Maintenance and Discontinuation of Buprenorphine

Goal

To train providers to maintain patients on buprenorphine successfully and taper off treatment as optimally as possible.

After completing this module, participants will be able to:

- Provide the treatment and monitoring that is routinely required throughout the maintenance phase of buprenorphine treatment
- Modify buprenorphine maintenance treatment as beneficial for patients receiving pain management or having substance use problems
- Follow procedures for patient selection, optimal tapering of dose, minimizing symptoms, and providing appropriate follow-up when terminating buprenorphine treatment
- Use buprenorphine for medically-supervised detoxification of patients with opioid use disorder
- Advise patients how to avoid and respond to overdose.

Professional Practice Gaps

Providers need to be able to maintain patients on buprenorphine, change treatment as needed, and know how to taper. Clinic visits should still occur during this time, but may be less frequent.

Patients should be maintained at a comfortable dose and feel minimal cravings and side effects. Some patients can taper off of buprenorphine after a year or two. Many need to continue taking it for years[1]. Because of a high relapse rate, if buprenorphine is discontinued[2], many patients need to be maintained on buprenorphine indefinitely[3].

Chapter 4 of TIP 40 on Treatment Protocols, includes a description of this processes[4], and this has been updated and clarified in the FSMB Model policy[5], and updated in later guidelines ASAM (2015), and SAMHSA (2016).

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MAINTENANCE TREATMENT PHASE

Patient Name: Mr. Richards

Age: 28 years old

Reason For Visit: Mr. Richards is beginning his maintenance phase of treatment.

Patient History: Mr. Richards became dependent on intranasal heroin, prescription opioids, and cocaine during his late teens.

Treatment History: He is currently maintained by you on buprenorphine/naloxone sublingual film and has been for the past month. He previously was able to obtain limited drug-free abstinence after an inpatient detoxification followed by involvement in NA meetings but relapsed after 6 weeks.

Maintenance On Buprenorphine

Many patients would do best if maintained on their stabilized dose of buprenorphine for years, due to a high rate of relapse when buprenorphine is discontinued[2]. Buprenorphine can be discontinued safely although there are clear risks and benefits of discontinuation. Determine the typical treatment and schedule after patients are stabilized on a buprenorphine dose that works well for them?

Maintenance Schedule

During the maintenance phase, patients should be seen in the office once weekly (or more frequently if risk is involved) for the first month.

Thereafter, if the patient is stable and assessment results are favorable, schedule maintenance once a month. Clinic visits can be decreased during maintenance, but you still need to see your patients regularly. Monitor cravings for opioids and adherence to psychosocial therapies and conduct periodic lab testing.

Typical Maintenance Period

For many patients, the length of the maintenance period is indefinite in order to prevent relapse[2]. Patients can be maintained at a 12-16 mg daily dose (generic sublingual tablets or the equivalent of other formulations) indefinitely, as long as they are comfortable and happy with treatment[6]. Research shows that 16 mg or greater or the equivalent is effective at suppressing illicit opioid use[3]. Some patients may require slight adjustments. The optimum maintenance period is unclear, but may be long-term or indefinite[7] for the majority of patients[4]. Longstanding changes to the brain caused by chronic opioid use that produce cravings for opioids and compulsions contribute to this effect[8].

Routine discontinuation of buprenorphine-assisted treatment is not supported by the available evidence[5]. Research comparing maintenance with a taper after detoxification has shown that long-term maintenance is superior to tapering in terms of retention and rate of relapse to opioid use[9]. In fact, tapering is associated with a high relapse rate, for example, in one study, only 8.6% were still abstinent at 8 weeks post taper[10]. A minority of patients can be weaned off buprenorphine successfully[4]. Patients who had a longer history of substance abuse are at greater risk of relapse when discontinuing treatment.

PRACTICE TIP

A reduction in the frequency of visits (and thus reduced cost) can feel like a reward to patients for positive changes they make.

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GENERAL MAINTENANCE GUIDELINES

Maintaining vigilance throughout the maintenance phase is important in order to prevent relapse. Patients maintained on the buprenorphine implant still benefit from monitoring, for self-efficacy, compliance with the remainder of the treatment, and signs of relapse even though their implant lasts 6 months[11]. Follow-up should be 1 week after implantation and no less than monthly. Some patients may require a supplemental dose taken through the oral mucosa.

Assess your patient's progress toward his or her treatment goals at each visit. For the following assessments, problematic results need to be addressed. For many patients, more treatment structure is beneficial, such as more frequent appointments or participation in counseling. When severe problems are identified, a higher level of care than office-based treatment may be indicated. When evaluating results, consider whether the patient is doing functionally well, or at least better than at intake.

The following are part of maintenance period assessment.

Behavioral Assessment

Assess the psychosocial status of the patient regularly and increase supports as needed, because stability is important for continued abstinence.

- Are they keeping appointments and other engagement in treatment?
- Do they adhere to the treatment agreement?
- Assess for changes in psychosocial stability and support systems.
- Assess participation in recommended professional counseling and support services.
- Assess the strength of your alliance with the patient – Ask if there are any problems or concerns.

Medication should not be stopped, however, because of non-adherence to counseling. Checking in with the provider or trained staff may also be an effective way to support maintenance.

Abstinence From Opioids Or Relapse, Use Of Other Drugs And Alcohol

- Conduct urine toxicology screen weekly for first 2 months (most likely time they are going to relapse) and then randomly, nearly monthly.
- Utilize the patient self-report substance screening tool, such as the NIDA Quick Screen.
- Use the Prescription Drug Monitoring program—check regularly and address positive results.
- Decide if you are going to use pill count/dose reconciliation and adjust treatment protocol structure as would benefit the patient. Develop a policy for what you will do if the pill counts are off, such as reducing the supply prescribed at one time. Some clinics find pill counts useful; others say it is ineffective. It may depend upon factors, such as the severity of a patient's opioid use disorder or their respect for authority.
- ASAM's guidelines for medication-assisted treatment recommend follow-up visits for pill/supply counts, in order to reduce diversion[12]. If someone sells a whole supply of medication early in the month, they will not have the correct amount left at the counting appointment.
- Physical consequences of drug use—address as would benefit the patient.

Medical Evaluation

- Conduct initial pregnancy tests for all women of childbearing age. Each month thereafter, ask if the patient thinks they may be pregnant or test the patient as seems indicated. Request to be notified if they think they are pregnant.
- Conduct liver function tests at 6 months, if the initial test was abnormal, or with liver disease.

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- Review side effects from buprenorphine.

Relapse Prevention

Encourage patients to develop a plan to deal with the following common factors that lead to relapse[7].

Factors That Contributed To Relapse

- Inability to manage stress or negative emotional states (most common)
- Interpersonal conflicts with family or others
- Poor adherence to the treatment regimen
- Negative thinking
- Insufficient motivation to change

Mr. Richards: Discussing Relapse Prevention

Provider: *I'd like to talk to you a little bit about your treatment history. You had inpatient detoxification a couple years ago, correct?*

> ***Mr. Richards****: Yes, and then when I got out I was going to NA meetings. But then I stopped going and started using again.*

Provider*: It's important to identify and understand situations that may prompt relapse. What do you believe prompted that one?*

> ***Mr. Richards****: I was having some issues at work and had a lot of stress. Everything seemed to be coming down on me at once and I just needed it, you know?*

Provider*: Sounds like a rough time. Maybe some extra support around then might have helped. NA can often be a resource in this way if you fully engage in the program. How involved were you?*

> ***Mr. Richards****: I have to admit I didn't take it seriously enough.*

Provider: That *can be an important resource. I encourage you to give it another try. But, like they say, it works if you work it. Tell me what else you tried to deal with the pressures.*

> ***Mr. Richards****: I got things under better control at work. I talked to my boss and we got my assignments worked out. I also scaled back on some other stuff I was doing so I'd have more time to decompress. That helped, but by then, I* was *hooked again. Now, things are okay at work.*

Provider*: Good to hear. Any ideas what you could do, instead of using, if things got tense like that at work again?*

> ***Mr. Richards****: I will give NA another try. It might help me get ready for the next stressful time at work.*

Provider*: That's good to hear.*

Steps to support your patient from the beginning of maintenance[5]:

- Together with your patients, identify environmental stressors and their cues to relapse.
- Help them learn skills in coping with negative emotional states or refer them for learning coping skills (for example, to cognitive behavioral therapy).
- Advocate for a balanced lifestyle.
- Work with your patient to understand how to manage temptations to use and to report cravings which may mean they are under-medicated.
- Develop an emergency plan for lapses, that is episodes of using once or twice, to avoid a complete relapse.

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- Help your patients develop or refer them for help in developing a support system, which can be families or more formal supports, such as 12 step programs.

Mr. Richards: Discussing Concerns

Provider: *You've been on buprenorphine/naloxone sublingual film for a month now. Do you have any problems to report?*

> ***Mr. Richards***: *No, I'm feeling good so far. No cravings, but there have been a few times where I have been tempted anyhow.*

Provider: *It's good to avoid places and people that lead to feeling tempted. How's your support system? Do you have some friends that are drug-free or attend a more formal support group?*

> ***Mr. Richards***: *I'm kind of between girlfriends right now. We actually had a fight the day I felt tempted to go back to using. I might need to go to more NA meetings and call my sponsor.*

Provider: *Good thinking! Stress can certainly contribute to lapses. It sounds like a good time to double up on support.*

Quiz: Maintenance Period

How Long Is The Buprenorphine Maintenance Period For Most Patients?

1. Weeks
2. Months
3. Years

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Maintenance Period Quiz Feedback

(1) Weeks,

(2) Months

Patients can, and many should be maintained on buprenorphine indefinitely. Most patients take buprenorphine for years[3,4]. Relapse is very common among addicts who discontinue treatment[2].

(3) Years

Correct. Patients can, and many should be maintained on buprenorphine indefinitely. Most patients take buprenorphine for years[3,4]. Relapse is very common among addicts who discontinue treatment[2].

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MAINTENANCE DOSE

Combination formulations of buprenorphine plus naloxone should be used during maintenance unless contraindicated or implants or injectable formulations are used. The stabilization dose will be set during induction and rarely needs to be increased or decreased. Patients should have no withdrawal and no cravings at their maintenance dose.

- Daily dose during the maintenance period should be between 8-32 mg* Research supports the effectiveness of 16 mg/day dose[3].
- Patients can be maintained at a 12-16 mg daily dose indefinitely, as long as the patient is comfortable and happy with treatment for most formulations of buprenorphine plus naloxone[3].
- *Doses described were established for sublingual tablets; use equivalent doses for other formulations. Because Zubsolv®* and Bunavail™* have different dosages from generic tablets and Suboxone® film, their target maintenance dosage differs. If a patient is ever shifted from one formulation to another formulation, a slight shift to the equivalent dose may be needed. A conversion table is available on the drug information.
- Doses for implants or injectables are determined by the product; implants are replaced at 6 months. The long-acting injection formulation is given monthly at a REMS certified clinic.
- Dosage limits: Doses above 24 mg of buprenorphine/day have not been shown to provide any greater effectiveness[3].
- As long as patients are compliant with treatment, they can be prescribed a 30 day supply during maintenance[13].

*We are using brand names since there is a difference in the product that is not reflected in the generic name. We are not advocating one or the other.

PRACTICE TIP

Be sure to have a pre-determined policy regarding refills during the maintenance period and for re-induction of patients who have relapsed.

Dose Modifications

If Dosage Is Too Low

If withdrawal symptoms are experienced for a 24-hour dosing interval, the dose is probably too low and needs to be increased. As during the Stabilization period, increase the dose in small increments (2 mg Suboxone or equivalent in other formulations). Allow 5 days between dose adjustments[7]. Withdrawal symptoms may be experienced, and therefore the dose may need to be raised for the following reasons[5,7]:

- Other prescriptions (starting, stopping, or dose change)
- Pregnancy
- Menopause
- Liver disease
- Weight change
- Change to a more efficiently absorbed buprenorphine formulation

Considerations For A High Dose

The apparent need for a higher dose should be evaluated carefully. Doses of 24 mg and up should be evaluated for possible stockpiling or diversion; higher doses should be treated as an exception to the norm. Dosages higher than 24

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mg have not demonstrated any clinical advantage[6]. Doses should be individualized with a maximum of 32 mg of Suboxone or equivalent in other formulations. The lowest dose that controls symptoms is the right dose. Relatively high doses can be decreased gradually after 6-12 months; most patients stabilize between 12 and 16 mg daily dose[6]. Even large doses are typically taken only once per day on a consecutive basis using around 8 mg at a time.

PRACTICE TIP

Buprenorphine formulated for treating opioid use disorder may not be sufficient as a pain treatment by itself, but some patients experience better pain control on buprenorphine than they experienced with opioids. While a single dose of buprenorphine works best to treat opioid use disorder to avoid a PRN mentality, some patients, especially those in chronic pain, may do better on a b.i.d. or t.i.d. dosing schedule.

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COUNSELING AND PSYCHOSOCIAL SUPPORT

Counseling

Several evidence-based guidelines for medication-assisted treatment of opioid addiction recommend behavioral treatment be concurrent with buprenorphine treatment[3,12,13]. Counseling should begin early in buprenorphine treatment[12]. Evidence points to improved treatment outcomes when psychosocial counseling is added to pharmacological therapy for treating opioid addiction[3].

Counseling can help patients in medication-assisted treatment for addiction in the following ways:

- Better engagement in treatment
- Improved attitudes and behaviors related to their substance use problem
- Improved health-related life skills
- Longer treatment retention

Forms of counseling that are considered effective with patients in buprenorphine treatment include[12]:

- Cognitive-behavioral therapy (CBT)
- Contingency management
- Relapse prevention
- Motivational interviewing

Discuss The Benefits Of Psychosocial Support

For example, to introduce the topic, a provider might say:

Provider: *I think you would benefit from attending counseling sessions, in addition to taking buprenorphine. I have a list of providers that we can look at to figure out who would be the best fit for you.*

Guidelines For Behavioral Support

Guidelines For Psychosocial Buprenorphine Treatment

Guidelines for medicine assisted therapy, which includes buprenorphine, recommend concurrent psychosocial treatment while in buprenorphine treatment[12]. At minimum, the recommendation is for:

- Assessing psychosocial needs
- Counseling – may be individual and/or group
- Derive as much benefit as possible from family support systems or equivalent
- Community-based services referrals

The following guidelines from *Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders*[13], produced by expert panel process will help you make sure that patients on buprenorphine are receiving psychosocial support.

- Providers should establish connections with a variety of psychosocial support providers to whom they can refer patients.
- Psychosocial counseling appointments should be included in a patient's buprenorphine treatment agreement.
- Early in treatment, patients should be attending psychosocial counseling appointments weekly until stabilized.

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- If a patient is not complying with psychosocial treatment, the patient should be contacted and this problem discussed.
- Psychosocial therapy appointments can be less frequent for stable patients in maintenance.
- For patients who suffer from co-occurring depression and/or anxiety:
    - Consider treating depression or anxiety with medication having low potential for abuse, such as SSRI's or tricyclic antidepressants, if patients are still symptomatic once stabilized in terms of buprenorphine.
    - Integrate the treatment for anxiety and/or depression with buprenorphine treatment; treat on site if possible.
    - Make sure patients are also attending evidence-based psychosocial treatment, such as Cognitive Behavioral Therapy, Relapse Prevention, or Contingency Management. Use of Motivational Interviewing in your practice or by other healthcare providers can also support recovery.
    - Refer patients to Twelve-Step Programs, such as Narcotics Anonymous, Alcoholics Anonymous, or Dual Recovery Anonymous.
    - Some groups, having a zero drug policy, may not welcome participation by people who are taking buprenorphine.
    - Refer patients to a specialist if they do not respond to your treatment of their depression or anxiety.

PRACTICE ACTIONS

1. If you do not yet have connections with psychosocial treatment providers, check SAMHSA's treatment or mental health locator for local providers.
2. See patients in maintenance on a regular basis. These office visits themselves can provide valuable psychosocial support[14].

Evidence-Based Counseling For Substance Use Disorders

It helps to have a basic understanding of the different types of counseling available to support your patients' recovery so that you can direct patients toward the one the might be best for them and answer their questions. A number of evidence-based treatment types have been shown to be effective for substance use disorders and can be used to supply the recommended psychosocial support for a buprenorphine patient.

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is grounded in the theory that certain patterns of behavior and thoughts can contribute to the development and maintenance of substance use disorders[15,16]. Weekly individual sessions (usually lasting 12-24 weeks) teach patients to identify thought and behavior patterns through self-monitoring and to cope with them as they arise in order to decrease substance use[15,16]. CBT has been shown to increase the rate of long-term treatment success and improve mental health outcomes for those with co-occurring mental health disorders[15,16].

Contingency Management And Community Reinforcement Approach

Contingency Management centers around tangible positive reinforcement for positive behavior change[15,16]. Positive behavior, such as participation in therapy sessions or having a negative urine drug test, is rewarded with vouchers that can be exchanged for desired objects, goods, or activities. Having a goal to work towards along with a tangible reward has been shown to be more effective than traditional treatment approaches in terms of longer abstinence and active engagement in treatment.

Community Reinforcement Approach (CRA) Plus Vouchers is an outpatient program that furthers the positive reinforcement approach by combining the voucher system with group therapy[15,16]. Group counseling sessions focus on how to reduce substance use and build support systems for long-term abstinence[15,16].

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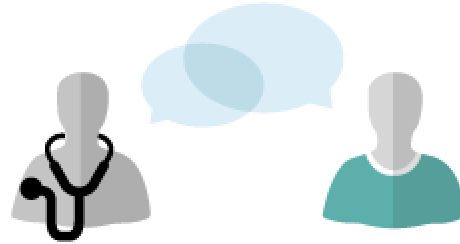
Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) utilizes motivational interviewing techniques to support patients having uncertainty about ceasing substance use[15,16]. Patients develop awareness of how their actions and goals are misaligned, which often increases motivation to change their behaviors to meet their goals. MET uses empathy and support rather than confrontational tactics in order to promote change, which leads to self-efficacy in the patient and better long-term outcomes.

Further Evidence-Based Counseling

Family Therapies

Family Therapies can be a means to improve a patient's psychosocial support, which can improve patient outcomes. These therapies engage family members and friends to help support the patient's recovery and long-term abstinence. Different kinds of family therapies meet a variety of patient needs. Family Behavior Therapy (FBT) and Behavioral Couples Therapy (BCT) are most often used by adult patients[15,16].



- Family Behavior Therapy (FBT) looks at not only the substance use but also surrounding family issues that may contribute, such as conflicts in the home or mental disorders in the family[15,16]. FBT helps the patient set goals, develop skills, eliminate or change factors that might prevent treatment success, and prepare both the patient and their social support system for treatment. Therapy can last up to 20 sessions[15,16].
- Behavioral Couples Therapy (BCT) involves both patient and their spouse. It includes the patient making a "daily sobriety contract" and the spouse supporting this commitment, giving the patient some accountability[15,16]. The couple also learns effective communication and how to become involved in positive social activities that are substance-free[15,16]. In some cases, a partner may support the old, addicted lifestyle and have difficulty supporting the patient's change to sobriety. Couples and individual counseling often have this issue; it sometimes results in relationships ending.

Twelve-Step Facilitation Therapy

Twelve-Step Facilitation Therapy (TSF) uses individual therapy sessions to support becoming involved in a 12-step program[15,16]. It includes milestones of acceptance, surrender, and active involvement, similar to 12-step programs.

The Matrix Model

The Matrix Model combines multiple evidence-based practices (family and group therapy, relapse prevention, self-help, reduction of other risky behaviors, and drug education) in a coordinated, sequential approach[15,16]. The treatment centers around group therapy (3 times a week for 16 weeks) which promotes social support, individual counseling, cognitive behavior therapy, family education, and urine drug testing in order to achieve the patient's overall goal of abstinence[15,16].

Psychosocial Issues And Other Supports

Ongoing Assessment Of Psychosocial Issues

Psychosocial issues should be evaluated and assessed routinely during maintenance. Continue to address psychosocial issues that were identified during the initial phases of treatment and identify any new issues. Family support and structured time in prosocial activities will continue to be important.

Modify treatment structure and agreements and treatments/referrals for comorbidities as would benefit the patient, based on these assessments. For patients who are not making progress toward treatment goals, consider referral to more intensive forms of behavioral and/or substance use treatment. Additional counseling and social supports often benefit patients who are dealing with employment problems, financial issues, and legal consequences of drug use.

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Other Supports When Formal Counseling Is Not An Option

If you cannot provide psychosocial services in-office, the SAMHSA treatment or mental health locator can be used to find local providers.

Some patients may refuse counseling for various reasons, including finances, time involved, and comfort with accepting counseling, and you will need to decide your policy in this situation. If you consider seeing these patients, some of the following supports may benefit patients, although they are not considered a substitute for counseling. Nurse check-ins may benefit patients who are unable to participate in counseling. Mutual help programs, such as 12-step programs, may also benefit patients, but should not be considered a substitute for counseling[3]. Primary care settings with limited on-site resources can integrate basic counseling principles, such as relapse prevention techniques, into office visits with patients in office-based treatment.

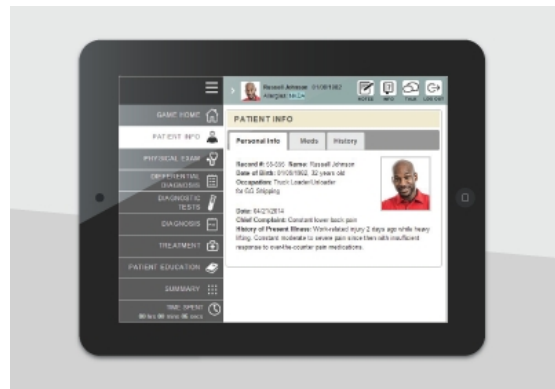
PRACTICE ACTIONS

Be sure to recognize patient progress toward treatment goals including positive changes in their psychosocial functioning and decreases in their addiction-related behaviors.

Technology-Supported Care

Treatment Technology

Emerging technologies have made it possible to support patient treatment inside the office and expand the exchange of information outside of office visits[16]:



- Telehealth delivery systems, such as electronic health records (EHR), allow for the exchange of patient information between providers, creating a more coordinated care approach for total health.
- Patient portals allow for web-based delivery of information.
- Mobile apps that can be used for patient education are readily available wherever the patient uses a mobile device and can be used to provide patient education.
- Telemedicine provides remote clinical services to patients through the use of two-way, real-time interactions, such as through video conference calling. It allows patients to receive diagnosis and care for a number of ailments when they are unable to physically get to the medical office.

Electronic Assessments

Electronic assessments can help aid in early intervention for substance abuse, and also help your patients with their overall addiction treatment needs. Studies show that patients are more likely to disclose substance use within an online/digital setting rather than in face-to-face assessments[16]. Studies have also shown that web-based, evidence-based assessments are effective in determining levels of substance use and identifying those who may benefit from treatment[16]. These types of assessments can be utilized for early interventions, which will, in turn, improve treatment outcomes for those who would benefit from addiction support. NIDA has developed one such online screening tool.

Electronic Interventions

Electronic interventions can be utilized to support and extend care outside the office setting. Ongoing electronic interventions, such as automatic motivational calls to patients with substance use issues, may help them to decrease their substance use over time and be more encouraged to work towards continued overall abstinence[16].

To find one of the many apps available that support recovery, direct patients to search their mobile app store for terms such as "substance abuse recovery apps" or "addiction apps."

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Recovery Support Services And Mutual Support

Recovery support programs and organizations and mutual support groups are an important resource for successful and sustained recovery. Long-term participation is important because significant risk of relapse continues even after a couple of years of recovery[16].

Recovery Support Services

Recover support services are "the collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use"[16]. These services help individuals in recovery acquire resources that will help them stay in recovery, such as better jobs, education, social opportunities, healthcare, and general well-being. In addition to this support, ongoing monitoring and early re-introduction to treatment are often additional goals of these services. Recovery support services are found in various places including schools, health care systems, housing systems, and other community settings. Specific recovery support services include[16]:

- **Recovery Coaching:** Helps individuals being discharged from treatment to connect with community services and resources as well as to overcome barriers or problems that might interfere with continued recovery.
- **Recovery Housing:** Provides a substance-free environment in which to recover as well as mutual support. Research on at least two such programs has shown improved long-term recovery rates
- **Recovery Management:** Follows a protocol to monitor individuals during recovery long term. May involve in-person checkups or telephone case monitoring.
- **Recovery Community Centers:** Often peer-led, recovery-focused. May provide any of the above recovery support services, 12-step meetings, education, social events, and access to resources that support recovery.

Mutual Support

Mutual support groups, such as Narcotics Anonymous (NA), are a source of psychosocial support that many patients find helpful. NA shares many of Alcoholics Anonymous' (AA's) features, including a social fellowship and an adherence to the 12 steps or actions as the basic roadmap to spiritual recovery and abstinence. Like AA, NA is an independent, self-supporting, group-based, and member-run, with no ties to or affiliation with other existing organizations. 12-step groups[16]:

- Have a spiritual underpinning
- Focus on a goal of abstinence
- Accept one's powerlessness over the addictive substance
- Support public confession of addiction
- Emphasize members' anonymity (first names only)
- Are free of charge

The typical forum consists of member-run group meetings where speakers and other group members explore the nature of addiction, the harm it has caused self and others, and the techniques for achieving and maintaining abstinence. Daily meeting attendance is encouraged during the initial 90-day induction period. Outside the meetings, members work through the 12 steps. NA provides group support for staying drug-free through testimonials, role modeling at group meetings, and sponsorship, in which members with a year or more of abstinence provide 24-hour support and encouragement to new members[17].

Secular organizations for drug-free living exist in many communities and provide self-help group alternatives for patients who prefer an approach free of NA's spiritual features.

Research has shown that treatment programs that facilitate participation in AA groups, result in reduced relapse rates and costs[16]

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Poll: If patients refuse to participate in recovery support services, groups, or counseling that you believe is indicated, what do you do (or plan to do) next?

- I do not get such patients.
- Tell them it is required if they want treatment in this clinic.
- Strongly recommend. If treatment goes poorly tell them we cannot continue unless they add a support group.
- Fully point out the benefits but leave the decision to them.
- Softly recommend it and move on to another topic.
- Does not (will not) apply to me.

What do you think? Take the poll yourself!

https://bup.clinicalencounters.com/maintenance-poll/

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MONITORING ADHERENCE AND EFFECTIVENESS

Guidelines For Buprenorphine Treatment Monitoring

SAMHSA's guidelines for Sublingual and Transmucosal Buprenorphine recommend the following to monitor treatment patient adherence and response to treatment because it improves "likelihood of positive clinical outcomes and reduces the possibility of diversion"[3]:

- Unannounced urine toxicology screening
- Medication counts – Require the patient bring their medication to each appointment and count to assure the correct number of tablets or films remain in the container; helps reduce diversion
- Observed ingestion – Often used near the start of therapy and serves the dual purpose of making sure the medication is being used and making sure it is being used properly; requires the patient bringing their medication to each appointment and can be required later in therapy to support adherence
- Checking Prescription Drug Monitoring Programs

The rationale and protocols for each of these precautions are described in this and other modules of the program.

n Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process, the guidelines with strongest consensus on monitoring treatment adherence and effectiveness are the following[13]:

- During induction and stabilization phases, urine drug screens should be done weekly to detect alcohol and other drugs of abuse, and also to look for evidence of the buprenorphine metabolites.
- During maintenance phase, urine drug screens should be conducted monthly or every two weeks to detect alcohol or other drugs of abuse and to look for the buprenorphine metabolite.

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BUPRENORPHINE IMPLANTS

An Option For Lower Dose Stable Patients

Buprenorphine implants have been approved as an option for maintenance at relatively lower doses (8 mg or lower)[11].

Patient Name: Andrea Sanchez

Age: 32 years old

Reason For Visit: Ms. Sanchez gets an injection every 3 months for birth control and she wonders if there is something similar for buprenorphine maintenance.

Present History: Ms. Sanchez has been on buprenorphine maintenance for over 3 months after getting off Vicodin®. She became dependent on Vicodin after surgery for an ovarian cyst three years earlier. She would also appreciate any time saved, even not having to fill a prescription every month, because as a schoolteacher and mother of two, her life is very busy.

> ***Ms. Sanchez:*** *Is there a shot or something I could get, like my birth control shot, where I wouldn't have to think about it every day and keep picking up the prescription?*

Provider: *There is an injectable form available but it's monthly. There also is an implant that goes just under the skin*[11] *that might address your concerns; it's replaced every 6 months. You meet the requirements by being in the maintenance phase and stable for 3-6 months at a dose of 8 mg or lower.*

> ***Ms. Sanchez:*** *The implant sounds interesting. Tell me more.*

Provider*: I would place four small rods under your skin in a simple procedure right here in the office; I've had special training in how to do the minor surgical procedure and am certified. Once the implant is in place, it would provide you with a steady level of the drug in your* bloodstream *for 6 months.*

> ***Ms. Sanchez:*** *Four rods? How big are they?*

Provider*: About the size of a wooden matchstick and an inch long. It would go on the inside of your upper arm, a little under the surface. After 6 months, the implants are removed and replaced.*

> ***Ms. Sanchez:*** *I guess it wouldn't bother me so much there. It would be nice to go 6 months without taking buprenorphine every day and not having to come in here. I'm very interested.*

Provider: *I'd still want to see you regularly – after one week and then at least monthly. The implant is just part of a complete treatment plan. Monitoring, social support,* and *counseling will still be important.*

> ***Ms. Sanchez:*** *Hmm. I'll have to think about that.* It doesn't *cause any problems?*

Provider: *Few side effects have been reported after healing from the initial placement. Most common are some irritation or itching at the implant site and side effects similar to the sublingual formulation. There is a remote risk from the implant itself moving or protruding or injuring a nerve. Another possible problem would be if you developed a need for a higher dose, which does not happen often, you would have to supplement it by taking a partial dose of sublingual buprenorphine.*

PRACTICE ACTIONS

1. Remind patients who have the implant to let other healthcare providers know that they are on this medication. Some patients may forget or not think of it as a medication they are "taking."
2. Be sure to have an excellent follow-up system in place so that the implants are replaced at 6 months.

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BUPRENORPHINE OVERDOSE RISK

Safety and efficacy of buprenorphine in the primary care setting have been demonstrated[18,19].

Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS) data shows that the risk of severe intoxication is lower for buprenorphine than for other opioids[20].

As a result of buprenorphine's agonist effect, overdose and abuse are possible, SAMHSA's update for buprenorphine therapy recommends[7]:

- Patient education about the possibility of buprenorphine overdose and opioid overdose if they return to opioid use.
- Consider prescribing naloxone for patients on buprenorphine to use in the event of an overdose.

When Risk Of Buprenorphine Overdose Is High:

- When taken with certain other drugs, including other opioids, benzodiazepines, alcohol, sedatives, or certain medications that interact with buprenorphine[3]. Misusing buprenorphine and sedative-hypnotics, particularly benzodiazepines, greatly increases the risk of overdose.
- In opioid-naive persons, and is particularly risky in children, underscoring the need for safe storage of buprenorphine.
- If dissolved and injected (which should be strongly discouraged).

Prevalence Of Overdose And Abuse

- In 2011, an estimated 21,483 emergency room visits for misuse and 3,625 cases of toxic buprenorphine exposure were reported[21].
- SAMHSA reported 30,135 hospital emergency department visits linked to buprenorphine in 2010, with 52% involving misuse. Of the misuse-related visits:
  - 41% involved just the use of buprenorphine
  - 59% involved the use of other substances, including benzodiazepines, narcotic pain relievers, marijuana, heroin, and cocaine[22]

Accidental and non-accidental ingestion of buprenorphine in children is also increasing in proportion to an increase in availability and clinical use: There were 2,380 overdoses in young children in 2009[23]. In a review of 4879 buprenorphine exposures in identified in children under age 6, around a third had a serious medical outcome and only one fatal outcome was reported[20]. Deaths have been reported, however, with low doses of buprenorphine in the form of sublingual tablets for analgesia in opioid naive individuals, as low as 2 mg[24], which underscores the importance of safe, preferably locked storage.

REMS

To counteract the risk of buprenorphine diversion and abuse, the FDA requires a Risk Evaluation and Mitigation Strategy from the manufacturers of certain buprenorphine products. The strategy includes provider education and medication guides for patients[25].

Overdose Recognition & Prevention

Signs And Symptoms Of Buprenorphine Overdose:

- Cold, clammy skin

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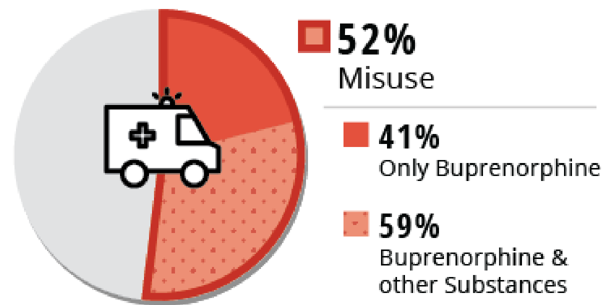
- Weakness
- Constricted pupils (**Note**: After brain damage occurs, pupils may dilate.)
- Hypotension
- Loss of consciousness/unresponsiveness
- Respiratory depression

Of these, respiratory depression may be fatal if untreated[4].



PRACTICE ACTIONS:

To prevent overdose:

- Advise your patients of the consequences of buprenorphine overdose[4]
- Warn against mixing buprenorphine and alcohol[4]
- Warn against mixing buprenorphine and benzodiazepines[4]
- Use caution when prescribing both buprenorphine and benzodiazepines or other sedating medications[4]
- Warn your patients not to inject buprenorphine
- Unless contraindicated, prescribe buprenorphine/naloxone combination tablets or film, which are less likely to be injected than medication containing only buprenorphine[4]

Overdose Special Considerations

Special Considerations For Benzodiazepines

US FDA Guidance on the risks and benefits of buprenorphine treatment in the context of benzodiazepine use has evolved from earlier warnings[26] to a later report highlighting that benzodiazepine use should not be the cause for discharge from buprenorphine treatment[27]. The report argues that the risk of opioid dependence may outweigh the risk of benzodiazepine use. As in the rest of medicine, benefits and risks should be weighed for each individual patient and decision is up to the provider if the patient must remain on benzodiazepines[28]:

- Start at a low dose of buprenorphine (1-2 mg) and slowly increase the dosage
- Use shorter-acting versions. Considerations:
    - oxazepam has a mean elimination half-life of 8.2 hours[29]
    - lorazepam's half-life is 12 hours and 18 hours for its metabolite[30]
    - diazepam has a half-life of 48 hours and up to 100 hours for metabolites[31]
- Avoid long-term use of benzodiazepines, if possible

Other Special Considerations

Additional patient populations that may need a lower starting dose and slower increase[28]:

- Patients <20 years old
- Patients >60 years old
    - Particularly those who are frail, have HIV, hepatitis C, cancer, or are taking other sedatives (e.g., lithium)
- Patients taking multiple drugs

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Overdose: Treatment

Buprenorphine overdose is treated with supportive care and an opioid antagonist, such as naloxone, to displace the buprenorphine. Recommendations for treating opioid overdose, for adults, are as follows:

1. Start with 0.4 mg to 2 mg naloxone (NARCAN) intravenously (or intramuscular or subcutaneous if intravenous is not available). If respiratory function has not improved sufficiently, repeat at 2 to 3-minute intervals up to a total dose of 10 mg[32]. Buprenorphine's affinity for opioid receptors is strong enough that a relatively higher dose of naloxone may be needed to reverse respiratory depression; reversal effects are gradual with buprenorphine[32]. **Note**: naloxone injection solution USP is supplied in 1mg/mL concentration[32].
2. If there has been no response, re-evaluate the diagnosis of opioid toxicity or partial opioid toxicity[32]. Respirations should be mechanically assisted and other measures for resuscitation can be used if clinically indicated.
3. Because the duration of naloxone is relatively short, continue to monitor the patient. Additional doses may be needed when the naloxone effect wears off. This varies with the amount of opioid taken and whether it was long-acting/extended release[32].
4. If respiratory depression is prolonged and continued boluses of naloxone are needed, continuous IV infusion of naloxone should be considered[33].

Considerations:

- **Withdrawal symptoms.** Patients who are physically dependent on opioids are likely to experience withdrawal symptoms with abrupt reversal of opioid effects by naloxone[32].
- **Caution for cardiac disease.** Use caution in patients with cardiac disease or who are on medications with potential adverse cardiovascular effects such as hypotension, ventricular tachycardia or fibrillation and pulmonary edema[32].
- **Is there also a benzodiazepine overdose?** Consider whether there is a mixed overdose with benzodiazepines that is contributing. Treatment for the benzodiazepine part of the overdose is usually supportive including maintaining airway, respiration, and hemodynamic support until there is natural recovery[34].

PRACTICE ACTION

Warn your patients to keep medications away from where children can find them.

FYI

Naloxone taken intravenously has good bioavailability. When buprenorphine/naloxone combination is injected by someone who is dependent on opioids, the naloxone can cause precipitated opioid withdrawal[35].

Naloxone for Overdose

Naloxone Overdose Reversal Kit

Naloxone kits are used for the reversal of a narcotic overdose, induced by opioids. Although rare, buprenorphine overdose can occur. The kits can be used to counteract a buprenorphine overdose. However, as described previously, naloxone does not work as well for buprenorphine as it does for other abused opioids. SAMHSA recommends considering prescribing naloxone for patients on buprenorphine[36].

The following kits have been available:

- Single-dose hand-held, auto-injector systems (FDA approved in 2014)

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- Muscle syringes. One syringe per 1 ml of naloxone (FDA approved)
- Intranasal spray (Narcan®)
- Injectable dosages for intravenous, intramuscular and subcutaneous administration include 1 mg/ml and 10 ml (multi-dose)

Candidates for naloxone kits may include patients who are:

- Taking high doses of opioid medication for the prolonged management of chronic pain/illness
- At risk for incomplete cross-tolerance
- Taking extended-release opioid preparations that may pose a risk for overdose
- At risk for overdose due to medically prescribed analgesia, combined with a suspected or confirmed history of substance abuse, or dependence

The FDA approved a user-friendly intranasal formulation of naloxone in November 2015. The amount of medication gets into the body and how rapidly it is effective is comparable to the injectable version[16].

PRACTICE TIP

Naloxone kits can be distributed to family members, friends, peers, employers, non-medical staff and volunteers in addition to the at-risk patient.

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PAIN MANAGEMENT

Simultaneous Pain And Opioid Use Disorder Treatment

Simultaneously treating addiction and (effectively) treating pain is challenging. An ASAM Consensus Panel on buprenorphine treatment determined that there is insufficient data to recommend the use of buprenorphine for the treatment of acute or chronic pain in patients with a history of opioid use disorder[7].

- If possible, non-opioids should be the first mode of treatment for pain among your patients who are already maintained on buprenorphine.
- Dividing the buprenorphine dose can help address pain somewhat. Keep in mind that its analgesic property is around 8 hours. Using the formula approved for treating opioid use disorder to treat pain is considered off-label use.
- However, patients maintained on buprenorphine might require opioid therapy for their pain if they develop acute or chronic pain that is not responsive to the buprenorphine treatment or treatment with non-opioids.
- If you are a new buprenorphine prescriber, you might want to consult with a more experienced provider or pain or addiction expert in such situations.

However, clinical studies demonstrated effective analgesia utilizing the analgesic properties of divided doses of buprenorphine and supplementing it with another opioid[37,38].

Buprenorphine for Pain Management

Buprenorphine, in different formulation, can be used to treat pain. The formulations for pain are specifically intended for that purpose (e.g., Buprenex, BuTrans) in contrast to the formulations specifically intended for treating opioid addiction, e.g., Suboxone, Bunavail, etc..

According to the DATA 2000 law, buprenorphine formulations for treating opioid use disorder are not to be used for pain management. That said, some patients who were previously managing pain using opioids may find the analgesia from their buprenorphine therapy for opioid use disorder is sufficient. In one study, patients tapered off high doses of opioids and placed on doses of sublingual buprenorphine typical for treating opioid use disorder on average reported less pain after making this change[39].

A buprenorphine formulation specifically for pain: A 7-day buprenorphine transdermal patch (BuTrans®) is FDA-approved for use in treatment of long-term, moderate-to-severe chronic pain[40]. Regarding this formulation:

- Patches are available in 5, 10, and 20 μg/hour strengths[41].
- Use is contraindicated in the management of acute or short-term, postoperative, mild, and intermittent pain.
- It is not approved for treatment of opioid use disorder[42].
- You do not need the DATA 2000 waiver in order to prescribe buprenorphine for pain.

Reasons To Consider Buprenorphine As An Analagesic Over Full Agonist Opioids

- Treats a broad range of pain types including cancer pain and neuropathic pain
- Produces less constipation, cognitive impairment
- Is not immunosuppressive (like morphine and fentanyl)
- Has a ceiling effect with respect to respiratory depression
- Does not harm HPA-axis or cause hypogonadism

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- Is not associated with QT prolongation (like methadone)
- Is effective in older population
- May be used in renal failure and patients on dialysis
- Has milder withdrawal and less abuse potential than full agonists[43]

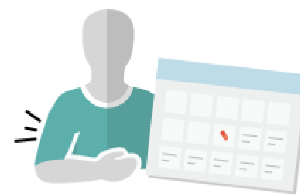
PRACTICE ACTION

Because pain—both acute and chronic—is an issue that affects a large number of patients seen within primary care settings, you might be approached by patients requesting a buprenorphine prescription for pain management. If you think this is warranted, be sure to use formulations specifically for treating pain.

Treating Acute Pain In Buprenorphine Patients

Treating Anticipated Acute Pain

If your patients who are on buprenorphine schedule elective surgery or another procedure in which they are going to have acute but short-term pain, you can plan accordingly to treat their pain safely and effectively. For situations in which non-opioid pain relievers are inadequate, follow these steps[44,45]:



- Have your patient take buprenorphine the morning prior to the day of procedure, then skip the buprenorphine dose the morning of the procedure.
- Prescribe opioids to produce adequate analgesia, to be taken the morning of the procedure, titrated to effect.
- Continue to treat with opioids to manage opioid use disorder. For inpatients who also are having parenteral pain management, use patient-controlled analgesia with no basal dose. If your patient does not require parenteral pain management and/or is an outpatient, use short-acting opioids.
- A higher dose opioid agonist may be needed due to physical tolerance on buprenorphine and unavailability of mu receptors due to recent buprenorphine doses.
- Opioids should be taken on schedule rather than as needed to avoid dose escalation.
- If your patient remains an inpatient, continue to hold buprenorphine.
- When opioids are no longer required for pain management, your patient should first experience mild to moderate opioid withdrawal and then be re-inducted onto buprenorphine.
- You may want to consult a more experienced buprenorphine provider or pain or addiction expert.
- You may want to consider consultation if this is outside your area of expertise.

Treating Unanticipated Acute Pain

Pain management is slightly more complicated for your patients on buprenorphine who are hospitalized with unanticipated acute pain (for instance, for emergency surgery). Follow these guidelines for treating unanticipated acute pain[44,46]:

- Determine when the last dose of buprenorphine was taken and temporarily stop buprenorphine; proceed with pain management in the manner described above.
- Other options include providing regional anesthesia, increasing the buprenorphine dose, adding a high-potency opioid, such as fentanyl, or temporarily switching your patient to methadone.
- When switching your patients to methadone, prescribe short-acting opioids in addition to the methadone as needed. The methadone will be treating the physical opioid dependence and something else is needed to treat the pain. When the pain is gone, your patient can be tapered off of methadone and re-inducted onto buprenorphine.

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- Consult the resources section for further details. You may want to consider consultation if this is outside your area of expertise.

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DISCONTINUING BUPRENORPHINE

Guidelines For Discontinuing Treatment

In Practice Guidance for Buprenorphine for the Treatment of Opioid Use Disorders, produced by expert panel process, the guidelines recommended most often on discontinuing treatment were the following[13]:

To discontinue treatments, it is best that these conditions are met:

- Patients must have expressed desire to discontinue treatment.
- Patients must have established stable living and income.
- Patients must have adequate psychosocial support.
- Termination of treatment and contingencies for treatment should be outlined in the treatment agreement.

Note: These are the guidelines for which there was strong consensus by expert review and not a complete protocol.

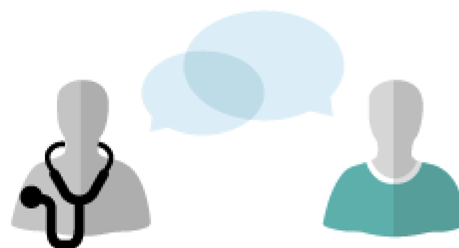
The Evidence For And Against Discontinuation

The optimal duration of medication-assisted treatment with buprenorphine is not clear[3], but it is clear that there is a high risk for relapse when medication-assisted treatment is discontinued, even if maintenance has been stable for a while[3,47]. NIDA's Clinical Trials Network Prescription Opioid Addiction Treatment Study found that treating prescription opioid-dependent patients with a brief buprenorphine taper and stabilization treatment plan (plus counseling) almost always led to relapse[48]. Around 88% positive urine drug tests were found at 3 months post-taper in another study[2].

If there is discontinuation of buprenorphine treatment, it often works best to involve a closely monitored, gradual reduction or tapering of the patient's maintenance dose, usually over a period of several months[12]. The VA/DOD guidelines, based on "strong" evidence for it, recommend transitioning to extended-release injectable naltrexone if discontinuing buprenorphine, although they recommend providers "strongly advise" patients to continue buprenorphine maintenance long-term[49].

Circumstances For Discontinuing Buprenorphine

Discontinuing buprenorphine is not required or even recommended. Patients can continue buprenorphine therapy indefinitely if they want to as long as they adhere to treatment and experience no complications[3].



Opioid abuse should not be grounds for terminating buprenorphine treatment. Alternative responses include checking on proper use of buprenorphine and dose, increased office visits, and making continued treatment contingent on increased psychosocial support.

Factors that are associated with successful discontinuation of buprenorphine include the following[12]:

- Being employed or otherwise engaged in meaningful activities
- Involvement in peer mutual self-help programs, such as 12-step programs
- Consistent and sustained abstinence from opioids and other substances
- Psychosocial environment that is improved and highly supportive
- Engagement in treatment before and after discontinuing buprenorphine

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Discussing Discontinuing Buprenorphine With Patients

Discontinuing buprenorphine should be discussed thoroughly with patients and their significant others. Ask patients why they want to discontinue treatment and encourage them to remain on the therapeutic dose as long as it is beneficial. Include a discussion of potential consequences and explain the following:

1. Relapse rates are high when buprenorphine is discontinued.
2. Continuing the medication reduces risk of relapse to patients, and is similar to taking medication for a chronic condition, such as hypertension being continued indefinitely.
3. Some patients can taper down to 2 or 4 mg (sublingual tablets or equivalent of other formulations) but cannot get off completely without uncomfortable withdrawal symptoms.
4. If patients wish to discontinue buprenorphine use, recovery support services[50] are even more important. Encourage patients to participate.
5. Alternative forms of pharmacotherapy may help them in remaining abstinent in the long-term.
6. Patients who discontinue buprenorphine should still be monitored and assessed for cravings and adherence to psychosocial therapies.
7. Encourage your patients to return for maintenance treatment if cravings develop after withdrawal.

A presentation at the American Psychiatric Association 2010 Annual Meeting reported that treating prescription opioid-dependent patients with a brief buprenorphine taper and stabilization treatment plan (plus counseling) almost always led to relapse[48]. The research reported was part of NIDA's Clinical Trials Network Prescription Opioid Addiction Treatment Study.

Abrupt cessation of buprenorphine should be avoided. If tapering to complete cessation is desired, it should be gradual and medically supervised with plenty of psychosocial support.

Warning

Patients are at risk for relapse to opioid use and, therefore, overdose when withdrawing from buprenorphine[49].

Potential Alternatives To Buprenorphine

Three alternatives to buprenorphine treatment can be considered for patients being maintained on buprenorphine wishing an alternative treatment for opioid use disorder:

- Medication-assisted treatment with methadone
- Medication-assisted treatment with naltrexone
- Medication-free treatment

All three approaches should include psychosocial treatments as part of the treatment[3,12].

Switching To An Alternative Pharmacotherapy

Patients who wish or need to stop buprenorphine treatment can be switched to another form of pharmacotherapy, such as methadone or naltrexone or long-acting naltrexone (Vivitrol®) maintenance. Such discontinuation and transfer to the new medication can be accomplished simply and on a timetable that is appropriate for the particular patient and medication.

Considerations For Drug-Free Treatment

Alternatively, all pharmacotherapy can be stopped. For most patients, switching to an alternate pharmacotherapy is a better option, because patients who quit pharmacotherapy altogether are unlikely to remain abstinent. Withdrawal from buprenorphine to no drug therapy should only be considered seriously for well-stabilized, motivated patients.

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Quiz: Case Study – Mr. Richards

Name: Mr. Richards

Age: 28 years old

Reason For Visit: Mr. Richards wishes to stop taking buprenorphine.

Patient History: Mr. Richards became dependent on intranasal heroin, prescription opioids, and cocaine during his late teens.

Treatment History: He is currently maintained by you on buprenorphine/naloxone sublingual film and has been for the past three months. He previously was able to obtain limited drug-free abstinence after an inpatient detoxification followed by involvement in NA meetings. Three months ago, you inducted him onto buprenorphine without incident, and he has been doing well on a 12 mg daily dose. He has not used heroin or other drugs since the induction, his mood is good, and he is positive about being able to get back to work.

Today's Visit: Mr. Richards reports that he felt a little tempted to use cocaine last weekend at a party when he was with friends who were using it, but he's having no problems staying away from opioids. He is no longer active in 12-step meetings and has cut back on visits to his therapist for relapse prevention, stating, "I don’t need it now that I'm cured."

What Are The Main Concerns About Starting A Taper For Mr. Richards? (Choose All That Apply)

1. Mr. Richards' overconfidence in his ability to remain abstinent
2. Mr. Richards' cut back on therapist visits in this early period of recovery
3. Mr. Richards' exposure and access to drugs through his friends

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QUIZ: CASE STUDY – MR. RICHARDS – QUIZ FEEDBACK

(1) Mr. Richards' Overconfidence In His Ability To Remain Abstinent,
(2) Mr. Richards' Cut Back On Therapist Visits In This Early Period Of Recovery,
(3) Mr. Richards' Exposure And Access To Drugs Through His Friends:

Correct. In fact, all of these issues are equally troubling. It is a concern that Mr. Richards has deviated from the treatment plan, decreasing therapist visits without discussing this with you, and that his assertion of 'being cured' reflects overconfidence or even denial about the chronic, relapsing nature of substance use disorders. Also, he is allowing himself to enter into 'high-risk' situations, attending parties on the weekends where he knows that drugs will be available. This calls into question his decision-making ability at this time.

Quiz: Discontinuing Buprenorphine Therapy

Which Of The Following Is A Valid Reason For Discontinuing Buprenorphine Therapy? (Choose All That Apply)

1. The patient wants to stop.
2. The patient wants to transfer to methadone.
3. The patient has had an adverse reaction to the buprenorphine.
4. None of the above.

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Discontinuing Buprenorphine Therapy Quiz Feedback

(1) The Patient Wants To Stop,

(2) The Patient Wants To Transfer To Methadone,

(3) The Patient Has Had An Adverse Reaction To The Buprenorphine

Correct. All are valid reasons for discontinuing buprenorphine pharmacotherapy.

(4) None Of The Above.

All of the listed choices are valid reasons for discontinuing buprenorphine pharmacotherapy.

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TAPERING PROTOCOL FOR QUITTING BUPRENORPHINE

Tapering

If, after weighing the risks of relapse, discontinuation of buprenorphine is selected, it should be achieved through a safe, structured protocol.

The rate of taper has more to do with percent decrease than absolute dose decrease. In other words, it is often easier for patients to go from 14 mg to 12 mg than 6 mg to 4 mg.*

*Doses described on this page were established with the original Suboxone® sublingual tablets and should be adjusted for the formulation you are using.

Guidelines Recommend Longer Tapering

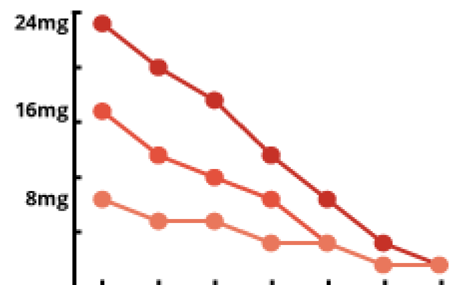
Guidelines on medication-assisted treatment produced by ASAM recommend that tapering and stopping buprenorphine should be achieved slowly, usually over several months, with close monitoring[12]. Furthermore, they recommend that patients remain in treatment for ongoing monitoring, even after buprenorphine is completely discontinued. A long-period may be more favorable for patients who would be less willing or able to seek outside support during treatment. Additionally, a more lengthy process may help decrease the severity and occurrence of withdrawal symptoms as the patient's dose is tapered.

Shorter Tapering

However, some research found no benefit for a 28-day taper in comparison to a 7-day taper. Another study conducted by the National Drug Abuse Treatment Clinical Trials Network, using a steady dose Suboxone®, also compared the 7- and 28-day taper. Researchers randomized 516 opioid-dependent individuals into one of the two treatment protocols. They found that there seems to be no benefit in prolonging the taper period to 28 days instead of 7 days, 58% completed the 7-day taper and provided a clean urine sample, compared with 38% of the 28-day taper condition. Additionally, individuals in the 7-day taper group were almost twice as likely to complete the taper and provide an opioid-negative urine sample compared with those in the 28-day taper group[51].

Another multi-site study sponsored by NIDA's Clinical Trials Network found similar results[2]. The following table highlights their 7-day tapering protocol.

Stabilization Dose	8 mg	16 mg	24 mg
Day 1	8	16	24
Day 2	6	12	20
Day 3	6	10	17
Day 4	4	8	12
Day 5	4	4	8
Day 6	2	2	4
Day 7	2	2	2



Reduction can also take place over a period of as short as 3 days, for those patients who have immediate and compelling reasons to discontinue use, such as a pending health issue (surgery) or job limitations regarding extended absences[4]. However, rapid tapers may increase the likelihood of withdrawal symptoms and subsequent relapse; new prescribers should consult with an experienced buprenorphine provider in such circumstances.

Quiz: Mr. Richards – Discuss Buprenorphine Taper

Patient History and Discussion: You discuss your concerns with Mr. Richards, and suggest that he remain on maintenance for a while longer until the cravings have subsided, he is further along, and engaged in a program of

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relapse prevention. He agrees, noting that his overall functional status has improved on buprenorphine and that he doesn't want to jeopardize his gains.

Follow Up

Three months later, Mr. Richards returns and is still on 12 mg daily. He is seeing his therapist every other week and attending weekly NA meetings, which have helped him become more aware of the "people, places, and things" that put him at risk for relapse. Mr. Richards is once again interested in starting a buprenorphine taper, despite your warnings of the risk of relapse.

How Do You Advise Him To Begin Tapering The Buprenorphine?

1. Initiate a 5-day taper of his buprenorphine similar to in-patient detoxification protocols
2. Suggest that he start tapering his buprenorphine on his own, and let you know the effects next month
3. Initiate a very gradual reduction in his dose of buprenorphine, with close monitoring by phone or more frequent office visits

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Mr. Richards – Discuss Taper Quiz Feedback

(1) Initiate A 5-day Taper Of His Buprenorphine Similar To In-patient Detoxification Protocols

This is not the best option. The ideal method of tapering off buprenorphine maintenance is usually longer than 5 days. While many inpatient detoxification protocols are for 5 days, there is concern that too rapid of a taper could result in excessive withdrawal, increased cravings, and lead to increased risk of relapse. Monitoring during the dose-tapering period is important to assess degree of withdrawal, cravings, change in affect, or other problems that may arise. Tapering is not an exact science but the general rule of thumb is 'slower is better'.

(2) Suggest That He Start Tapering His Buprenorphine On His Own, And Let You Know The Effects Next Month

This is not the best option. Patients who are tapering off of buprenorphine should be closely monitored to assess degree of withdrawal, cravings, change in affect, or other problems that may arise. Tapering is not an exact science but the general rule of thumb is 'slower is better'.

(3) Initiate A Very Gradual Reduction In His Dose Of Buprenorphine, With Close Monitoring By Phone Or More Frequent Office Visits

Correct. The ideal method of tapering off buprenorphine maintenance is usually longer than 5 days. While many inpatient detoxification protocols are for 5 days, there is concern that too rapid of a taper could result in excessive withdrawal, increased cravings, and lead to increased risk of relapse. Monitoring during the dose-tapering period is important to assess degree of withdrawal, cravings, change in affect, or other problems that may arise. Tapering is not an exact science but the general rule of thumb is 'slower is better'.

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TAPERING CHALLENGES

Withdrawal During Tapering Of Buprenorphine

Monitor Patients Carefully During Tapering

Withdrawal symptoms, psychosocial status, and drug use should be monitored carefully during the tapering phase.

If and when these symptoms arise, temporarily suspend tapering until the patient is stabilized at his/her current dose. Patients may be prescribed non-opioid medications to manage specific withdrawal symptoms:

- Non-opioid pain relievers (NSAIDs or acetaminophen, while considering risks vs. benefits)
- Antidiarrheal agents
- Antiemetics
- Antispasmodics

Withdrawal symptoms are treated the same during tapering as they are treated during induction.

Non-Pharmacological Support

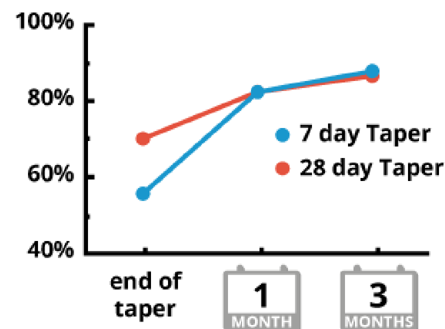
Patients being tapered off buprenorphine should be encouraged to:

- Seek non-pharmacological support and programs, such as 12-step programs, that will help ensure that they will remain abstinent from opioid use[3].
- Return for maintenance treatment if cravings develop after tapering.

Relapse After Buprenorphine Taper

Relapse After Taper Is Common

Relapse is common when buprenorphine is stopped, both for patients who discontinue their treatment under a clinician's guidance and for those who stop on their own:



- In one long-term, NIDA-funded study of over 500 patients who tapered off buprenorphine, relapse rates at 3-months after both 7 and 28-day tapers were 87 to 88% as measured by positive urine drug tests[2].
- Weiss and colleagues found that treating patients using prescription pain medications and having opioid use disorder with a brief buprenorphine taper after stabilization on a buprenorphine treatment plan (plus counseling) almost always led to relapse. Only 6.6% were abstinent at 8 weeks after a protocol of 2-week stabilization followed by a 2-week taper[10]. Even a long stabilization period of 3 months with counseling followed by a 4-week taper resulted in a high relapse rate of around 90% at 8 weeks post taper[10].
- 6 weeks of stabilization followed by a slower, 3-week taper, was also associated with a high relapse rate[9].

Some patients, feeling that they are cured or wanting to be completely free of medications, self-taper from buprenorphine, successfully at first, but then relapse and come back[52]. They want to see if they 'are still addicted.' The wish for a cure, rather than pharmacologically-mediated control is common among all chronic illnesses.

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Patients who relapse to misuse of opioids should be returned to medication-assisted treatment[12]. Patients who are abusing opioids and have been off of buprenorphine for more than a few days will likely do best by going through induction again.

Quiz: Mr. Richards – Adjust Dosing

Mr. Richards is adamant about tapering off of buprenorphine but consents to being closely monitored during the taper period.

He agrees to taper over a longer period of time if it will help keep the withdrawal level low. You elect to decrease his dose in 2 mg increments, instructing him not to drop the dose any more often than every 7 days, approximately the amount of time needed for the buprenorphine levels in the brain to reach steady state. Keep in mind that the rate of taper has more to do with percent decrease than absolute dose decrease. In other words, it is often easier for patients to go from 14 mg to 12 mg than 6 mg to 4 mg.

Further Follow Up

You remain in regular contact with Mr. Richards weekly by phone or through office visits. He has been decreasing by 2 mg every other week. He was doing well during a check-in when he had tapered to 6 mg. About a month later, he calls complaining of withdrawal after dropping from 6 mg to 4 mg earlier in the month. His main complaint is difficulty sleeping, and he is a bit achy and irritable. His cravings are intermittent but intense.

How Do You Proceed?

1. Increase his daily dose to 10 mg
2. Return to a dose slightly higher than 6 mg
3. Stay with 4 mg daily and additionally prescribe a medication to help with sleep

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Mr. Richards – Adjust Dosing Quiz Feedback

(1) Increase His Daily Dose To 10 Mg

This is not the best option. Backing up to a slightly higher dose at which the patient was definitely stable is often helpful during tapering. Before his recent decrease in dosage, Mr. Richards seemed to be stable on 6 mg, so returning to this dose or slightly higher is indicated. But 10 mg does not seem indicated and does not fit with his desire to be on the lowest possible dose. Also, after re-stabilizing at the slightly higher dose, slowing down the taper to minimize withdrawal symptoms, but continuing the taper, is consistent with the patient's wishes.

(2) Return To A Dose Slightly Higher Than 6 Mg

Correct. Backing up to a slightly higher dose at which the patient was definitely stable is often needed during tapering. Before his recent decrease in dosage, Mr. Richards seemed to be stable on 6 mg, but soon was not stable, so returning to this dose or slightly higher is indicated. Also, after re-stabilizing at the slightly higher dose, slowing down the taper to minimize withdrawal symptoms, but continuing the taper, is consistent with the patient's wishes.

(3) Stay With 4 Mg Daily And Additionally Prescribe A Medication To Help With Sleep

This is not the best option. Before his recent decrease in dosage, Mr. Richards seemed to be stable on 6 mg, so returning to this dose or slightly higher is indicated. Given that he is having intense cravings that may put him at risk for relapse, it would be safer not to rely on just adjunctive medication to manage withdrawal. Also, after re-stabilizing at the slightly higher dose, slowing down the taper to minimize withdrawal symptoms is consistent with the patient's wishes.

Mr. Richards – Other Treatment Concerns

Following your advice, Mr. Richards returned to an 8 mg dose for six weeks and then 6 mg for six weeks. Then, he slowed down the taper, decreasing by 2 mg every 8 weeks. A couple of days after stopping the final dose, he had mild insomnia that he was able to work through with sleep hygiene techniques and avoiding caffeine after the morning. He continued to see his psychotherapist, who has helped him cope with intermittent cravings that are now briefer. He has remained abstinent so far but says that tapering off buprenorphine and avoiding relapse is one of the hardest things he has ever done.

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LAPSES, RELAPSE, AND RETURN TO TREATMENT

Responding To Relapse

Consider the possibility of relapse if patients seem less stable[5]. The causes of relapse are often complex. The extent of the relapse can vary and should be determined in terms of dose and frequency as well as the psychosocial impact.

Relapse does not mean that buprenorphine treatment is not effective for that particular patient. Instead, it may mean that a higher dose or more intensive psychosocial treatment or support system or other increase in structure, such as more frequent appointments, would be helpful.

Patients who wish to return to buprenorphine maintenance should not be turned away, in most cases. Instead, modify the treatment agreement to be more strict, conduct urine testing and office visits more frequently, and require more involvement in group or individual therapies. Patients should be referred to an addiction specialist if they have issues that can not be adequately handled in primary care.

More Tips For Dealing With Relapse

- Relapse is common, formulate a plan for what you would do in various relapse situations.
- Identify patients who have a history of failed treatment attempts or other issues that may put them at risk for relapse.
- Keep the door open for re-admission if possible.
- In some cases, re-admission means repeating induction, which can be time consuming, so it is good to think about how to handle that.
- With relapse, patients often benefit from increased contact. One way to emphasize this would be to require office induction rather than home induction, shorten the time interval between prescriptions, obtaining the medication could be an engagement strategy.

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QUIZ: CASE – MR. PATEL

Name: Mr. Patel

Age: 27 years old

Reason For Visit: Mr. Patel is experiencing a relapse in heroin use and comes in for an appointment. He would like to get back on buprenorphine. Mr. Patel wonders if you would call in a refill to the pharmacy where he got his prescription filled before.

History of Present Illness: He recently dropped out of buprenorphine treatment under your care and has been starting to use heroin again. He struggles to keep his use down.

Medical and Psychosocial History: Mr. Patel had abused heroin and prescription opioids for ten years prior to starting buprenorphine. Mr. Patel is married and works as a lab technician at his uncle's medical device company.

Treatment History: He has had various treatment episodes, including methadone maintenance, residential, and most recently buprenorphine maintenance under your care for the past 4 months. His uncle pays for his treatment.

What Further Questions Should You Ask Mr. Patel To Determine His Candidacy For Buprenorphine Treatment? (Choose All That Apply)

1. What triggers led to your relapse?
2. Ask about other substance use
3. Whether he relapsed due to persistent withdrawal symptoms
4. Ask about his support system

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CASE – MR. PATEL QUIZ FEEDBACK

Meet Your Patient

(1) What Triggers Led To Your Relapse?

Correct. It is important to support the development of insight into his vulnerabilities. From there, you could brainstorm with him ideas on how to handle these triggers differently.

(2) Ask About Other Substance Use

Correct. He may not be aware that other substance use is likely to increase risk of relapse. This should be discussed.

(3) Whether He Relapsed Due To Persistent Withdrawal Symptoms

Correct. It is important to understand whether his dose of buprenorphine was insufficient to manage his withdrawal symptoms, in which case you should use a higher dose this time.

(4) Ask About His Support System

Correct. A support system is one of the most critical factors in recovery from substance use.

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Mr. Patel – Interview

Provider: *Before we talk about restarting your buprenorphine treatment, I would like to get a better understanding of what triggered your relapse.*

> ***Mr. Patel:*** *Things were getting rough at work, and I just needed to forget for a while. But I know I'm letting myself down, and my uncle, too. He's also my boss, so I need to get back into treatment.*

Provider: *And your uncle is supportive of your treatment?*

> ***Mr. Patel:*** *Yes, both he and my wife have been very understanding. They know I hit a rough patch and they are willing to forgive me if I get help.*

Provider: *When you went back on the heroin, was it because you were having withdrawal symptoms while taking buprenorphine?*

> ***Mr. Patel:*** *Yes, and I was taking the heroin at the same time as the buprenorphine for the first couple of days, but then I switched over to just heroin.*

Provider: *And are you taking any other drugs aside from heroin or drinking alcohol?*

> ***Mr. Patel:*** *No, just the heroin. And I don't want to be dependent on it anymore.*

PRACTICE TIP

Because situations like this, where a patient relapses and wishes to re-start treatment will arise in a buprenorphine practice, it is important to have a predetermined policy regarding refills and re-induction. Some clinicians would never comply with Mr. Patel's request because they require the patient to be physically present for refills of buprenorphine. Other offices do home inductions and re-inductions for most patients. Also, some offices strongly encourage (or require) the involvement of family members in treatment decisions and administration, such as Mr. Patel's wife or his uncle in this case.

Mr. Patel – Re-induction Considerations

Determining Location For Re-Induction: Home Vs. Office

In some cases, re-induction at home is safe and may be an appropriate choice. For instance, this may be an option for a patient who is familiar with how to use buprenorphine, is far away or cannot come in for several days, or has a spouse who will help monitor the patient for withdrawal symptoms. If you choose this approach, you should give the patient some instructions over the phone.

Mr. Patel has the following factors against and in favor of home treatment:

Con: Although it is a clinical judgment, there are several reasons why you may not want Mr. Patel to repeat the induction at home.

- It may be difficult for him to be objective in evaluating his own withdrawal; it probably all feels severe.
- Precipitated withdrawal is a possibility, especially with a high dose, but Mr. Patel is currently using 300 mg of heroin, which is an average dose.
- You could see him in your office to get a baseline urine sample for other substances and check for physical effects of his heroin use, such as abscesses.
- Relapse often signals problems that might benefit from more psychosocial contact and support. Requiring a visit to obtain medication rather than home induction could be a patient engagement strategy.

Pro: Other considerations are in favor of a home induction:

- Mr. Patel is very familiar with taking buprenorphine by now.

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- You already know that he has been taking heroin, so an initial urine sample is not as important.
- He sounds like he will be highly motivated if he is allowed to do a home induction.
- He does have a strong family support system.

Discussion

Because situations like this will arise in a buprenorphine practice, it is important to have a pre-determined policy regarding refills and re-induction. Some clinicians would never comply with Mr. Patel's request because they require the patient to be physically present for refills of buprenorphine. Also, some offices strongly encourage (or require) the involvement of family members, such as Mr. Patel's wife or his uncle, in treatment decisions and administration.

Poll: Would you allow Mr. Patel to repeat the induction on his own at home?

Mr. Patel has stated that he wishes to resume buprenorphine treatment. He also implied that he would prefer to resume treatment without any further assistance, as he simply wants you to call in a refill for him. Based on what you know so far, would you be inclined to allow Mr. Patel to repeat the induction on his own at home in this situation?

- Yes
- No

How about you? If you haven't taken the polls yet, follow the link below:

https://bup.clinicalencounters.com/maintenance-poll/

Mr. Patel – Before Re-Induction

Interview

A phone interview may help you determine the best setting for Mr. Patel's re-induction and check on the status of his participation in counseling. For example:

Provider: *Have you been attending your regular counseling appointments?*

> ***Mr. Patel:*** *I missed a few because I was really busy with work.*

Provider: *If we start buprenorphine treatments again, you will need to start making weekly appointments until your dose and symptoms are stable. Is this something you would be willing to do?*

> ***Mr. Patel:*** *Yes, I just need to stop using heroin.*

Provider: *Great, I think you will really benefit from these counseling sessions, along with taking buprenorphine. Tell me what leads you to request home induction.*

> ***Mr. Patel:*** *I was a little embarrassed about failing to stick with it last time, but it's mostly that I am too busy at work.*

Provider: *The important thing is that you are back on track now. It sounds like the time you'd save is important. Let me ask a few more questions to help decide if starting again on your own at home is likely to be successful. For example, how much heroin are you using now?*

> ***Mr. Patel:*** *It's not that much, really, about 300 mg a day, and I've tried to cut back. But I know that any use is a problem.*

Provider: *The instructions are the same as last time you started taking buprenorphine, except you would be doing it from home this time. So I would send them in writing, too. How confident do you feel about following them on your own?*

> ***Mr. Patel:*** *I can handle it, with it all written down.*

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Provider: *You mentioned things have been "rough." Are you aware of any barriers you might face to taking your medication and abstaining from any opioids, such as finances?*

> ***Mr. Patel:*** *No, it should be okay.*

Provider: *Okay, I don't see any reason not to do a home re-induction of buprenorphine. Here's how we can* to *proceed..*

PRACTICE ACTIONS

Tips for home induction:

- Have the patient list his withdrawal symptoms in order of their usual appearance and tell him to postpone his first dose until he experiences at least three symptoms.
- Have the patient call you when he thinks he is ready. Both of you could review his symptoms on the phone and decide the next step together.
- Another approach might be to wait at least 24 hours for severe withdrawal and just go by the clock.

Patient Communication – Prepare Patients For Possible Relapse

Provider*: It's important to have a plan in place in case you slip up and use. I'm not saying that's going to happen, but if it does, it's not the end of your recovery. It will help to have a plan in place ahead of time to get back on track.*

> ***Mr. Patel:*** *That makes sense. So I could still come see you?*

Provider*: Absolutely. In fact, I hope you would call immediately so we could talk about what to do regarding medication, and then come see me as soon as possible* afterward *if that ever happens. What else might help you get back on track if you had a slip?*

> ***Mr. Patel****: I had a buddy who went to NA. He said I could call him if I needed to.*

Provider: *Good. Anything else? What gets you centered when you get out of balance?*

> ***Mr. Patel****: Basketball. A night of basketball and I always get my head back on straight.*

Provider*: So, that could be part of the plan, too. Good. You have a solid plan. I encourage you to seek help from your recovery supports early – prevention is key.*

> ***Mr. Patel****: Okay.*

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KEY POINTS

- The majority of patients do best in terms of not relapsing to opioid use if they are maintained on buprenorphine indefinitely because of a high rate of relapse in patients who stop taking buprenorphine.
- Monitoring patients for sufficient psychosocial support, such as continuing counseling or peer support groups, improves patient outcomes on average.
- Adequate pain management is another important factor in improving the chances of long-term abstinence for those patients having chronic pain conditions.
- Random monitoring with urine drug testing, checking of the prescription drug monitoring plan, and periodic (usually monthly) office visits also support long-term abstinence.
- The biggest danger of overdose with buprenorphine is from combination with sedating substances, especially benzodiazepines.
- Buprenorphine should be kept in a locked cabinet to avoid risk of accidental poisoning, especially of children.
- Naloxone kits should be prescribed for patients on chronic opioid therapy, which includes buprenorphine.

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SUMMARY

Buprenorphine Maintenance Guidelines

- Buprenorphine maintenance should continue indefinitely for most patients; unless there is a compelling reason to stop, due to the high rate of relapse when buprenorphine is discontinued.
- Concurrent and psychosocial support is an important part of treatment. Periodic psychosocial assessment is indicated throughout treatment.
- Maintenance dose with no withdrawal and no cravings is between 12-16 mg (Suboxone® or generic, slightly less for Zubsolv® or Bunavail™) for most patients.
- Conduct lab tests and periodic psychosocial assessments throughout the maintenance phase.
- The buprenorphine implant is an alternative for patients who have been maintained on a stable dose of submucosal buprenorphine of 8 mg or less for at least 3 months. It is placed under the skin in a minor surgical procedure by a REMS-certified prescriber and replaced every 6 months.
- The injectable form of buprenorphine is an alternative for patients who have been maintained at a stable dose of submucosal buprenorphine for at least 7 days. It is administered monthly in REMS-certified clinics.

Tapering Off Of Buprenorphine

- If patients wish to discontinue buprenorphine use, alternative forms of pharmacotherapy may be their best chance for remaining abstinent.
- A gradual taper, usually over a period of around 2 weeks, is used for discontinuation of buprenorphine.
- Shorter and longer tapers are safe and can be used if needed, based on circumstance.
- Patients should be monitored carefully for signs of withdrawal if tapered off buprenorphine.

Relapse

- Relapse is common among addiction patients and usually should not be ground for dismissal from a treatment program.
- Relapse may mean that a higher dose or more intensive psychosocial treatment is needed.

Treating Pain In Patients On Buprenorphine For Opioid Use Disorder

- Detoxification is not as effective as long-term medication maintenance treatment, with buprenorphine, for example, in helping patients stay otherwise opioid-free over the long-term.
- Patients in detoxification should be carefully monitored, offered appropriate psychosocial support, and offered medication maintenance treatment, such as buprenorphine, if they become unstable.
- Patients on buprenorphine who develop moderate to severe pain should be treated with non-opioids if possible. If that is not possible, a careful regimen may be followed to safely treat their pain with opioids.
- Patients with chronic pain who require opioid replacement therapy could be maintained on methadone rather than buprenorphine.
- Although risk of overdose with buprenorphine is lower than with other opioids, it still exists. Risk is increased with use of certain sedating medications, particularly benzodiazepines, injections, and being opioid-naive. Naloxone is used to reverse overdose.

Avoiding Overdose

To avoid overdose risk from buprenorphine, advise patients:

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- Exercise caution when combining buprenorphine with sedating medications or substances, especially benzodiazepines. Avoid if possible.
- Learn to use their naloxone kit and advise those around them what it is and how to use it.
- Never inject buprenorphine themselves.
- Keep their medication supply locked up. Opioid naive individuals are particularly at risk for overdose.

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RESOURCES

Behavioral Health Treatment Services Locator: The behavioral health treatment services locator is an online source of information for persons seeking treatment facilities in the United States or U.S. Territories for substance abuse/ addiction and/or mental health problems.

Buprenorphine Product Formulations Comparison: Describes the different formulations of buprenorphine for treatment of opioid use disorder. Includes Brand Names, How Supplied, Dosage, Maintenance Target Dose, and Instructions for Use.

Clinical Pathway for Buprenorphine: This flowchart for buprenorphine treatment displays the steps to patient recovery, from initial patient contact or referral, through intake process, induction, day #2, stabilization, maintenance, and tapering.

Management Guidelines - Patient Maintained on Buprenorphine Scheduled for Surgery or other Procedures: Guidelines from Boston Medical Center designed for patient maintained on buprenorphine underdoing invasive procedures.

Narcotics Anonymous: Find A Meeting: This page provides a search form for regional branches of Narcotics Anonymous to locate meetings in a specific area.

NIDA Quick Screen: The NIDA Quick Screen can be used in clinical practice to screen patients for substance use disorders.

PCSS-MAT Guidance: Treatment of Acute Pain in Patients Receiving Buprenorphine / Naloxone: This article provides guidance on the management and treatment of acute pain in patients receiving buprenorphine/naloxone.

Principles of Drug Addiction Treatment, A Research-Based Guide: This booklet provides a general overview of the principles that characterize effective treatment for drug addiction, and can be used to introduce staff and patients to this topic.

Protracted Withdrawal: Bulletin describes the phenomenon of protracted withdrawal from addictive substances, including opioids, lasting months to years.

Relapse Prevention and the Five Rules of Recovery: Describes the main ideas in relapse prevention.

Sleep Hygiene Tips: List of sleep hygiene tips that can be used to improve sleep

TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders: Practical tools and guidance for treating chronic pain in adults who have a history of substance use disorders. Topics include chronic pain management, treatment with opioids, substance abuse assessments and referrals.

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