

Counseling Buprenorphine Patients

Information and Treatment Approaches for Counselors

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Buprenorphine

- **Overview and background**
- **Some general issues in treating buprenorphine patients**
- **Treatment approaches**

Background: Medication treatments for opioid dependence

- **1960's – present**
 - Methadone
 - Only in Narcotic Treatment Programs
- **1984 - Naltrexone**
 - Detoxified patients only
 - Poor compliance
- **1993 – LAAM**
 - Only in NTPs
 - Few patients; Black Box Warning

Medication Treatments

- **Substitution treatment (methadone, buprenorphine)**
- **Detoxification**
- **Antagonist treatment (naltrexone)**

Buprenorphine: 2002

- **Drug Addiction and Treatment Act (DATA, 2000)**
 - Allows qualified MDs to prescribe approved narcotic medications for for opioid dependence
- **Subutex and Suboxone, FDA approved in 2002**

Why Buprenorphine Treatment?

- **Office-based**
- **Methadone stigma**
- **Convenience vs daily visits**
- **Safety**

Buprenorphine Patients

- Rx opioid users
- Middle class users
- Patients who will not enter methadone treatment

Opioids

- **Relieve pain**
- **Produce and alleviate morphine-like withdrawal**
- **Morphine, heroin, methadone, codeine, hydrocodone (Vicodin), oxycodone (Percodan), Darvon, Demerol**

Opioid Dependence

- **Repeated use results in tolerance (more is required for desired effect)**
 - and,
- **Withdrawal upon cessation of use**
 - Chills, gooseflesh, sweating, yawning
 - Runny nose, tearing eyes, dilated pupils,
 - Nausea, diarrhea,
 - Insomnia, anxiety, craving

Buprenorphine: What is it?

- **Full Agonists**
 - Bind to and activate the opioid receptors
- **Antagonists**
 - Bind to and block receptors from activation
- **Partial Agonists (Buprenorphine)**
 - Same as full agonist at low dose
 - Higher doses reach a ceiling

Buprenorphine Safety

- **Sublingual administration**
 - Swallowed pills have little effect
- **Buprenorphine/naloxone tablet (Suboxone)**
 - Sublingual naloxone has no effect
 - Dissolved and injected tablet precipitates withdrawal
- **Ceiling effect**

Buprenorphine: Who can prescribe?

- **Qualified Physicians**
 - Board certified in addiction psychiatry
 - Certified in addiction medicine by ASAM, or AOA
 - Investigator in buprenorphine clinical trials

Buprenorphine: Who can prescribe?

- **Qualified Physicians**

- Completed 8 hours training (ASAM, AAAP, AMA, AOA, APA)
- Training/experience determined by state medical licensing board
- Other criteria established by Secretary, DHHS

Practitioner Requirements

- 1. Be a “qualifying physician”**
- 2. Be able to refer patients for appropriate counseling**
- 3. Treat no more than 30 patients at any time**

Range of Counselor Experience

- **Broad experience with SA dependence treatment, including opioid dependence**
- **SA treatment experience, but not with opioid dependence**

Range of Counselor Experience

- **Counselors with no SA treatment experience**
- **In SA treatment programs, or in private practice**

Counseling Buprenorphine Patients: Some General Issues

1. Recovery and pharmacotherapy
2. Patient orientation towards recovery
3. 12-Step meetings
4. Patient management
5. A Cog/Behavioral approach

Recovery and Pharmacotherapy

- **Patients may have ambivalence regarding medication**
- **The recovery community may ostracize patients taking medication**
- **Counselors need to have accurate information**

Recovery and Pharmacotherapy

- Focus on “getting off”
buprenorphine may convey taking medication is “bad”
- Suggesting recovery requires cessation of medication is wrong
- Support patient’s medication-taking
- “Medication,” not “drug”

Recovery and Pharmacotherapy: Facts and Myths

- “Just substituting one drug for another”
- “Patients are still addicted”
- But,
 - Medications are legal
 - Oral vs injected
 - Taken under medical supervision
 - Inexpensive (\$8/day vs \$60/day)

Recovery and Pharmacotherapy: Facts and Myths

- **“Patients are getting high”**
- **But,**
 - Long acting, slow onset
 - Matches level of addiction

Patient orientation towards recovery

- Often a narrow focus; physical relief is sufficient
- Focus on not using illicit opiates vs. new behaviors
- Counseling may be viewed as an unnecessary imposition

Patient orientation towards recovery

- **Patient orientation, counselor response**
 - Impatience, confrontation, “you’re not ready for treatment”
or,
 - Deal with patients at their stage of acceptance and readiness

Patient orientation towards recovery

- **Patient orientation, counselor response**
 - Be flexible
 - Don't impose high expectations
 - Don't confront
 - Non-judgmental acceptance
 - A motivational interviewing approach

12-Step Meetings

- **What is the 12-Step Program?**
- **Benefits**
- **Meetings: speaker, discussion, Step study, Big Book readings**
- **Self-help vs treatment**

12-Step Meetings

- **Medication and the 12-Step program**
 - **Program policy**
 - “The AA Member: Medications and Other Drugs”
 - NA: “The ultimate responsibility for making medical decisions rests with each individual”
- **Some meetings are more accepting of medications than others**

Patient Management

- **“Manipulation,” and boundaries**
- **Safety and security**
- **Intoxication**
- **Loitering**
- **Drug Dealing**

Patient Management

- **“Manipulation”**
 - A vestige of the drug-using lifestyle
 - An old survival skill
 - An unlikable quality in the world
 - A manifestation of the disorder in treatment

Patient Management

- **“Manipulation”**
 - **Counselor’s responses**
 - **Protective cynicism**
 - **Trust and openness**

Patient Management

- **Pushing Boundaries**
 - Inappropriate familiarity
 - Reflexive manipulation
 - May result from past counseling experiences

Patient Management

- **Theft**
 - **A vestigial survival skill**
 - **Reflexive theft a possibility**
 - **A topic for relapse prevention
(a “using behavior”)**

Patient Management

- **Intoxication**
 - **Manage the situation, don't counsel**
 - **Ensure patient safety**
 - **Arrange transportation**

Patient Management

- **Loitering**
 - **May have been acceptable in prior treatments**
 - **Creates opportunities for dealing**
 - **Not the best use of time**
 - **Not well tolerated by neighbors**
 - **May reflect problems at home**

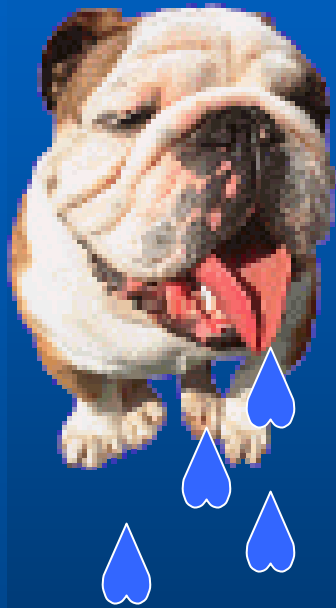
Patient Management

- **Drug dealing**
 - **Undermines office-based buprenorphine treatment**
 - **Must inform MD**
 - **Address with patient and remind of possible consequences**

Counseling Buprenorphine Patients

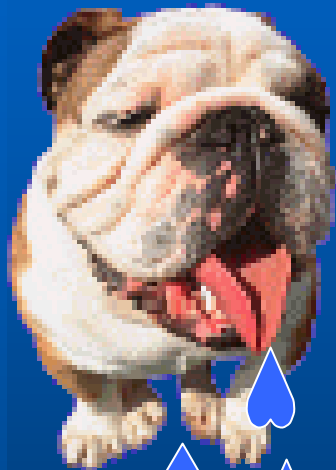
- **Early Recovery Information and Skills**
 - **Conditioning Process**
 - **Craving**

Early Recovery Information: Conditioning



Pavlov's Dog

Early Recovery Information: Conditioning



Pavlov's Dog

Counseling Buprenorphine Patients

- **Early Recovery Skills**
 - Getting Rid of Paraphernalia
 - Scheduling
 - Thought-Stopping
 - Trigger Charts

Counseling Buprenorphine Patients

- **Relapse Prevention**
 - Patients need to develop new behaviors
 - Learn to monitor signs of vulnerability to relapse
 - Recovery is more than not using illicit opioids
 - Recovery is more than not using drugs and alcohol

Counseling Buprenorphine Patients

- **Relapse Prevention Topics**
 - **Relapse Prevention Overview**
 - Overview of the concept
 - **Using Behavior**
 - Old behaviors need to change
 - Re-emergence signals relapse risk
 - **Relapse Justification**
 - “Stinking thinking”
 - Recognize and stop

Buprenorphine in the Treatment of Opioid Addiction: A Counselor's Guide

- **McCann, Obert, and Ling (2003)**
- **Developed by CEATTC and PSATTC**
- **Funded by CSAT/SAMHSA**
- **7 course modules; 3 hours**
- **www.danyalearningcenter.org**
- **<http://www.ceattc.org/>**

SAMHSA Buprenorphine Site

- www.buprenorphine.samhsa.gov
- Physician locator