dose is due
- If a dose of VIVITROL is missed
- After VIVITROL treatment stops

Patients should tell their family and people close to them about the increased sensitivity to opioids and the risk of overdose even when using lower doses of opioids or amounts that they used before treatment. Using large amounts of opioids, such as prescription pain pills or heroin, to overcome effects of VIVITROL can lead to serious injury, coma, and death.

Risk of severe reactions at the injection site

Remind patients of these **possible** symptoms at the **injection site:**

- Intense pain
- The area feels hard
- Large areas of swelling
- Lumps
- Blisters
- Open wound
- Dark scab

Some of these injection site reactions have required surgery.
Tell your patients to contact a healthcare provider if they have any reactions at the injection site.

Risk of liver injury, including liver damage or hepatitis

Remind patients of the possible symptoms of liver damage or hepatitis.

- Stomach area pain lasting more than a few days
- Dark urine
- Yellowing of the whites of eyes
- Tiredness

Patients may not feel the therapeutic effects of opioid-containing medicines for pain, cough or cold, or diarrhea while taking VIVITROL.

Patients should carry written information with them at all times to alert healthcare providers that they are taking VIVITROL, so they can be treated properly in an emergency.

A Patient Wallet Card or Medical Alert Bracelet can be ordered from: 1-800-848-4876, Option #1.

PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE.

Alkermes®

www.vivitrol.com

Vivitrol®
(naltrexone for extende - lease I le suspensi

Available online (www.vivitrolrems.com/content/pdf/patinfo-counseling-tool.pdf).

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Sample XR-NTX Treatment Agreement

This form is for educational/informational purposes only. It doesn't establish a legal or medical standard of care. Healthcare professionals should use their judgment in interpreting this form and applying it in the circumstances of their individual patients and practice arrangements. The information provided in this form is provided "as is" with no guarantee as to its accuracy or completeness.

TREATMENT AGREEMENT

I agree to accept the following treatment agreement for extended-release injectable naltrexone office-based opioid use disorder treatment:

1. The risks and benefits of extended-release injectable naltrexone treatment have been explained to me.
2. The risks and benefits of other treatment for opioid use disorder (including methadone, buprenorphine, and nonmedication treatments) have been explained to me.
3. I will be on time to my appointments and respectful to the office staff and other patients.
4. I will keep my healthcare provider informed of all my medications (including herbs and vitamins) and medical problems.
5. I agree not to obtain or take prescription opioid medications prescribed by any other healthcare provider.
6. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.
7. If I miss a scheduled appointment for my next extended-release naltrexone injection, I understand that I should reschedule the appointment as soon as possible because it is important to receive the medication on time to reduce the risk of opioid overdose should I return to use.
8. If I come to the office intoxicated, I understand that my healthcare provider will not see me.
9. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from the clinic.
10. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.
11. I understand that initially I will have weekly office visits until my condition is stable.
12. I can be seen every 2 weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row.
13. I may be seen less than every 2 weeks based on goals made by my healthcare provider and me.
14. I understand that people have died trying to overcome the opioid blockade by taking large amounts of opioids.
15. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to follow my healthcare provider's recommendations for additional counseling and/or for help with other problems.
16. I understand that there is no fixed time for being on naltrexone and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
17. I understand that my risk of overdose increases if I go back to using opioids after stopping naltrexone.
18. I have been educated about the other two FDA-approved medications used to treat opioid use disorder, methadone and buprenorphine, and I prefer to receive treatment with naltrexone.
19. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting naltrexone treatment and have been informed about methods for preventing pregnancy.
20. I have been informed that if I become pregnant during naltrexone treatment, I should inform my provider and have a discussion about the risks and benefits of continuing to take naltrexone.

Other specific items unique to my treatment include:

Patient Name (print): _____

Patient Signature: _____ Date: _____

This form is adapted from ASAM's Sample Treatment Agreement, which is updated periodically; the most current version of the agreement is available online (www.asam.org/docs/default-source/advocacy/sample-treatment-agreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn=0).

Adapted with permission.[54]

Glossary of TIP Terminology

Abuse liability: The likelihood that a medication with central nervous system activity will cause desirable psychological effects, such as euphoria or mood changes, that promote the medication's misuse.

Addiction: As defined by ASAM,[55] "a primary, chronic disease of brain reward, motivation, memory, and related circuitry." It is characterized by 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. Like other chronic diseases, addiction often involves cycles of **relapse** and **remission**. The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition[56] (DSM-5), does not use the term for diagnostic purposes, but it commonly describes the more severe forms of opioid use disorder.

Bioavailability: Proportion of medication administered that reaches the bloodstream.

Care provider: Encompasses both **healthcare professionals** and other professionals who do not provide medical services, such as counselors or providers of supportive services. Often shortened to "provider."

Cross-tolerance: Potential for people tolerant to one opioid (e.g., heroin) to be tolerant to another (e.g., methadone).

Dissociation: Rate at which a drug uncouples from the receptor. A drug with a longer dissociation rate will have a longer duration of action than a drug with a shorter dissociation rate.

Half-life: Rate of removal of a drug from the body. One half-life removes 50 percent from the plasma. After a drug is stopped, it takes five half-lives to remove about 95 percent from the plasma. If a drug is continued at the same dose, its plasma level will continue to rise until it reaches steady state concentrations after about five half-lives.

Healthcare professionals: Physicians, nurse practitioners, physician assistants, and other medical service professionals who are eligible to prescribe medications for and treat patients with OUD. The term "**prescribers**" also refers to these healthcare professionals.

Induction: Process of initial dosing with medication for OUD treatment until the patient reaches a state of stability; also called initiation.

Intrinsic activity: The degree of receptor activation attributable to drug binding. **Full agonist, partial agonist**, and **antagonist** are terms that describe the intrinsic activity of a drug.

Maintenance treatment: Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint (as with the typical standard of care in medical and psychiatric treatment of other chronic illnesses).

Medically supervised withdrawal (formerly called detoxification): Using an opioid agonist (or an alpha-2 adrenergic agonist if opioid agonist is not available) in tapering doses or other medications to help a patient discontinue illicit or prescription opioids.

Medical management: Process whereby healthcare professionals provide medication, basic brief supportive counseling, monitoring of drug use and medication adherence, and referrals, when necessary, to addiction counseling and other services to address the patient's medical, mental health, comorbid addiction, and psychosocial needs.

Mutual-help groups: Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and NA are the most

widespread and well-researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).

Office-based opioid treatment (OBOT): Providing medication for OUD in settings other than certified OTPs.

Opiates: A subclass of opioids derived from opium (e.g., morphine, codeine, thebaine).

Opioid misuse: The use of prescription opioids in any way other than as directed by a prescriber; the use of any opioid in a manner, situation, amount, or frequency that can cause harm to self or others.[57]

Opioid receptor agonist: A substance that has an affinity for and stimulates physiological activity at cell receptors in the central nervous system that are normally stimulated by opioids. **Mu-opioid receptor full agonists** (e.g., methadone) bind to the mu-opioid receptor and produce actions similar to those produced by the endogenous opioid beta-endorphin. Increasing the dose increases the effect. **Mu-opioid receptor partial agonists** (e.g., buprenorphine) bind to the mu-opioid receptor. Unlike with full agonists, increasing their dose may not produce additional effects once they have reached their maximal effect. At low doses, partial agonists may produce effects similar to those of full agonists.

Opioid receptor antagonist: A substance that has an affinity for opioid receptors in the central nervous system without producing the physiological effects of opioid agonists. Mu-opioid receptor antagonists (e.g., naltrexone) can block the effects of exogenously administered opioids.

Opioid receptor blockade: Blunting or blocking of the euphoric effects of an opioid through opioid receptor occupancy by an opioid agonist (e.g., methadone, buprenorphine) or antagonist (e.g., naltrexone).

Opioids: All natural, synthetic, and semisynthetic substances that have effects similar to morphine. They can be used as medications having such effects (e.g., methadone, buprenorphine, oxycodone).

Opioid treatment program (OTP): An accredited treatment program with SAMHSA certification and DEA registration to administer and dispense opioid agonist medications that are approved by FDA to treat opioid addiction. Currently, these include methadone and buprenorphine products. Other pharmacotherapies, such as naltrexone, may be provided but are not subject to these regulations. OTPs must provide adequate medical, counseling, vocational, educational, and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement.[58]

Opioid use disorder (OUD): Per DSM-5,[59] a disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. Tolerance and withdrawal do not count toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision. OUD covers a range of severity and replaces what the DSM-IV termed "opioid abuse" and "opioid dependence." An OUD diagnosis is applicable to a person who uses opioids and experiences at least 2 of the 11 symptoms in a 12-month period. (See Exhibit 2.11 in Part 2 for full DSM-5 diagnostic criteria for OUD.)

Peer support: The use of peer support specialists in recovery to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.

Peer support specialist: Someone in recovery who has lived experience in addiction plus skills learned in formal training. Peer support specialists may be paid professionals or volunteers. They are distinguished from members of mutual-

help groups because they maintain contact with treatment staff. They offer experiential knowledge that treatment staff often lack.

Prescribers: Healthcare professionals who are eligible to prescribe medications for OUD.

Psychosocial support: Ancillary services to enhance a patient's overall functioning and well-being, including recovery support services, case management, housing, employment, and educational services.

Psychosocial treatment: Interventions that seek to enhance a patient's social and mental functioning, including addiction counseling, contingency management, and mental health services.

Receptor affinity: Strength of the bond between a medication and its receptor. A medication with high mu-opioid receptor affinity requires lower concentrations to occupy the same number of mu-opioid receptors as a drug with lower mu-opioid receptor affinity. Drugs with high mu-opioid receptor affinity may displace drugs with lower affinity.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their SUDs and regain health and social function. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature. Patients taking FDA-approved medication to treat OUD can be considered in recovery.

Recovery capital: The sum of the internal (e.g., motivation, self-efficacy, spirituality) and external (e.g., access to health care, employment, family support) resources that an individual can draw on to begin and sustain recovery from SUDs.

Recovery-oriented care: A service orientation that supports individuals with behavioral health conditions in a process of change through which they can improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Relapse: A process in which a person with OUD who has been in **remission** experiences a return of symptoms or loss of remission. A relapse is different from a **return to opioid use** in that it involves more than a single incident of use. Relapses occur over a period of time and can be interrupted. Relapse need not be long lasting. The TIP uses relapse to describe relapse prevention, a common treatment modality.

Remission: A medical term meaning a disappearance of signs and symptoms of the disease.[60] DSM-5 defines remission as present in people who previously met OUD criteria but no longer meet any OUD criteria (with the possible exception of craving).[61] Remission is an essential element of **recovery**.

Return to opioid use: One or more instances of **opioid misuse** without a return of symptoms of OUD. A return to opioid use may lead to **relapse**.

Tolerance: Alteration of the body's responsiveness to alcohol or other drugs (including opioids) such that higher doses are required to produce the same effect achieved during initial use. See also **medically supervised withdrawal**.

Notes

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