NEW INNOVATIONS IN OPIOID TREATMENT: BUPRENORPHINE

Participant’s Reference Guide and Workbook

NAADAC, the Association for Addiction Professionals
1001 N. Fairfax Street, Suite 201
Alexandria, VA 22314
703.741.7686 • 800.548.0497
fax: 703.741.7698 • 800.377.1136
e-mail: naadac@naadac.org

presented by:

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
www.naadac.org

NAADAC
KNOWLEDGE CENTER
Life-Long Learning Series
# TABLE OF CONTENTS

A Special Thank You ................................................................. 3  
Executive Summary ................................................................. 7  
Trainer Biographies ................................................................. 8  
Seminar Agenda ................................................................. 11  
Seminar Objectives ................................................................. 11

**Section One: Introduction to Opioids and Opioid Dependence**  
An Open Conversation About Medication-Assisted Treatment for Opioid Dependence .......... 15  
Medication-Assisted Treatment Myths ........................................... 16  
Locating Opioid Dependence .................................................. 18  
Prevalence of Opioid Abuse, Dependence and Treatment ..................... 19  
Identifying Opiates and Opioids ................................................ 20  
History of Opioid Use and Treatment ........................................ 23  
The Drug Addiction Treatment Act of 2000 (Data 2000) ............... 25

**Section Two: Psychopharmacology of Opioids**  
Basic Brain Functioning 101 ................................................... 29  
Effects of Opioid Consumption in the Brain ................................ 30

**Section Three: Opioid Dependence Defined**  
Defining Opioid Dependence .................................................. 37

**Section Four: Opioid Dependence Treatment**  
Reasons for Not Entering Treatment ......................................... 43  
Naltrexone Fact Sheet ........................................................... 44  
Methadone Fact Sheet ........................................................... 46  
Buprenorphine Fact Sheet ....................................................... 48  
How Does Buprenorphine Work? ............................................... 50  
Scientific Research About Buprenorphine .................................. 52  
Side Effects and Contraindications for Buprenorphine .................... 54

**Section Five: Identification of Clients for Buprenorphine Treatment**  
Matching Buprenorphine with Appropriate Clients ....................... 59  
Additional Client Considerations for Buprenorphine ..................... 62  
Case Study - Ryan ............................................................... 64

**Section Six: Coordinated Care**  
Holistic Treatment for Opioid Dependence .................................. 67  
Successful Coordinated Care .................................................. 68  
Defining Expectations of Physician, Counselor and Client ................ 70
Section Seven: Counseling Buprenorphine Clients

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementing Medication-Assisted Treatment</td>
<td>75</td>
</tr>
<tr>
<td>Assessing Readiness to Change</td>
<td>76</td>
</tr>
<tr>
<td>Igniting Internal Motivation to Change</td>
<td>78</td>
</tr>
<tr>
<td>Combining Different Interventions</td>
<td>79</td>
</tr>
</tbody>
</table>

Section Eight: Program Review

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying The Stage of Change</td>
<td>85</td>
</tr>
<tr>
<td>Solidifying Learned Information</td>
<td>88</td>
</tr>
</tbody>
</table>

Section Nine: Appendices

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A: Commonly Used Terms</td>
<td>91</td>
</tr>
<tr>
<td>Appendix B: Clinical Opiate Withdrawal Scale (COWS)</td>
<td>92</td>
</tr>
<tr>
<td>Appendix C: Abstracts of Pivotal Clinical Trials for Buprenorphine</td>
<td>93</td>
</tr>
<tr>
<td>Appendix D: Sample Blank Treatment Form</td>
<td>95</td>
</tr>
<tr>
<td>Appendix E: Drug Test Information</td>
<td>96</td>
</tr>
<tr>
<td>Appendix F: Sample Confidentiality Release Plan</td>
<td>97</td>
</tr>
<tr>
<td>Appendix G: Sample Client Update Report</td>
<td>98</td>
</tr>
<tr>
<td>Appendix H: Triggers and Cravings</td>
<td>99</td>
</tr>
</tbody>
</table>

Section Ten: Resources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction and Opioid Dependency Resources</td>
<td>103</td>
</tr>
<tr>
<td>Naadac, The Association for Addiction Professionals</td>
<td>104</td>
</tr>
<tr>
<td>Addiction Technology Transfer Center (ATTC) Regional Map</td>
<td>105</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Opioid dependence afflicts almost two million people in the United States each year, with only approximately one half of dependent persons receiving any form of addiction treatment. Over the past few decades, researchers and scientists have developed several new medications to assist clients with opioid dependence. The most recent advancement is buprenorphine, which is approved by the Food and Drug Administration (FDA) for the treatment of opioid dependence. Buprenorphine works by alleviating uncomfortable opioid withdrawal symptoms and prohibiting any illicit opioids from producing their desired effect. Medication-assisted treatments for opioid dependence, such as buprenorphine, are only one component of treatment, and they can be extremely effective for some clients.

NAADAC’s Life-Long Learning Series New Innovations in Opioid Treatment: Buprenorphine explores the role of medication-assisted treatments in the treatment of opioid dependence. Many addiction counselors and other helping professionals are uncomfortable with the notion of recommending a medication to treat a client’s addiction to opioids. By providing useful, unbiased, scientific information concerning opioids and opioid dependence, this educational seminar is intended to help addiction counselors and other helping professionals understand the impact opioids have on the brain and what this means for subsequent treatment options.

When opioids are repeatedly consumed, the regulation of certain neurotransmitters in the brain is altered and results in opioid dependence. These adaptations in the brain impede many opioid dependent clients from discontinuing illicit opioids due to the onset of highly uncomfortable withdrawal symptoms. Medication-assisted treatments for opioid dependence, such as buprenorphine, allow clients to live their lives without illicit opioids and the related withdrawal symptoms. Research indicates that clients who utilize medication-assisted treatments for opioid dependence stay in treatment longer and consume less illicit opioids than their counterparts.

Medication-assisted treatments for opioid dependence, such as buprenorphine, are not ideal for all clients. It is the final decision of a specially certified and licensed physician whether or not to prescribe buprenorphine, but all members of the multidisciplinary addiction treatment team should contribute to this decision. In addition, opioid dependence treatment is most effective when it is holistic, coordinated and addresses the biological, psychological, social and spiritual components of this disease. Further, by utilizing techniques from Motivational Interviewing, integrating medication-assisted treatments for opioid dependence into a client’s treatment plan can be extremely helpful for clients at any Stage of Change.
AN OPEN CONVERSATION ABOUT MEDICATION-ASSISTED TREATMENT FOR OPIOID DEPENDENCE

The purpose of today’s educational seminar is to provide addiction and other helping professionals with useful, unbiased information concerning medication-assisted treatment for opioid dependence so clients are afforded the best available resources and options for their treatment. However, there are many strongly felt emotions held by addiction and other helping professionals toward medication-assisted treatment for opioid dependence. Many of these beliefs can unnecessarily limit the resources available to clients who suffer from opioid dependence and may not be factual. The intention of today’s educational seminar is not to persuade opinions or disprove beliefs, but rather to educate and strengthen current knowledge of medication-assisted treatment for opioid dependence.

To best identify your feelings towards medication-assisted treatment, please divide into groups and answer each question on the white paper located at various points of the training room. Please be open and honest with your responses so your colleagues can learn from your opinion. When finished, please return to your seat and write each question posed to the group under each heading below. During the discussion portion of this exercise, please write down the responses of your colleagues and evaluate your opinion toward medication-assisted treatment for opioid dependence.

Question #1: _____________________________
______________________________
______________________________

Responses from the group: ________________
______________________________
______________________________
______________________________

Question #2: _____________________________
______________________________
______________________________

Responses from the group: ________________
______________________________
______________________________
______________________________

Question #3: _____________________________
______________________________
______________________________

Responses from the group: ________________
______________________________
______________________________
______________________________

This section provides an introduction to opiates and opioids: what they are, where they are used and who are using them. Opinions, myths and the history of medication-assisted treatment for opioid dependence are also discussed.
As the previous section identified, addiction and other helping professionals have varying opinions and beliefs about medication-assisted treatment for opioid dependence. Some of the beliefs held by the profession are accurate, while, other opinions do not reflect current research, literature or current practice. This section will discuss some of the most commonly held misconceptions concerning opioid dependence and pharmacotherapies.

- Medications are not a part of treatment.
  - The three pharmacotherapies for opioid dependence that are approved by the Food and Drug Administration (FDA) should be used in conjunction with psycho-social-educational-spiritual therapy. Therefore, medications can be used as a part of treatment, but only one part.
  - Medications are used in the treatment of many diseases, including opioid dependence.
  - Making the final decision about whether or not medications are a part of a client’s treatment is out of the counselor’s scope of practice. Prescribers, doctors and any other appropriate professionals are tasked with this responsibility.

- Medications are drugs, and you cannot be clean if you are taking anything.
  - Addiction counselors and other helping professionals need to change their terminology to reflect current trends in the addiction profession. “Drugs” are illicit psychoactive substances that are used to achieve a “high.” “Medications” are available by prescription and are used to treat an illness, disorder or disease. Buprenorphine is an example of a legally prescribed medication.
  - Millions of Americans use the patch, inhalers and/or buproprion (Zyban) to quit smoking, and this practice is widely encouraged by addiction professionals. However, nicotine replacement therapies work in the same way opioid replacement therapies work. These methods are pharmacotherapies and have gained broad social acceptance.
Using medications to treat opioid dependence is replacing one addiction with another.

- An addiction to opioids and a physical dependence to a medication used to prevent withdrawal symptoms are not the same thing. Addiction and physical dependence are different. Addiction is defined by the pathological behaviors and compulsivity of use, not by the body’s adaptation to a medication. Physical dependence is only one criterion of many that are required for a diagnosis of opioid dependence (addiction).

- The goal of addiction treatment is always to assist a client in stopping his or her compulsive use of drugs or alcohol and progress to living a normal, functional life. Medication-assisted treatment for opioid dependence can help some clients achieve this goal.

- Addiction to opioids creates a myriad of negative effects to the dependent client, his or her family and friends and society as a whole. Most of these devastating effects of opioid dependence are due to the illicit nature of the drug, debilitating side effects of constant use and the dependent’s inability to perform normal functions in society, such as working and parenting. Removing negative effects of opioid use allows a client to live a normal life and contribute to society.

- Medication-assisted treatment with opioid replacement medications can be highly effective for opioid dependent clients.

- Medications will get you high.
  - If appropriately administered, medication-assisted treatments for opioid dependence will not produce euphoric effects, but will help the person to feel normal. While misuse is possible, behavioral treatments and ongoing support can help the client use the medication appropriately and achieve his or her goal.
  - Buprenorphine is specifically designed to decrease the street value and abuse liability exhibited by previous medications to treat opioid dependence. One version of buprenorphine has a mechanism that deters clients from administering it intravenously or else risking full-blown withdrawal symptoms.

- Methadone, buprenorphine and naltrexone occupy the same receptors in the brain as illicit opioids; therefore, these medications can block the euphoric effects of exogenously administered opioids.

- Medications are a crutch.
  - The single most accurate predictor of successful treatment outcome is the length of time in treatment. Pharmacotherapies can help clients remain in treatment longer, continue to stay committed to meeting their treatment goals and maintain long-term sobriety.
  - The client can think more clearly without so many physiological distractions taking away from counseling objectives.
  - Pharmacotherapies are effective. Clinical data suggest that medication-assisted opioid dependence treatment can help clients reduce their illicit opioid use and stay in treatment.
  - Anything can be a “crutch” in treatment – food, sex, work, shopping, smoking, another person, etc. For example, if an individual injures his or her leg, a crutch helps him or her protect the leg until it is strong enough to bear weight. Not all “crutches” are detractors from sobriety goals, and not all “crutches” are bad. A client needs some allowances to get them through each day in treatment, and any unhealthy “crutches” can be addressed therapeutically in treatment.

- Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) does not support the use of medications.
  - Contrary to popular belief, neither Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) literature nor either of its founding members spoke or wrote against using medications as a component of a recovery plan for dependence. This belief was held by leaders of specific chapters and spread erroneously to be AA/NA doctrine.
  - Even today, AA/NA does not endorse encouraging AA/NA participants to discontinue taking prescribed medications for the treatment of addiction.
The Big Book, the primary reference tool written by the founders of AA, states, “God has abundantly supplied this world with fine doctors, psychologists, and practitioners of various kinds. Do not hesitate to take your health problems to such persons. Most of them give freely of themselves, that their fellows may enjoy sound minds and bodies. Try to remember that though God has wrought miracles among us, we should never belittle a good doctor or psychiatrist. Their services are often indispensable in treating a newcomer and in following his case afterward.”

The Narcotics Anonymous (NA) website states the following: “In Narcotics Anonymous, members are encouraged to comply with complete abstinence from all drugs including alcohol. It has been the experience of NA members that complete and continuous abstinence provides the best foundation for recovery and personal growth. NA as a whole has no opinion on outside issues, including prescribed medications. Use of psychiatric medication and other medically indicated drugs prescribed by a physician and taken under medical supervision is not seen as compromising a person’s recovery in NA.”

Opioid dependence is not a regional problem that only plagues inner cities or rural communities. Opioids are being bought, sold, injected, snorted, swallowed, crushed and abused in all corners of this country, at all parts of the day. There are many different opioids of abuse circulating in the United States, and each region deals with its own unique problems. This next section will discuss the what, where and why of opioids and opioid dependence.

On the map below, please write the opioids you feel to be a problem in your region. If you know any information about other regions, please include it as well. This exercise illustrates the vast range of abuse that plagues the United States and what makes opioid dependence treatment so unique.
PREVALENCE OF OPIOID ABUSE, DEPENDENCE AND TREATMENT

Opioid dependence is not a problem that only plagues certain populations, occupations or age groups. This next section will discuss who is using, abusing and dependent on opioids.

- In 2006, 22.6 million people aged 12 or older were either abusing or dependent upon one or more substances, which is 9.2% of the general population.
- Of those people, almost two million were abusing opioids.
  - 1,635,000 abused pain relievers.
  - 323,000 abused heroin.
- Each month, 300,000 people used heroin, and 5.2 million people used pain relievers, with 300,000 of those using OxyContin.
- In 2006, 91,000 people tried heroin for the first time.
- In 2006, approximately 2.1 million people tried pain relievers for the first time.
  - This equals 249 new heroin users and 5,890 new pain reliever users per day.

In 2006, four million people aged 12 or older received treatment for drugs or alcohol, which is 1.6% of the general population. The following chart illustrates the locations addiction treatment was provided to this population: xi

In 2006, over one million people received treatment for opioids. The following chart illustrates the substance of abuse for which clients were receiving addiction treatment:xii

Ten percent of the entire abusing and dependent population (2.26 million people) state that they did not receive substance abuse treatment because it was inconvenient or no transportation was available.xiii

Between the years of 1995 and 2005, the substance of abuse for clients receiving treatment shifted in many noteworthy ways.

- Although alcohol remains the primary substance of dependence for clients receiving treatment, its dominance has decreased.
- Cocaine use has also decreased, whereas marijuana, stimulants and opioid use has increased.
- In 1995, heroin comprised 93% of all opioid-related treatment admissions; heroin comprised only 79% of all opioid-related treatment admissions in 2005.
- The following chart illustrates the primary substance of abuse for clients entering addiction treatment during 1995 and 2005:xv
Of all people entering treatment in 2005, most clients were non-Hispanic whites, had a high school education or less and were unemployed or not in the labor force.  

- 71% of clients aged 16 or older who entered treatment in 2005 were unemployed or not in the labor force; 21% of clients were employed full-time.
- 34% of clients aged 18 or older who entered treatment in 2005 had not completed high school; 22% of clients had above a high school education.
- The following chart illustrates the race of clients entering addiction treatment:

![Race of Clients Entering Treatment](image)

Source: Substance Abuse and Mental Health Services Administration, 2007

Of heroin users who received treatment in 2005, 32% were non-Hispanic white males, 18% were non-Hispanic white females, 15% were non-Hispanic black males and 11% were of Puerto Rican origin. Of clients who were receiving treatment for opioid dependence other than heroin, 48% were non-Hispanic white males and 41% were non-Hispanic white females.

### IDENTIFYING OPIATES AND OPIOIDS

To understand the vast span of opioid use in the United States, it is essential to understand what these drugs are, what they look like, how they are classified and how they are abused. The following list of medications can be broken down into two categories: opiates and opioids.

Opiates are drugs or medications that are derived directly from the opium poppy. Opioid is a broader term referring to opiates, as well as other synthetically derived drugs or medications that operate on the opioid receptor system. Most people use these terms interchangeably. For the purposes of this seminar, “opioids” will be used to indicate all drugs or medications that work on the opioid receptor system, regardless of whether they are derived from the opium poppy or synthetically manufactured.

As a side note, the opioid/opiate debate is not the only terminology associated with opioid dependence that needs to be defined. Many people use terms like “speedballing,” “kicking” and “fix” to describe the many facets of opioid dependence, but not everyone knows what these terms mean. Appendix A: Commonly Used Terms in this manual defines many “street slang” terms regarding opioids, opioid dependence and use.

Regardless of the type of opioid, naturally occurring or synthetic, each opioid works basically in the same way in the brain and body and can be divided further into three groups: agonists, partial agonists and antagonists. Each of these categories will be discussed separately.

Agonists activate opioid receptors and cause the physiological and psychological effects most commonly associated with opioid use. The following effects increase until the receptor is fully activated and a maximum effect is reached:

- pain relief
- euphoria
- bobbing head (nodding)
- warm flushing of skin, face, neck and chest
- constricted, pinpoint pupils
- suppression of cough
SECTION ONE: Introduction to Opioids and Opioid Dependence

- reduction of respiratory functions
- decrease in blood pressure
- drowsiness
- slurred speech
- constipation
- nausea
- sedation
- vomiting
- itching
- inability to urinate
- mental clouding
- impaired judgment
- decreased anxiety
- lowered libido
- dry mouth

Most opioids fall into the agonist category. These opioids are usually administered through intravenous injection, smoking, snorting or orally in pill form. The duration of effects can last anywhere from three to six hours for codeine and 12 to 36 hours for methadone, which is why opioids are often referred to as short-acting opioids and long-acting opioids. Agonist opioids include:

- Opium - a naturally occurring short-acting opioid that is also commonly known as Laudanum, Pantopon or Paregoric.

Morphine - a naturally occurring short-acting opioid that is also commonly known as Roxanol. MS Contin is a morphine extended-release product and is therefore, long-acting.

- Codeine - a naturally occurring short-acting opioid that is also commonly included in Tylenol #3 or Empirin.

- Diacetylmorphine - a synthetically manufactured short-acting opioid that is also commonly known as heroin.

- Hydromorphone - a synthetically manufactured short-acting opioid that is also commonly known as Dilaudid.

- Oxycodone - a synthetically manufactured short-acting opioid that is contained in OxyContin, Percodan, Perocet or Tylox.