



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

For Healthcare and Addiction Professionals

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

TIP Navigation

Executive Summary

For healthcare and addiction professionals, policymakers, patients, and families

Part 1: Introduction to Medications for Opioid Use Disorder Treatment

For healthcare and addiction professionals, policymakers, patients, and families

Part 2: Addressing Opioid Use Disorder in General Medical Settings

For healthcare professionals

Part 3: Pharmacotherapy for Opioid Use Disorder

For healthcare professionals

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

For healthcare and addiction professionals

Part 5: Resources Related to Medications for Opioid Use Disorder

For healthcare and addiction professionals, policymakers, patients, and families

KEY MESSAGES

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





Contents

Overview and Context	4-1
Scope of the Problem	4-1
Setting the Stage	4-4
Distinguishing OUD From Physical Dependence on Opioid Medications	4-4
Understanding the Benefits of Medication for OUD	4-5
Reviewing the Evidence on Counseling in Support of Medication To Treat OUD	4-6
Using a Recovery-Oriented Approach to Treating Patients With OUD	4-8
Quick Guide to Medications	4-12
Understanding the Neurobiology of OUD	4-12
Learning How OUD Medications Work	4-12
Knowing What Prescribers Do	4-16
Counselor–Prescriber Communications	4-18
Obtaining Consent	4-18
Structuring Communications With Prescribers	4-19
Helping Clients Overcome Challenges in Accessing Resources	4-19
Creation of a Supportive Counseling Experience	4-20
Maintaining the Therapeutic Alliance	4-20
Educating Patients About OUD and a Chronic Care Approach to Its Treatment	4-21
Counseling Patients on Overdose Prevention and Treatment	4-21
Helping Patients Cope With Bias and Discrimination	4-22
Helping Patients Advocate for Themselves	4-26
Addressing Discrimination Against Clients Who Take OUD Medication	4-26
Helping Clients Find Accepting Mutual-Help Groups	4-30
Facilitating Groups That Include Patients Taking OUD Medication	4-33
Other Common Counseling Concerns	4-34
Notes	4-37



Exhibits

Exhibit 4.1. Key Terms 4-2

Exhibit 4.2. Recommending Versus Requiring Counseling 4-5

Exhibit 4.3. Jessica’s Story About Medication 4-6

Exhibit 4.4. Engaging Reluctant Family Members in a Client’s Treatment. 4-11

Exhibit 4.5. FDA-Approved Medications Used To Treat OUD: Key Points 4-13

Exhibit 4.6. Example of Counselor–Prescriber Communication 4-18

Exhibit 4.7. Tips for Discussing Patient Care With Prescribers. 4-19

Exhibit 4.8. Conversation: Addressing Misinformation 4-23

Exhibit 4.9. Addressing the Misconception That an Opioid Medication
Is “Just Another Drug” 4-24

Exhibit 4.10. When a Patient Wants To Taper Medication or Stop Altogether 4-24

Exhibit 4.11. Responding to a Patient’s Desire To Taper Medication for OUD 4-25

Exhibit 4.12. Conversation: Redirecting a Concern to the Prescriber 4-26

Exhibit 4.13. Conversation: Helping a Client Self-Advocate. 4-27

Exhibit 4.14. Summary of Current Guidance for the Treatment
of Pregnant Women With OUD 4-30

Exhibit 4.15. Redirecting Negative Comments. 4-33

Exhibit 4.16. Common Collaborative Care Issues and Possible Counselor Responses 4-35

This page intentionally left blank.

PART 4 of 5

Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals

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

Overview and Context

Scope of the Problem

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

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

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

2.1 MILLION people in the U.S., ages 12 and older, had OUD involving **PRESCRIPTION OPIOIDS, HEROIN,** or both in 2016.²



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

Counseling clients who take OUD medication requires understanding:

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



EXHIBIT 4.1. Key Terms

Addiction: As defined by the American Society of Addiction Medicine,³ “a primary, chronic disease of brain reward, motivation, memory, and related circuitry” (p. 1). It is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of **relapse** and **remission**. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*⁴ (DSM-5), does not use the term for diagnostic purposes, but it commonly describes the more severe forms of OUD.

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

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

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

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

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

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

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

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

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



EXHIBIT 4.1. Key Terms (continued)

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

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

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

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

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

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

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

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

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

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

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

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



Setting the Stage

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

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

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

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

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

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

discusses recommending versus requiring counseling as part of medication treatment for OUD.

Distinguishing OUD From Physical Dependence on Opioid Medications

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

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

Properly taken, some medications cause tolerance and physical dependence.

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

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

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

EXHIBIT 4.2. Recommending Versus Requiring Counseling

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

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

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

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

OUD is often a chronic medical illness.¹⁷ Treatment isn't a cure.

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

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

Understanding the Benefits of Medication for OUD

Medication is an effective treatment for OUD.^{18,19,20} People with OUD should be referred for an assessment for pharmacotherapy unless they decline.²¹ To be supportive and effective

when counseling clients who could benefit from or who take medication for OUD, know that:

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



EXHIBIT 4.3. Jessica's Story About Medication

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



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

- **Randomized clinical trials indicate that OUD medication improves treatment retention and reduces illicit opioid use.**^{32,33,34} Retention in treatment increases the opportunity to provide counseling and supportive services that can help patients stabilize their lives and maintain recovery.
 - **The longer patients take medication, the less likely they are to return to opioid use,** whereas short-term medically supervised withdrawal rarely prevents return to use:^{35,36,37,38,39}
 - Conducting short-term medically supervised withdrawal may increase the risk of unintentional fatal overdose because of decreased tolerance after withdrawal completion.^{40,41}
 - Providing short-term medical treatment for OUD is the same as treating a heart attack without managing the underlying coronary disease.
 - Providing longer courses of medication that extend beyond withdrawal can allow patients to stabilize.
 - Getting stabilized, which may take months or even years, allows patients to focus on building and maintaining a healthy lifestyle.
 - **Patients taking OUD medication can achieve long-term recovery.** People who continue to take medication can be in remission from OUD and live healthy, productive lives.⁴²
- Reviewing the Evidence on Counseling in Support of Medication To Treat OUD**
- Dedicated counseling can help clients address the challenges of extended recovery.** For clients who seek a self-directed, purposeful life, counseling can help them:
- Improve problem-solving and interpersonal skills.
 - Find incentives for reduced use and abstinence.
 - Build a set of techniques to resist drug use.
 - Replace drug use with constructive, rewarding activities.
- Moreover, evidence shows that counseling can be a useful part of OUD treatment** for people who take OUD medication. Impact studies of counseling for people with SUDs show that:
- **Motivational enhancement/interviewing is generally beneficial.**⁴³ This approach helps get people into treatment. It also supports behavior change and, thus, recovery.

- **Cognitive-behavioral therapy (CBT) has demonstrated efficacy in the treatment of SUDs**, whether used alone or in combination with other strategies.⁴⁴ Clinical trials have not shown that CBT added to buprenorphine treatment with medical management is associated with significantly lower rates of illicit opioid use.^{45,46} However, a secondary analysis of one of those trials found that CBT added to buprenorphine and medical management was associated with significantly greater reduction in any drug use among participants whose OUD was primarily linked to misuse of prescription opioids than among those whose OUD involved only heroin.⁴⁷ Thus, CBT may be helpful to those patients receiving buprenorphine treatment who have nonopioid drug use problems.
- **Case management helps establish the stability necessary for SUD remission.**^{48,49,50} Case management helps some people in SUD treatment get or sustain access to services and necessities, such as:
 - Food.
 - Shelter.
 - Income support.
 - Legal aid.
 - Dental services.
 - Transportation.
 - Vocational services.
- **Family therapy can address SUDs and various other family problems** (e.g., family conflict, unemployment, conduct disorders). Several forms of family therapy are effective with adolescents⁵¹ and can potentially address family members' biases about use of medication for OUD.⁵²
- **There is more research on combined methadone treatment and various psychosocial treatments (e.g., different levels of counseling, contingency management) than on buprenorphine or naltrexone treatment in office-based settings.** More research is needed to identify the best interventions to use with specific medications, populations, and treatment phases in outpatient settings.⁵³
- **Motivational intervention, case management, or both can improve likelihood of entry into medication treatment for OUD** among people who inject opioids, according to a systematic review of 13 studies plus data from a prior systematic review.⁵⁴
- **Clinical trials have shown no differences in outcomes for buprenorphine with medical management between participants who get adjunctive counseling and those who don't** (i.e., prescriber-provided guidance focused specifically on use of the medication).^{55,56,57,58}

RESOURCE ALERT

Principles of Effective Treatment

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

- **“No single treatment is effective for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success

in returning to productive functioning in the family, workplace, and society.”

- **“Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.”



Yet those trials:

- Relied on well-structured medical management sessions that may not be typical in practice.
 - Excluded patients with certain co-occurring disorders or factors that complicated treatment.
- **Benefits from counseling may depend on factors such as the number of sessions and adherence.**⁶⁰

Using a Recovery-Oriented Approach to Treating Patients With OUD

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

- Other SUDs (e.g., alcohol use disorder, cannabis use disorder).^{62,63,64}
- Mental distress⁶⁵ (i.e., high levels of symptoms) and disorders^{66,67,68} (e.g., major depressive disorder, posttraumatic stress disorder).
- Medical problems (e.g., hepatitis, diabetes).⁶⁹
- History of trauma.^{70,71}
- Poor diet, lack of physical activity, or both.⁷²
- Lack of social support.⁷³
- Unemployment.⁷⁴

Acknowledge many pathways to recovery

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

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

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

RESOURCE ALERT

Recovery-Oriented Treatment

Recovery-Oriented Methadone Maintenance:

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

Supporting Recovery From Opioid Addiction:

Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/MethadoneBestPracticeGuideline.pdf) and

Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Buprenorphine and Suboxone (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/Community_Care_BP_Guidelines_for_Buprenorphine_and_Suboxone.pdf)

outline phase-specific tasks and accompanying strategies for programs that provide services to clients who take these medications.

SAMHSA'S GUIDING PRINCIPLES OF RECOVERY⁷⁶

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

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

Promote recovery for clients with OUD

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

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

- Forging new relationships with friends/family
- Obtaining support from friends, family, partners, and communities
- Using positive coping strategies
- Finding meaning or a sense of purpose in life
- Engaging in a church or in spiritual practices
- Pursuing education, employment, or both
- Engaging in new interests or activities (e.g., joining a community group, exercising)

- Building confidence in ability to maintain abstinence (i.e., increasing abstinence-related self-efficacy)
- Finding ways to help other individuals who are new to recovery

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

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

Provide person-centered care

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

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

RESOURCE ALERT

Decision-Making Tool

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

RESOURCE ALERT

Relapse Prevention and Recovery Promotion TIP

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



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

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

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

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

Promote family and social support

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

Most clients are willing to invite a substance-free family member or friend to support

RESOURCE ALERT

Treatment Guidance for Co-Occurring Substance Use and Mental Disorders

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

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

their recovery.⁹⁸ Most have at least one nearby family member who does not use illicit drugs.⁹⁹ A client's community may provide a cultural context for their recovery and culturally specific supports that may not otherwise be available in treatment.¹⁰⁰

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

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

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

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

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

Provide trauma-informed care

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

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

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

- Trauma histories and trauma-related disorders may increase clients' risk for various problems, including early drop-out from treatment¹⁰² and greater problems with pain.¹⁰³

- Childhood trauma is highly prevalent among people with OUD.^{104,105}
- People often suffer multiple traumas during opioid misuse.¹⁰⁶
- An intervention that integrated trauma treatment and standard care (which goes further than the trauma-informed care detailed here) had better outcomes than standard care alone in a diverse group of women treated in various settings, including an OTP.¹⁰⁷

RESOURCE ALERT

Trauma-Informed Care TIP

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



Quick Guide to Medications

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

Understanding the Neurobiology of OUD

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

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

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

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

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

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

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

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

Learning How OUD Medications Work

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



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

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



Buprenorphine

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

Buprenorphine has the benefit of a ceiling effect. Its effectiveness and sedation or respiratory effects don't increase after a certain dosing level, even if more is taken. This lowers risk of overdose and misuse.¹¹³ Groups at particular risk for buprenorphine overdose include children who accidentally ingest the medication¹¹⁴ and patients who also use CNS depressants like benzodiazepines or alcohol.^{115,116} (See Part 3 of this TIP for more information on concurrent use of CNS depressants and buprenorphine.)

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

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

The most common buprenorphine formulation contains naloxone to reduce misuse. Naloxone is an opioid antagonist. It blocks rather than activates receptors and lets no opioids sit on

receptors to activate them. Naloxone is poorly absorbed under the tongue/against the cheek, so when taking the combined medication as directed, it has no effect. If injected, naloxone causes sudden opioid withdrawal.

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

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

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

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

Methadone

Methadone is highly effective. Many studies over decades of research show that it:^{117,118,119}

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

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

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

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

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

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

Patients must attend a clinic for dose administration 6 to 7 days per week during the start of treatment. Healthcare professionals can thus

observe patients’ response to medication and discourage diversion to others. Visit frequency can lessen after patients spend time in treatment and show evidence of progress.

Methadone can cause certain side effects.

Common potential side effects of methadone include:

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

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

Naltrexone

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

Naltrexone appears to reduce opioid craving¹²⁰ but not opioid withdrawal (unlike buprenorphine and methadone, which reduce both craving and withdrawal). Someone starting naltrexone must be abstinent from short-acting opioids for at least 7 days and from long-acting opioids for 10 to 14 days before taking the first dose. Otherwise, it will cause opioid withdrawal, which can be more severe than that caused by reducing or stopping opioid use.



Naltrexone comes in two forms: tablet and injection.

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

Naltrexone can produce certain side effects, which may include:

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

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

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

Knowing What Prescribers Do

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

Administer buprenorphine

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

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

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

Administer methadone

Only SAMHSA-certified OTPs may provide methadone by physician order for daily observed administration onsite or for self-administration at home by stable patients.¹²⁷

The physician will start patients on a low dose of methadone. People in early methadone treatment are required by federal regulation to visit the OTP six to seven times per week to take their medication under observation. The physician will monitor patients' initial response to the methadone and slowly increase the dose until withdrawal is completely relieved for 24 hours.

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

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

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

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

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

Administer naltrexone

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

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

Healthcare professionals manage withdrawal symptoms with nonopioid medication.

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

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

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

Set expectations

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

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

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

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



Counselor–Prescriber Communications

OUD medication can support counselors' work with clients who have OUD, and counseling supports the work prescribers do with them.

Good communication facilitates mutually supportive work (Exhibit 4.6). A counselor will probably:

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

Obtaining Consent

Get written consent from patients allowing communication directly with their providers

(unless the counselor and the providers work in the same treatment program). The consent must explicitly state that the patient allows

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

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

the counselor to discuss substance-use-related issues. It should also specify which kinds of information the counselor can share (e.g., medical records, diagnoses). Consent forms must comply with federal and state confidentiality laws that govern the sharing of information about patients with SUDs.^{136,137}

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

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

EXHIBIT 4.6. Example of Counselor–Prescriber Communication

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

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

Structuring Communications With Prescribers

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

Helping Clients Overcome Challenges in Accessing Resources

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

- **Ability to pay for OUD medication.** Counselors are often already skilled in helping clients address treatment costs (e.g., facilitating Medicaid applications, linking them to insurance navigators). Try to refer clients who face difficulty meeting prescription costs or copays back to the agency's financial

department for sliding scale adjustments and ability-to-pay assessments. Also try to help patients find and apply for relevant pharmaceutical company medication prescription plans.

- **Transportation.** Options to offer clients may include:
 - Providing vouchers for public transportation.
 - Providing information on other subsidized transportation options.
 - Linking clients to peer support specialists and case managers who can arrange transportation.
 - Assisting eligible clients in navigating Medicaid to obtain transportation services.
 - If available, arranging for telehealth services to overcome clients' transportation barriers.
- **Access to medication in disaster situations.** Counselors can review options with patients for obtaining prescription replacements and refills or daily medicine dosing under various scenarios. This could include if their usual clinic or primary pharmacy is closed or if they're relocated without notice because of an unforeseen emergency. Also advise patients on the items to take with them in such scenarios to facilitate refills from a new

EXHIBIT 4.7. Tips for Discussing Patient Care With Prescribers

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



medication-dispensing facility. Key materials include:

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

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

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

Encourage buprenorphine prescribers to make known their availability if they are prepared to accept new patients. Help disseminate lists of addiction treatment providers and share their information via peer recovery specialists (see Part 5).

- **Rapid assessment and treatment initiation:** Try to help OUD pharmacotherapy providers, particularly in OTPs, streamline counseling intake processes to help patients receive medication efficiently. The expert panel of this TIP recognizes that same-day admission of patients with OUD may not be possible in all settings, but it's a worthwhile goal. Every program should streamline its intake processes and expedite admissions.

- **Return to treatment:** When patients discontinue treatment prematurely and return to use of opioids, it can be hard for them to reengage in treatment because of the shame they feel or because there is a waiting list for admission. The waitlist problem may not be solvable because of capacity limitations, but all collaborative care team members—including counselors and prescribers—should:
 - Inform patients from intake onward that the program will readmit them even if they drop out.
 - Encourage patients to seek readmission if they return to opioid use or feel that they are at risk for returning to opioid use.
 - **Inform patients of the importance of overdose prevention** (see the “Counseling Patients on Overdose Prevention and Treatment” section).
 - Provide continued monitoring if possible; it can range from informal quarterly check-ins to regularly scheduled remote counseling or peer support (e.g., from a recovery coach).
 - Offer an expedited reentry process to encourage patients to return if they need to.
 - Engage in active outreach and reengagement with OTP patients, which can be effective.^{138,139} Try to contact patients who have dropped out to encourage them to return.

Creation of a Supportive Counseling Experience

Maintaining the Therapeutic Alliance

The therapeutic alliance is a counselor's most powerful tool for influencing outcomes.¹⁴⁰

It underlies all types and modalities of therapy and helping services. A strong alliance welcomes patients into treatment and creates a sense of safety.

COUNSELING PATIENTS WITH OUD WHO DON'T TAKE MEDICATION

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

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

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

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

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

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

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

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

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

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

Counseling Patients on Overdose Prevention and Treatment

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

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



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

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

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

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

Consider working with the program administrators to set up a program to distribute naloxone directly to patients. Many states allow organizations to do this under a standing

order from a physician. Clients are more likely to access naloxone if their program provides it directly to them rather than sending them to another organization to get it. Learn more at Prescribe to Prevent (<http://prescribetoprevent.org>).

Helping Patients Cope With Bias and Discrimination

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

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

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

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

RESOURCE ALERT

Overdose Prevention/Treatment

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

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

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

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

EXHIBIT 4.8. Conversation: Addressing Misinformation

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

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

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

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

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

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



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

Concerned Colleague: These patients are just replacing one drug with another. Instead of heroin, they’re using buprenorphine or methadone.

Counselor: Actually, there’s substantial research that medication for opioid use disorder helps patients stop feeling withdrawal and craving and allows them to get their life back on track. These medications keep patients in treatment and reduce crime and HIV risk behavior.

Concerned Colleague: Yeah, but aren’t they still addicted?

Counselor: Physically dependent, yes; but addicted, no. There’s an important difference. Someone addicted to heroin has to take the drug several times a day to avoid withdrawal. This usually leads to craving, loss of control, and taking more than intended. Drug-seeking behavior causes loss of family and friends. It makes the person unable to perform daily roles and meet obligations.

Concerned Colleague: Yes, I know how addiction works. But isn’t taking methadone an addiction, too?

Counselor: Patients only take methadone once a day, and its makeup is different from heroin. Daily methadone lets the body stabilize so patients don’t have the highs and lows that come from heroin use. If patients use heroin, the methadone blocks its effects; they don’t get high. Methadone is taken orally, so there isn’t the same danger of infection that comes with injection drug use. Taking methadone as part of a treatment program lets patients feel normal and focus on changing the other aspects of their lives that led to drug use.

Concerned Colleague: But you just said they take methadone every day.

Counselor: Yes. That is true of most medications for any disease, if you think about it. Patients have a physical dependence on the medication but are in remission from addiction.

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

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

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

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

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

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

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

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

Focus on common ground—all patients want a healthy recovery, and judging or isolating someone for return to use doesn't aid anyone's recovery. A divide may occur between

patients in a group setting over return to opioid use. People in the OUD community typically are forgiving of return to opioid use and recognize that it can occur on the path to long-term recovery. However, some people in mutual-help communities judge those who return to use (see the "Helping Clients Find Accepting Mutual-Help Groups" section). Address judgmental attitudes through this analogy: People with diabetes whose blood sugar spikes aren't condemned and ejected from treatment.

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



EXHIBIT 4.12. Conversation: Redirecting a Concern to the Prescriber

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

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

Helping Patients Advocate for Themselves

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

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

Offer clients' family and friends education on these topics as well so that they can advocate for their loved ones. Encourage patients to let

family and friends know how important they are and how valuable their support is. Also urge patients to ask loved ones to help them express concerns or fears.

Role-playing can help patients self-advocate.

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

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

Addressing Discrimination Against Clients Who Take OUD Medication

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



EXHIBIT 4.13. Conversation: Helping a Client Self-Advocate

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

Help clients address employment-related issues

Under the Americans With Disabilities Act, employers cannot discriminate against patients taking medication for OUD.¹⁴⁸

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

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

RESOURCE ALERT

Becoming a Certified Medication-Assisted Treatment Advocate

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



Understand potential legal issues

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

Many jails (short term) and prisons (long term) restrict or disallow access to OUD medication

despite the federal mandate that people who are incarcerated have access to medical care.^{149,150}

For example:

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

Help negotiate patient access to OUD medication during incarceration.

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

Encourage patients to reengage in treatment as soon as they're released.

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

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

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

OPIOID ADDICTION
is linked with high rates of
ILLEGAL ACTIVITY and
INCARCERATION.^{151,152}



Support patients in getting legal advice or counsel via their OUD medication prescribers' healthcare organization.

Members of the TIP expert panel have observed situations in which law enforcement personnel arrested patients leaving methadone clinics and charged them with driving under the influence or arrested them after finding buprenorphine prescription bottles in their cars. Discussions among treatment organizations and local law enforcement leadership can help address such situations.

Address concerns and advocate for addiction specialists to select treatments best suited for each patient.

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

Address issues in dealing with healthcare providers

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

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

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

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

Demonstrate awareness of pregnancy and parenting issues

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

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

Hospital policies on screening infants for prenatal substance exposure vary considerably.

A positive screen may trigger involvement of Child Protective Services. This may occur even when the positive screen results from treatment with OUD medication under a physician's care rather than opioid misuse.

Help pregnant and postnatal clients in these situations by:

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

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

RESOURCE ALERT

Treatment of Pain in Patients With OUD

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

RESOURCE ALERT

Pregnancy- and Parenting-Related Issues

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



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

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

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

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

Helping Clients Find Accepting Mutual-Help Groups

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

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

For example:

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

RESOURCE ALERT

Addressing Bias and Discrimination

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

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

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

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

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

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

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

Facilitate positive mutual-help group experiences

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



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

RESOURCE ALERT

How To Use Technology-Based Tools in Behavioral Health Services

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

Online mutual-help groups

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

RESOURCE ALERT

Mutual Help for Clients With OUD

William White's *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States*: Publication that gives more information on the pros and cons of 12-Step groups for people receiving medication for OUD and how to prepare them for meetings¹⁶⁶ (<http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf>)

White, Galanter, Humphreys, and Kelly's "The Paucity of Attention to Narcotics Anonymous in Current Public, Professional, and Policy Responses to Rising Opioid Addiction": Peer-reviewed journal article on the benefits of NA and the need to include it among the options offered to people receiving medication for OUD¹⁶⁷ (www.tandfonline.com/doi/abs/10.1080/07347324.2016.1217712)

Mutual-help groups specific to OTPs

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

Facilitating Groups That Include Patients Taking OUD Medication

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

- **Establish ground rules** about being respectful, avoiding negative comments about group members, and keeping statements made in the group confidential—as with any group.

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

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

Additional tips for leading mixed groups include the following:

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

EXHIBIT 4.15. Redirecting Negative Comments

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



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

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

Other Common Counseling Concerns

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

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

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



Patients may not consent to communication among providers if they:

- **Have experienced discrimination in health-care systems.**
- **Have developed OUD after taking opioid pain medication.**
- **Have legitimate cause not to trust providers** (e.g., perceiving themselves as having been abused by a healthcare professional).¹⁷¹
- **Are not ready to make primary care providers aware of their disorder,** even

(or especially) if those providers have been prescribing opioid pain medication.

- **Encounter problems in making progress toward recovery.** After typically consenting to communication among providers, a patient's sudden revocation may signal trouble in recovery.

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

EXHIBIT 4.16. Common Collaborative Care Issues and Possible Counselor Responses

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

Continued on next page



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

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



Notes

- Centers for Disease Control and Prevention. (2016). Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *Morbidity and Mortality Weekly Report*, 65(50–51), 1445–1452.
- Center for Behavioral Health Statistics and Quality. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- American Society of Addiction Medicine. (2011). Definition of addiction. Retrieved October 30, 2017, from www.asam.org/resources/definition-of-addiction
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Department of Health and Human Services, Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration. (2015). *Federal guidelines for opioid treatment programs*. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- National Cancer Institute. (n.d.). Remission. In *NCI dictionary of cancer terms*. Retrieved November 22, 2017, from www.cancer.gov/publications/dictionaries/cancer-terms?cdrid=45867
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Manchikanti, L. (2007). National drug control policy and prescription drug abuse: Facts and fallacies. *Pain Physician*, 10, 399–424.
- Jones, C. M. (2013). Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers—United States, 2002–2004 and 2008–2010. *Drug and Alcohol Dependence*, 132(1–2), 95–100.
- Hedegaard, H., Chen, L. H., & Warner, M. (2015). *Drug-poisoning deaths involving heroin: United States, 2000–2013*. NCHS Data Brief, No. 190. Hyattsville, MD: National Center for Health Statistics.
- Centers for Disease Control and Prevention. (2016). Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *Morbidity and Mortality Weekly Report*, 65(50–51), 1445–1452.
- Substance Abuse and Mental Health Services Administration. (n.d.). Opioid treatment program directory. Retrieved October 19, 2017, from <https://dpt2.samhsa.gov/treatment/directory.aspx>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Carroll, K. M., & Weiss, R. D. (2016). The role of behavioral interventions in buprenorphine maintenance treatment: A review. *American Journal of Psychiatry*, 174(8), 738–747.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13), 1689–1695.
- Connery, H. S. (2015). Medication-assisted treatment of opioid use disorder: Review of the evidence and future directions. *Harvard Review of Psychiatry*, 23(2), 63–75.
- Fullerton, C. A., Kim, M., Thomas, C. P., Lyman, D. R., Montejano, L. B., Dougherty, R. H., ... Delphin-Rittmon, M. E. (2014). Medication-assisted treatment with methadone: Assessing the evidence. *Psychiatric Services*, 65(2), 146–157.
- Thomas, C. P., Fullerton, C. A., Kim, M., Montejano, L., Lyman, D. R., Dougherty, R. H., ... Delphin-Rittman, M. E. (2014). Medication-assisted treatment with buprenorphine: Assessing the evidence. *Psychiatric Services*, 65(2), 158–170.
- American Society of Addiction Medicine. (2015). *The ASAM national practice guideline for the use of medications in the treatment of addiction involving opioid use*. Chevy Chase, MD: Author.
- Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., ... Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *British Medical Journal (Clinical Research Ed.)*, 357, j1550.
- Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews*, 2014(2), 1–84.
- Auriacombe, M., Fatséas, M., Dubernet, J., Daulouède, J. P., & Tignol, J. (2004). French field experience with buprenorphine. *American Journal on Addictions*, 13(Suppl. 1), S17–S28.
- Degenhardt, L., Randall, D., Hall, W., Law, M., Butler, T., & Burns, L. (2009). Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: Risk factors and lives saved. *Drug and Alcohol Dependence*, 105(1–2), 9–15.



- 26 Gibson, A., Degenhardt, L., Mattick, R. P., Ali, R., White, J., & O'Brien, S. (2008). Exposure to opioid maintenance treatment reduces long-term mortality. *Addiction, 103*(3), 462–468.
- 27 Merlo, L. J., Greene, W. M., & Pomm, R. (2011). Mandatory naltrexone treatment prevents relapse among opiate-dependent anesthesiologists returning to practice. *Journal of Addiction Medicine, 5*(4), 279–283.
- 28 Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews, 2011*(4), 1–45.
- 29 Fullerton, C. A., Kim, M., Thomas, C. P., Lyman, D. R., Montejano, L. B., Dougherty, R. H., ... Delphin-Rittmon, M. E. (2014). Medication-assisted treatment with methadone: Assessing the evidence. *Psychiatric Services, 65*(2), 146–157.
- 30 Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews, 2014*(2), 1–84.
- 31 Kresina, T. F., & Lubran, R. (2011). Improving public health through access to and utilization of medication assisted treatment. *International Journal of Environmental Research and Public Health, 8*(10), 4102–4117.
- 32 Krupitsky, E., Nunes, E. V., Ling, W., Illeperuma, A., Gastfiend, D. R., & Silverman, B. L. (2011). Injectable extended-release naltrexone for opioid dependence: A double-blind, placebo-controlled, multicentre randomized trial. *Lancet, 377*(9776), 1506–1533.
- 33 Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews, 2014*(2), 1–84.
- 34 Timko, C., Schultz, N. R., Cucciare, M. A., Vittorio, L., & Garrison-Diehn, C. (2016). Retention in medication-assisted treatment for opiate dependence: A systematic review. *Journal of Addictive Diseases, 35*(1), 22–35.
- 35 Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine, 174*(12), 1947–1954.
- 36 Kakko, J., Svanborg, K. D., Kreek, M. J., & Heilig, M. (2003). 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: A randomised, placebo-controlled trial. *Lancet, 361*(9358), 662–668.
- 37 Sees, K. L., Delucchi, K. L., Masson, C., Rosen, A., Clark, H. W., Robillard, H., ... Hall, S. M. (2000). Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *JAMA, 283*(10), 1303–1310.
- 38 Weiss, R. D., Potter, J. S., Fiellin, D. A., Byrne, M., Connery, H. S., Dickinson, W., ... Ling, W. (2011). Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: A 2-phase randomized controlled trial. *Archives of General Psychiatry, 68*(12), 1238–1246.
- 39 Amato, L., Davoli, M., Minozzi, S., Ferroni, E., Ali, R., & Ferri, M. (2013). Methadone at tapered doses for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews, 2013*(2), 1–68.
- 40 Bart, G. (2012). Maintenance medication for opiate addiction: The foundation of recovery. *Journal of Addictive Diseases, 31*(3), 207–225.
- 41 Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine, 174*(12), 1947–1954.
- 42 White, W. L. (2012). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases, 31*(3), 199–206.
- 43 Substance Abuse and Mental Health Services Administration. (1999). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. (SMA) 13-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 44 McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33*(3), 511–525.
- 45 Ling, W., Hillhouse, M., Ang, A., Jenkins, J., & Fahey, J. (2013). Comparison of behavioral treatment conditions in buprenorphine maintenance. *Addiction, 108*(10), 1788–1798.
- 46 Fiellin, D. A., Barry, D. T., Sullivan, L. E., Cutter, C. J., Moore, B. A., O'Connor, P. G., & Schottenfeld, R. S. (2013). A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *American Journal of Medicine, 126*(1), 74.e11–74.e17.
- 47 Moore, B. A., Fiellin, D. A., Cutter, C. J., Biondo, F. D., Barry, D. C., Fiellin, L. E., ... Schottenfeld, R. S. (2016). Cognitive behavioral therapy improves treatment outcomes for prescription opioid users in primary care buprenorphine treatment. *Journal of Substance Abuse Treatment, 71*, 54–57.



- 48 Abbott, P. J. (2010). Case management: Ongoing evaluation of patients' needs in an opioid treatment program. *Professional Case Management, 15*(3), 145–152.
- 49 Morgenstern, J., Neighbors, C. J., Kermis, A., Riordan, A., Blanchard, K. A., McVeigh, K. H., ... McCredie, B. (2009). Improving 24-month abstinence and employment outcomes for substance-dependent women receiving temporary assistance for needy families with intensive case management. *American Journal of Public Health, 99*(2), 328–333.
- 50 Substance Abuse and Mental Health Services Administration. (2000). *Comprehensive case management for substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 51 National Institute on Drug Abuse. (2012). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). NIH Publication No. 12–4180. Bethesda, MD: Author.
- 52 Woo, J., Bhalerao, A., Bawor, M., Bhatt, M., Dennis, B., Mouravska, N., ... Samaan, Z. (2017). "Don't judge a book by its cover": A qualitative study of methadone patients' experiences of stigma. *Substance Abuse: Research and Treatment, 11*, 1–12.
- 53 Dugosh, K., Abraham, A., Seymour, B., McLoyd, K., Chalk, M., & Festinger, D. (2016). A systematic review on the use of psychosocial interventions in conjunction with medications for the treatment of opioid addiction. *Journal of Addiction Medicine, 10*(2), 93–103.
- 54 Roberts, J., Annett, H., & Hickman, M. (2011). A systematic review of interventions to increase the uptake of opiate substitution therapy in injecting drug users. *Journal of Public Health, 33*(3), 378–384.
- 55 Fiellin, D. A., Barry, D. T., Sullivan, L. E., Cutter, C. J., Moore, B. A., O'Connor, P. G., & Schottenfeld, R. S. (2013). A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *American Journal of Medicine, 126*(1), 74.e11–74.e17.
- 56 Ling, W., Hillhouse, M., Ang, A., Jenkins, J., & Fahey, J. (2013). Comparison of behavioral treatment conditions in buprenorphine maintenance. *Addiction, 108*(10), 1788–1798.
- 57 Weiss, R. D., Potter, J. S., Fiellin, D. A., Byrne, M., Connery, H. S., Dickinson, W., ... Ling, W. (2011). Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: A 2-phase randomized controlled trial. *Archives of General Psychiatry, 68*(12), 1238–1246.
- 58 Ling, W., Hillhouse, M., Ang, A., Jenkins, J., & Fahey, J. (2013). Comparison of behavioral treatment conditions in buprenorphine maintenance. *Addiction, 108*(10), 1788–1798.
- 59 National Institute on Drug Abuse. (2012). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). NIH Publication No. 12–4180. Bethesda, MD: Author.
- 60 Weiss, R. D., Griffin, M. L., Potter, J. S., Dodd, D. R., Dreifuss, J. A., Connery, H. S., & Carroll, K. M. (2014). Who benefits from additional drug counseling among prescription opioid-dependent patients receiving buprenorphine-naloxone and standard medical management? *Drug and Alcohol Dependence, 140*, 118–122.
- 61 Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R. J., ... Taylor, R. S. (2007). Methadone and buprenorphine for the management of opioid dependence: A systematic review and economic evaluation. *Health Technology Assessment, 11*(9), 1–171, iii–iv.
- 62 De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). Quality of life among opiate-dependent individuals: A review of the literature. *International Journal on Drug Policy, 21*(5), 364–380.
- 63 Carpentier, P. J., Krabbe, P. F., van Gogh, M. T., Knapen, L. J., Buitelaar, J. K., & de Jong, C. A. (2009). Psychiatric comorbidity reduces quality of life in chronic methadone maintained patients. *American Journal on Addictions, 18*(6), 470–480.
- 64 Muller, A. E., Skurtveit, S., & Clausen, T. (2016). Many correlates of poor quality of life among substance users entering treatment are not addiction-specific. *Health and Quality of Life Outcomes, 14*, 1–10.
- 65 De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). Quality of life among opiate-dependent individuals: A review of the literature. *International Journal on Drug Policy, 21*(5), 364–380.
- 66 Carpentier, P. J., Krabbe, P. F., van Gogh, M. T., Knapen, L. J., Buitelaar, J. K., & de Jong, C. A. (2009). Psychiatric comorbidity reduces quality of life in chronic methadone maintained patients. *American Journal on Addictions, 18*(6), 470–480.
- 67 Fei, J. T. B., Yee, A., Habil, M. H. B., & Danaee, M. (2016). Effectiveness of methadone maintenance therapy and improvement in quality of life following a decade of implementation. *Journal of Substance Abuse Treatment, 69*, 50–56.
- 68 Millson, P., Challacombe, L., Villeneuve, P. J., Strike, C. J., Fischer, B., Myers, T., ... Hopkins, S. (2006). Determinants of health-related quality of life of opiate users at entry to low-threshold methadone programs. *European Addiction Research, 12*(2), 74–82.
- 69 Krebs, E., Kerr, T., Wood, E., & Nosyk, B. (2016). Characterizing long-term health related quality of life trajectories of individuals with opioid use disorder. *Journal of Substance Abuse Treatment, 67*, 30–37.



- 70 Millson, P., Challacombe, L., Villeneuve, P. J., Strike, C. J., Fischer, B., Myers, T., ... Hopkins, S. (2006). Determinants of health-related quality of life of opiate users at entry to low-threshold methadone programs. *European Addiction Research, 12*(2), 74–82.
- 71 De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). Quality of life among opiate-dependent individuals: A review of the literature. *International Journal on Drug Policy, 21*(5), 364–380.
- 72 Muller, A. E., Skurtveit, S., & Clausen, T. (2016). Many correlates of poor quality of life among substance users entering treatment are not addiction-specific. *Health and Quality of Life Outcomes, 14*, 1–10.
- 73 Cavaiola, A. A., Fulmer, B. A., & Stout, D. (2015). The impact of social support and attachment style on quality of life and readiness to change in a sample of individuals receiving medication-assisted treatment for opioid dependence. *Substance Abuse, 36*(2), 183–191.
- 74 Millson, P., Challacombe, L., Villeneuve, P. J., Strike, C. J., Fischer, B., Myers, T., ... Hopkins, S. (2006). Determinants of health-related quality of life of opiate users at entry to low-threshold methadone programs. *European Addiction Research, 12*(2), 74–82.
- 75 Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference report*. HHS Publication No. (SMA) 07–4276. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 76 Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's working definition of recovery. Retrieved November 24, 2017, from <https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf>
- 77 Jackson, L. A., Buxton, J. A., Dingwell, J., Dykeman, M., Gahagan, J., Gallant, K., ... Davison, C. (2014). Improving psychosocial health and employment outcomes for individuals receiving methadone treatment: A realist synthesis of what makes interventions work. *BMC Psychology, 2*, 1–20.
- 78 Kaplan, L. (2008). *The role of recovery support services in recovery-oriented systems of care*. HHS Publication No. (SMA) 08-4315. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 79 White, W. L., & Mojer-Torres, L. (2010). *Recovery-oriented methadone maintenance*. Retrieved October 23, 2017, from www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph_RM_Methadone.pdf
- 80 Hser, Y. I. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51–60.
- 81 Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use and Misuse, 43*(1), 27–54.
- 82 Skinner, M. L., Haggerty, K. P., Fleming, C. B., Catalano, R. F., & Gainey, R. R. (2011). Opiate-addicted parents in methadone treatment: Long-term recovery, health, and family relationships. *Journal of Addictive Diseases, 30*(1), 17–26.
- 83 Substance Abuse and Mental Health Services Administration. (2016). Person- and family-centered care and peer support. Retrieved October 23, 2017, from <https://www.samhsa.gov/section-223/care-coordination/person-family-centered>
- 84 Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners, 20*(12), 600–607.
- 85 Substance Abuse and Mental Health Services Administration. (planned). *Relapse prevention and recovery promotion in behavioral health services*. Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 86 White, W., & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor, 8*(4), 12–30.
- 87 Lindgren, B. M., Eklund, M., Melin, Y., & Graneheim, U. H. (2015). From resistance to existence—Experiences of medication-assisted treatment as disclosed by people with opioid dependence. *Issues in Mental Health Nursing, 36*(12), 963–970.
- 88 Stoller, K. B., Stephens, M. A. C., & Schorr, A. (2016). Integrated service delivery models for opioid treatment programs in an era of increasing opioid addiction, health reform, and parity. Retrieved October 23, 2017, from www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper-.pdf
- 89 Brooner, R. K., King, V. L., Kidorf, M., Schmidt, C. W., Jr., & Bigelow, G. E. (1997). Psychiatric and substance use comorbidity among treatment-seeking opioid abusers. *Archives of General Psychiatry, 54*(1), 71–80.
- 90 Savant, J. D., Barry, D. T., Cutter, C. J., Joy, M. T., Dinh, A., Schottenfeld, R. S., & Fiellin, D. A. (2013). Prevalence of mood and substance use disorders among patients seeking primary care office-based buprenorphine/naloxone treatment. *Drug and Alcohol Dependence, 127*(1–3), 243–247.
- 91 Brooner, R. K., Kidorf, M. S., King, V. L., Peirce, J., Neufeld, K., Stoller, K., & Kolodner, K. (2013). Managing psychiatric comorbidity within versus outside of methadone treatment settings: A randomized and controlled evaluation. *Addiction, 108*(11), 1942–1951.
- 92 Hser, Y. I., Evans, E., Grella, C., Ling, W., & Anglin, D. (2015). Long-term course of opioid addiction. *Harvard Review of Psychiatry, 23*(2), 76–89.



- 93 Flynn, P. M., Joe, G. W., Broome, K. M., Simpson, D. D., & Brown, B. S. (2003). Recovery from opioid addiction in DATOS. *Journal of Substance Abuse Treatment, 25*(3), 177–186.
- 94 Havassy, B. E., Hall, S. M., & Wasserman, D. A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. *Addictive Behaviors, 16*(5), 235–246.
- 95 Tuten, M., & Jones, H. E. (2003). A partner's drug-using status impacts women's drug treatment outcome. *Drug and Alcohol Dependence, 70*(3), 327–330.
- 96 Schroeder, J. R., Latkin, C. A., Hoover, D. R., Curry, A. D., Knowlton, A. R., & Celentano, D. D. (2001). Illicit drug use in one's social network and in one's neighborhood predicts individual heroin and cocaine use. *Annals of Epidemiology, 11*(6), 389–394.
- 97 Trocchio, S., Chassler, D., Storbjörk, J., Delucchi, K., Witbrodt, J., & Lundgren, L. (2013). The association between self-reported mental health status and alcohol and drug abstinence 5 years post-assessment for an addiction disorder in U.S. and Swedish samples. *Journal of Addictive Diseases, 32*(2), 180–193.
- 98 Kidorf, M., Latkin, C., & Brooner, R. K. (2016). Presence of drug-free family and friends in the personal social networks of people receiving treatment for opioid use disorder. *Journal of Substance Abuse Treatment, 70*, 87–92.
- 99 Kidorf, M., Latkin, C., & Brooner, R. K. (2016). Presence of drug-free family and friends in the personal social networks of people receiving treatment for opioid use disorder. *Journal of Substance Abuse Treatment, 70*, 87–92.
- 100 Substance Abuse and Mental Health Services Administration. (2014). *Improving cultural competence. Treatment Improvement Protocol (TIP) Series 59.* HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 101 Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 102 Kumar, N., Stowe, Z. N., Han, X., & Mancino, M. J. (2016). Impact of early childhood trauma on retention and phase advancement in an outpatient buprenorphine treatment program. *American Journal on Addictions, 25*(7), 542–548.
- 103 Barry, D. T., Beitel, M., Cutter, C. J., Garnet, B., Joshi, D., Rosenblum, A., & Schottenfeld, R. S. (2011). Exploring relations among traumatic, posttraumatic, and physical pain experiences in methadone-maintained patients. *Journal of Pain, 12*(1), 22–28.
- 104 Sansone, R. A., Whitecar, P., & Wiederman, M. W. (2009). The prevalence of childhood trauma among those seeking buprenorphine treatment. *Journal of Addictive Disorders, 28*(1), 64–67.
- 105 Lawson, K. M., Back, S. E., Hartwell, K. J., Moran-Santa, M. M., & Brady, K. T. (2013). A comparison of trauma profiles among individuals with prescription opioid, nicotine, or cocaine dependence. *American Journal of Addiction, 22*(2), 127–131.
- 106 Jessell, L., Mateu-Gelabert, P., Guarino, H., Vakharia, S. P., Syckes, C., Goodbody, E., ... Friedman, S. (2017). Sexual violence in the context of drug use among young adult opioid users in New York City. *Journal of Interpersonal Violence, 32*(19), 2885–2907.
- 107 Amaro, H., Dai, J., Arévalo, S., Acevedo, A., Matsumoto, A., Nieves, R., & Prado, G. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health, 84*(4), 508–522.
- 108 Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine, 374*(4), 363–371.
- 109 Edelman, E. J., Chantarat, T., Caffrey, S., Chaudhry, A., O'Connor, P. G., Weiss, L., ... Fiellin, L. E. (2014). The impact of buprenorphine/naloxone treatment on HIV risk behaviors among HIV-infected, opioid-dependent patients. *Drug and Alcohol Dependence, 139*, 79–85.
- 110 Gibson, A., Degenhardt, L., Mattick, R. P., Ali, R., White, J., & O'Brien, S. (2008). Exposure to opioid maintenance treatment reduces long-term mortality. *Addiction, 103*(3), 462–468.
- 111 Rosenthal, R. N., Ling, W., Casadonte, P., Vocci, F., Bailey, G. L., Kampman, K., ... Beebe, K. L. (2013). Buprenorphine implants for treatment of opioid dependence: Randomized comparison to placebo and sublingual buprenorphine/naloxone. *Addiction, 108*(12), 2141–2149.
- 112 Sullivan, L. E., Moore, B. A., Chawarski, M. C., Pantaloni, M. V., Barry, D., O'Connor, P. G., ... Fiellin, D. A. (2008). Buprenorphine/naloxone treatment in primary care is associated with decreased human immunodeficiency virus risk behaviors. *Journal of Substance Abuse Treatment, 35*(1), 87–92.
- 113 Substance Abuse and Mental Health Services Administration. (2016). Buprenorphine. Retrieved October 23, 2017, from www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
- 114 Lovegrove, M. C., Mathew, J., Hampp, C., Governale, L., Wysowski, D. K., & Budnitz, D. S. (2014). Emergency hospitalizations for unsupervised prescription medication ingestions by young children. *Pediatrics, 134*(4), e1009–e1016.



- 115 Hakkinen, M., Launiainen, T., Vuori, E., & Ojanpera, I. (2012). Benzodiazepines and alcohol are associated with cases of fatal buprenorphine poisoning. *European Journal of Clinical Pharmacology*, 68(3), 301–309.
- 116 Schuman-Olivier, Z., Hoepfner, B. B., Weiss, R. D., Borodovsky, J., Shaffer, H. J., & Albanese, M. J. (2013). Benzodiazepine use during buprenorphine treatment for opioid dependence: Clinical and safety outcomes. *Drug and Alcohol Dependence*, 132(3), 580–586.
- 117 Fullerton, C. A., Kim, M., Thomas, C. P., Lyman, D. R., Montejano, L. B., Dougherty, R. H., ... Delphin-Rittmon, M. E. (2014). Medication-assisted treatment with methadone: Assessing the evidence. *Psychiatric Services*, 65(2), 146–157.
- 118 Gibson, A., Degenhardt, L., Mattick, R. P., Ali, R., White, J., & O'Brien, S. (2008). Exposure to opioid maintenance treatment reduces long-term mortality. *Addiction*, 103(3), 462–468.
- 119 Gowing, L. R., Farrell, M., Bornemann, R., Sullivan, L. E., & Ali, R. L. (2006). Brief report: Methadone treatment of injecting opioid users for prevention of HIV infection. *Journal of General Internal Medicine*, 21(2), 193–195.
- 120 Lee, J. D., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, R. A., Jr., ... O'Brien, C. P. (2016). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374(13), 1232–1242.
- 121 Merlo, L. J., Greene, W. M., & Pomm, R. (2011). Mandatory naltrexone treatment prevents relapse among opiate-dependent anesthesiologists returning to practice. *Journal of Addiction Medicine*, 5(4), 279–283.
- 122 Washton, A. M., Gold, M. S., & Pottash, A. C. (1984). Successful use of naltrexone in addicted physicians and business executives. *Advances in Alcohol and Substance Abuse*, 4(2), 89–96.
- 123 Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews*, 2011(4), 1–45.
- 124 Cornish, J. W., Metzger, D., Woody, G. E., Wilson, D., McLellan, A. T., Vandergrift, B., & O'Brien, C. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment*, 14(6), 529–534.
- 125 Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews*, 2011(4), 1–45.
- 126 Merlo, L. J., Greene, W. M., & Pomm, R. (2011). Mandatory naltrexone treatment prevents relapse among opiate-dependent anesthesiologists returning to practice. *Journal of Addiction Medicine*, 5(4), 279–283.
- 127 Substance Abuse and Mental Health Services Administration. (2016). *Medication-assisted treatment of opioid use disorder pocket guide*. HHS No. (SMA) 16-4892PG. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 128 Faggiano, F., Vigna-Taglianti, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews*, 2003(3), 1–45.
- 129 Fareed, A., Casarella, J., Amar, R., Vayalapalli, S., & Drexler, K. (2010). Methadone maintenance dosing guideline for opioid dependence, a literature review. *Journal of Addictive Diseases*, 29(1), 1–14.
- 130 Substance Abuse and Mental Health Services Administration. (2015). *Clinical use of extended-release injectable naltrexone in the treatment of opioid use disorder: A brief guide*. HHS Publication No. (SMA) 14-4892R. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 131 National Library of Medicine. (2015). VIVITROL – naltrexone. Retrieved October 23, 2017, from <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd11c435-b0f0-4bb9-ae78-60f101f3703f>
- 132 Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine*, 174(12), 1947–1954.
- 133 Kakko, J., Svanborg, K. D., Kreek, M. J., & Heilig, M. (2003, February 22). 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: A randomised, placebo-controlled trial. *Lancet*, 361(9358), 662–668.
- 134 Sees, K. L., Delucchi, K. L., Masson, C., Rosen, A., Clark, H. W., Robillard, H., ... Hall, S. M. (2000). Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *JAMA*, 283(10), 1303–1310.
- 135 Weiss, R. D., Potter, J. S., Fiellin, D. A., Byrne, M., Connery, H. S., Dickinson, W., ... Ling, W. (2011). Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: A 2-phase randomized controlled trial. *Archives of General Psychiatry*, 68(12), 1238–1246.
- 136 Confidentiality of Substance Use Disorder Patient Records. ; HHS Final Rule, 82 Fed. Reg. 6052 (January 18, 2017) (to be codified at 42 CFR pt. 2). Retrieved November 13, 2017, from <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>



- 137 Jost, T. S. (2006). Appendix B: Constraints on sharing mental health and substance-use treatment information imposed by federal and state medical records privacy laws. In Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, *Improving the quality of healthcare for mental and substance-use conditions*. Quality Chasm Series. Washington, DC: National Academies Press. Retrieved January 3, 2018, from <https://www.ncbi.nlm.nih.gov/books/NBK19829>
- 138 Coviello, D. M., Zanis, D. A., Wesnoski, S. A., & Alterman, A. I. (2006). The effectiveness of outreach case management in re-enrolling discharged methadone patients. *Drug and Alcohol Dependence*, 85(1), 56–65.
- 139 Goldstein, M. F., Deren, S., Kang, S. Y., Des Jarlais, D. C., & Magura, S. (2002). Evaluation of an alternative program for MMTP drop-outs: Impact on treatment re-entry. *Drug and Alcohol Dependence*, 66(2), 181–187.
- 140 Duncan, B. (2010). On becoming a better therapist. *Psychotherapy in Australia*, 16(4), 42–51.
- 141 Wampold, B. E. (2011). Qualities and actions of effective therapists. Retrieved October 23, 2017, from www.apa.org/education/ce/effective-therapists.pdf
- 142 American Medical Association. (2017). End the epidemic. Retrieved October 23, 2017, from <https://www.end-opioid-epidemic.org/types/ama>
- 143 Kampman, K., & Jarvis, M. (2015). American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use. *Journal of Addiction Medicine*, 9(5), 358–367.
- 144 National Institute on Drug Abuse. (n.d.). Effective treatments for opioid addiction. Retrieved October 23, 2017, from <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>
- 145 Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: Department of Health and Human Services.
- 146 Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 147 Carter, A., & Hall, W. (2007). The ethical use of psychosocially assisted pharmacological treatments for opioid dependence. Retrieved October 23, 2017, from www.who.int/substance_abuse/activities/ethical_use_opioid_treatment.pdf
- 148 Equal Employment Opportunity Commission. (1992). *A technical assistance manual on the employment provisions (Title I) of the Americans with Disabilities Act*. Washington, DC: Author.
- 149 Friedmann, P. D., Hoskinson, R., Gordon, M., Schwartz, R., Kinlock, T., Knight, K., ... Frisman, L. K. (2012). Medication-assisted treatment in criminal justice agencies affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, barriers & intentions. *Substance Abuse*, 33(1), 9–18.
- 150 Legal Action Center. (2011). *Legality of denying access to medication assisted treatment in the criminal justice system*. Retrieved October 23, 2017, from www.lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf
- 151 World Health Organization. (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva, Switzerland: WHO Press.
- 152 Soyka, M., Träder, A., Klotsche, J., Haberthür, A., Bühringer, G., Rehm, J., & Wittchen, H. U. (2012). Criminal behavior in opioid-dependent patients before and during maintenance therapy: 6-year follow-up of a nationally representative cohort sample. *Journal of Forensic Sciences*, 57(6), 1524–1530.
- 153 Substance Abuse and Mental Health Services Administration. (2016). *A collaborative approach to the treatment of pregnant women with opioid use disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 154 Donovan, D. M., Ingalsbe, M. H., Benbow, J., & Daley, D. C. (2013). 12-step interventions and mutual support programs for substance use disorders: An overview. *Social Work in Public Health*, 28(3–4), 313–332.
- 155 Humphreys, K., Blodgett, J. C., & Wagner, T. H. (2014). Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. *Alcoholism: Clinical and Experimental Research*, 38(11), 2688–2694.
- 156 McCrady, B. S., & Tonigan, S. (2014). Recent research into twelve-step programs. In R. K. Ries, D. A. Fiellin, S. C. Miller, & R. Saitz (Eds.), *The ASAM principles of addiction medicine* (pp. 1043–1059). Philadelphia, PA: Wolters Kluwer.
- 157 Crape, B. L., Latkin, C. A., Laris, A. S., & Knowlton, A. R. (2002). The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence*, 65(3), 291–301.
- 158 Monico, L. B., Gryczynski, J., Mitchell, S. G., Schwartz, R. P., O'Grady, K. E., & Jaffe, J. H. (2015). Buprenorphine treatment and 12-step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, 57, 89–95.



- 159 Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction, 103*(1), 119–125.
- 160 Parran, T. V., Adelman, C. A., Merkin, B., Pagano, M. E., Defranco, R., Ionescu, R. A., & Mace, A. G. (2010). Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy. *Drug and Alcohol Dependence, 106*(1), 56–60.
- 161 Narcotics Anonymous World Services. (2016). *Narcotics Anonymous and persons receiving medication-assisted treatment*. Chatsworth, CA: Author.
- 162 Monico, L. B., Gryczynski, J., Mitchell, S. G., Schwartz, R. P., O’Grady, K. E., & Jaffe, J. H. (2015). Buprenorphine treatment and 12-step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment, 57*, 89–95.
- 163 White, W., Galanter, M., Humphreys, K., & Kelly, J. (2016). The paucity of attention to Narcotics Anonymous in current public, professional, and policy responses to rising opioid addiction. *Alcoholism Treatment Quarterly, 34*(4), 437–462.
- 164 Kelly, J. F., Greene, M. C., & Bergman, B. G. (2014). Do drug-dependent patients attending Alcoholics Anonymous rather than Narcotics Anonymous do as well? A prospective, lagged, matching analysis. *Alcohol and Alcoholism, 49*(6), 645–653.
- 165 Substance Abuse and Mental Health Services Administration. (2015). *Using technology-based therapeutic tools in behavioral health services*. Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 166 White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction in the United States*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual Disability Services.
- 167 White, W., Galanter, M., Humphreys, K., & Kelly, J. (2016). The paucity of attention to Narcotics Anonymous in current public, professional, and policy responses to rising opioid addiction. *Alcoholism Treatment Quarterly, 34*(4), 437–462.
- 168 Ginter, W. (2012). Methadone Anonymous and mutual support for medication-assisted recovery. *Journal of Groups in Addiction and Recovery, 7*(2–4), 189–201.
- 169 Ronel, N., Gueta, K., Abramssohn, Y., Caspi, N., & Adelson, M. (2011). Can a 12-step program work in methadone maintenance treatment? *International Journal of Offender Therapy and Comparative Criminology, 55*(7), 1135–1153.
- 170 Glickman, L., Galanter, M., Dermatis, H., Dingle, S., & Hall, L. (2004). Pathways to recovery: Adapting 12-step recovery to methadone treatment. *Journal of Maintenance in the Addictions, 2*(4), 77–90.
- 171 Palis, H., Marchand, K., Peng, D., Fikowski, J., Harrison, S., Spittal, P., ... Oviedo-Joekes, E. (2016). Factors associated with perceived abuse in the health care system among long-term opioid users: A cross-sectional study. *Substance Use and Misuse, 51*(6), 763–776.

This page intentionally left blank.



This TIP has been divided into an executive summary and five parts so that you can quickly find what you want to know about medications for opioid use disorder (OUD).

ALL READERS (including healthcare and addiction professionals, policymakers, patients, and families)

- **Executive Summary:** Overview of OUD medications and other recovery supports
- **Full TIP:** Executive Summary, Parts 1–5 available as a single document
- **Part 1:** Introduction to the use and characteristics of OUD medications
- **Part 5:** Resources and key terms relating to OUD and OUD medications

HEALTHCARE PROFESSIONALS

- **Part 2:** Guidance on addressing OUD in general medical settings
- **Part 3:** Detailed guidance on OUD pharmacotherapy
- **Part 4:** Information on working with addiction professionals

ADDICTION PROFESSIONALS

- **Part 4:** Guidance on working with clients who take or may be candidates for OUD medication

SAMHSA Store Ordering Information

Order or download TIP 63 products from the SAMHSA Store at <https://store.samhsa.gov> or order by phone from 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).