The Opioid Crisis: Identifying My Role as a Community Provider

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Registered 500-Hour Yoga Teacher

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Disclosures

- Member of MedComp Sciences speakers bureau providing presentations on the science and clinical applications of pharmacogenetics.

- Off-label use of medications will be discussed.
How do individuals find their way to STI?

- Internet - By far the most frequent source.
  - STI website
  - www.suboxone.com
  - www.vivitrol.com

- Referral from inpatient rehab and detox facilities.

- Referral from present and former patients and family members.
  - Always very gratifying.

- Court mandated – Rarely.
  - Although many of our patients are having or have had adventures with the legal system.
Establishment of diagnosis and severity:

- **DSM5 Criteria for Substance Use Disorders**
  1. Taking the substance in larger amounts or for longer than you're meant to.
  2. Wanting to cut down or stop using the substance but not managing to.
  3. Spending a lot of time getting, using, or recovering from use of the substance.
  4. Cravings and urges to use the substance.
  5. Not managing to do what you should at work, home, or school because of substance use.
  6. Continuing to use, even when it causes problems in relationships.
  7. Giving up important social, occupational, or recreational activities because of substance use.
  8. Using substances again and again, even when it puts you in danger.
  9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
 10. Needing more of the substance to get the effect you want (tolerance).
 11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

- **Severity of Substance Use Disorders**
  - Mild: 2 or 3 symptoms
  - Moderate: 4 or 5 symptoms
  - Severe: 6 or more symptoms

- **DSM4 Criteria used the terms “use, abuse, dependence.”**
  - Today’s nomenclature views substance use disorder as a spectrum of behaviors and severity.
Determine most appropriate level of care

<table>
<thead>
<tr>
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| Level 0.5 | Early intervention  
Assessment and education                                                   |
| Level 1 | Outpatient services  
Adult: <9 hours of service per week  
Adolescent: <6 hours of service per week                                    |
| Level 2 | Intensive outpatient (IOP)/partial hospitalization services (PHP)  
Adult: >9 hours of service per week  
Adolescent: >6 hours of service per week  
PHP: 20 or more hours of service per week                                   |
| Level 3 | Residential Inpatient services  
24-hour structure with trained counselors                                   |
| Level 4 | Medically managed intensive inpatient services  
24-hour nursing care and daily physician care, counseling available         |


Need for detox: Can most often be done as an outpatient but will occasionally require inpatient management.
Determine most appropriate level of care

### Table 4. ASAM Patient Placement Criteria Levels of Service

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Treatment Plan at STI

- Counseling (individual and/or group therapy) – a requirement.
- Recommendations for medication assistance.
- Assessment for possible co-existing psych issues.
- Medical and nutritional assessment.
- Weekly visits with physician and counselor for 1st month or so (+/-), then every 2 weeks for a couple of sessions (+/-) and, if everything’s OK, visits may then be extended to monthly.
- Urine drug screens (UDS) weekly at first (+/-), then random (controversial).
- Medication counts in beginning.
- We check the Pharmacy Board CSPMP on every patient, every visit.
- Participation in education sessions – a requirement.
- Encouragement to participate in 12-step or other self-help mutual support group(s), e.g. AA, NA, SmartRecovery, Celebrate Recovery, AA Agnostica, Refuge Recovery, etc.
- Usual duration of treatment – at least 1 year.
Important Principles of Treatment at the Community Level (...anywhere actually)

- How do you handle a relapse or a dirty positive UDS?
  - Some clinics and practitioners will discharge patient after a single positive UDS.
  - Nonjudgmental attitude.
  - Can be a positive learning opportunity.
  - Might need to tighten program, e.g. increase frequency of visits.
  - Might need to consider referral to a higher level of care, e.g. IOP or residential inpatient treatment.

- Establishment of trust (necessary in *every* area of medicine).
  - Nonjudgmental attitude.
  - *It’s a two-way street!!*

- Be mindful of language and words.
  - Words means things.
  - Addict... Alcoholic... Dirty...

- Addressing *stigma and shame.*
The best way to decrease the *stigma* toward addiction in the public and in individuals with substance use disorder towards themselves is through education and increased awareness.
Addiction:
Is it really a Defect?
(as many people continue to believe)
Substance Abuse (and the stigma attached to it) is as old as Mankind

And Noah planted a vineyard. And he drank of the wine, and became drunken. And he was naked and dirty in his tent. And Ham saw the nakedness of his father, and told his two brothers. And Shem and Japheth took a garment...and covered the nakedness of their father; and they turned their faces away, so as to avert their eyes from their father’s nakedness and shame.

- Genesis 9:20-23
Moving Beyond the Moral Model

- Addiction is a result of human weakness.
- Addiction is a result of a defect of character.
- Addiction is a result of poor choices.
- Addicts have a lack of willpower or moral strength.
- Addiction is a moral failing.
- Addiction is associated with evil and sin.
Anti-Alcohol Prohibition Poster - 1887
Women’s Christian Temperance Union (1919 Photo)
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- Punishment is a more appropriate response to addiction than treatment.
- The medical profession is not immune to moral model attitudes.
The Biological Basis of Addiction

Traditionally, medical doctors have viewed substance abuse and addiction as problems rooted in psychology, not biology. Intentionally or unintentionally, this viewpoint increases the chances that a physician will regard a substance abuser or addict as a victim of nothing more than his or her poor decisions… This is worrisome because evidence shows it can reduce appropriate treatment.
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- The medical profession is not immune to moral model attitudes.
- Addicts and alcoholics are “defectives” and should be sterilized.
Eugenics supporters hold signs criticizing various "genetically inferior" groups. Wall Street, New York, c. 1915.
Sterilizing the Unfit

By Dr. John B. Shea, MD, FRCP(C)

“...David Marsland, a British professor of sociology at Brunel University, London, holds that after five years of treatment drug addicts, alcoholics, and people with psychological problems, should be permanently sterilized to prevent child neglect and abuse.”

Turning the Moral Model Back on Oneself

- “I’m weak.”
- “I have no willpower.”
- “I coulda/shoulda done something sooner.”
- “I’m a worthless piece of s***.”
- Guilt and shame – There’s a difference.
- Result: Relapse or ongoing suffering
- “I mustn’t let anyone know. I must keep things secret.”
DISEASE?
An Enquiry into the Effects of Spirituous Liquors upon the Human Body, and their Influence upon the Happiness of Society.

By Benjamin Rush, M.D.
Professor of Chemistry in the University of Philadelphia.

Philadelphia: Printed by Thomas Bradford, in Front Street, four doors from the Coffee House.

Title page to Rush's famous pamphlet. Courtesy of the Library of Congress.

1784
What is addiction?

**American Society of Addiction Medicine:**
Addiction is a primary, *chronic disease* of brain reward, motivation, memory and related circuitry.¹

**National Institute on Drug Abuse (NIDA):**
Addiction is a *chronic, relapsing brain disease* characterized by *compulsive* drug-seeking and use, despite harmful consequences and by long-lasting structural and functional changes in the brain.²

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¹ American Society of Addiction Medicine, Public Policy Statement: Definition of Addiction, April 12, 2011
### Similarities to Other Chronic Diseases

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Drug Dependence</th>
<th>Diabetes, Asthma, and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well studied</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Chronic disorder</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Predictable course</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Effective treatments</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Curable</td>
<td><strong>NO</strong></td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Heritable</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires continued care</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires adherence to treatment</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires ongoing monitoring</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Influenced by behavior</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Tends to worsen if untreated</td>
<td>✔</td>
<td>✔</td>
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</tbody>
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Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

The Intended Message

- Most addiction specialists have been trying to get the public to understand and accept the fact that addiction is not a moral failing or a character flaw.

- *That addiction is a chronic brain disease with characteristics similar to diabetes and hypertension and asthma.*

- That addiction is a legitimate medical disorder which should be compassionately addressed as a health problem rather than a criminal justice problem.¹

¹ Humphreys, K. How to Deliver a More Persuasive Message Regarding Addiction as a Medical Disorder. *J Addict Med.* May/June 2017; 11:3, 174-175
Enough of this ... Let’s talk about the elephant in the room ...
The Elephant in the Room

- People with diabetes don't rob stores or steal from family and friends to be able to pay for their insulin.

- AND...People with high blood pressure don’t kill other people with their cars because they’re “drunk” on Lisinopril.

- We know that people with an addiction often break the law and are often the perpetrators of violence. So the criminal justice system still has an obvious and important part to play.

- Even though addiction is a legitimate medical disorder, we need to acknowledge that there are lots of people who’ve been victimized and hurt by somebody with an addiction problem. We mustn’t invalidate the resulting pain that people have suffered.

- So...It makes sense that there would still be a lot of intense negative feelings and mistrust and fear and anger toward people with an addiction problem.
What Works and What Doesn’t?

- Even though the **criminal justice system** has an obvious and important part to play, we can’t jail our way out of this national crisis.

- There’s overwhelming evidence of what works best: *medication in conjunction with counseling*. It certainly doesn’t work in all cases, but it does decrease deaths and improve lives and can save huge amounts of money.
Treatment for Addiction Should Target the Whole Brain

**Prefrontal Cortex**
- Reasoning
- Decision Making
- Impulse Control
- Coping Skills
- “Will Power”

**Limbic System**
- Emotions
- Drives
- Compulsions
- Cravings

**Pharmacotherapy**
- Buprenorphine
- Methadone
- Vivitrol
- Naltrexone
- Vivitrol
- Acamprosate
- Disulfiram
- NRT
- Bupropion (Zyban)
- Chantix

**Brain Stem**
- Stress Sensitivity
- Fight or Flight
- Withdrawal

**Stress Management Techniques**
- Breathing Exercises
- Yoga
- Meditation
- Physical Exercise
- Etc.

**Psychosocial Counseling**
- Group Therapy
- 12-Step
- SmartRecovery
Chances of succeeding when trying to stop using just about any substance

- Try to stop on your own just “cold turkey” or just with detox:
  - Chances of long-term success: <5%

- Add medication assistance:
  - Chances of long-term success: ~25%

- Add counseling, including development of new coping skills, lifestyle, etc.:
  - Chances of long-term success: ~50%

- With a comprehensive program including medication, counseling, education and 12-Step or other mutual support group participation:
  - Chances of long-term success can approach: 90% ²


² Urschel, HC. Healing the Addicted Brain. “It’s A Disease!”. Chapter 1.
FDA-Approved Medications Used To Treat Opioid Addiction

**Methadone**
- **1949**: Shown to be effective for detoxing people from heroin. But there was a >90% relapse rate.
- **1972**: Approved by FDA for use in treating opiate addiction.
- May be dispensed only in licensed Opioid Treatment Programs (i.e. methadone clinics), rather than in private offices.
- Full opioid agonist.

**Buprenorphine (Suboxone, Subutex, Zubsolv, Bunavail)**
- **2002**: Sublingual Suboxone and Subutex approved by FDA for management of opioid dependence.
- **2017**: FDA approves once-a-month injectable buprenorphine.
- May be prescribed in the office setting by a “qualified provider.”
- Partial opioid agonist and partial antagonist.

**Naltrexone (Vivitrol)**
- **1984**: FDA approves use of oral naltrexone for treatment of opiate addiction.
- **1994**: FDA approves use of naltrexone for treatment of alcohol dependence.
- **2006**: FDA approves use of once-a-month injectable Vivitrol for treatment of alcohol dependence.
- **2010**: FDA approves Vivitrol for prevention of relapse to opioid dependence, following opioid detoxification.
- Full opioid antagonist.
Full vs. Partial Opioid Agonists

Definitions:

- **Antagonist**: Something (or someone) that *opposes* an action
  - When an opioid antagonist attaches to a receptor in the brain, it blocks or prevents any opioid from attaching to that receptor.
    - Examples: Naloxone (Narcan), Naltrexone (Vivitrol)

- **Agonist**: Something that *does* an action

- **Full opioid agonist**: When a full agonist attaches to a receptor, it allows the receptor to manifest *ALL* of its capabilities, e.g. pain control, constricted pupils, release of dopamine
  - Examples: Percocet, OxyContin, Vicodin, Heroin, Methadone

- **Partial opioid agonist**: When a partial agonist attaches to a receptor, it allows the receptor to manifest only *SOME* of its capabilities, e.g. pain control, constricted pupils, but *NO* release of dopamine.
  - Example: Buprenorphine
So...

We have this problem in our country today. There’s this chronic disease out there (i.e. substance abuse/addiction) which is at *epidemic* proportions. The evidence-based literature is very clear that medication assistance improves outcomes,

and yet...
“Why the Resistance to Addiction Meds?”

“Medical intervention can dramatically increase recovery success rates. But without an attitude adjustment in the rooms and most rehabs, new and better drugs will remain elusive.”

"We have this crime where thousands of addicts are going to abstinence-only-based treatment for opiates.”

By Sacha Z. Scoblic, October 3, 2012
Use of Medications in Treatment Facilities

- More than two-thirds of the clinics and treatment centers in this country still don’t offer medications to help treat addiction, despite research showing their effectiveness!!!

- Hazelden (the Minnesota Model folks) started using medications (buprenorphine and Vivitrol) in 2013.

- They offered the medications to 500 individuals with opioid dependence who participated in their intensive outpatient programs between 2013 and 2015.

- Prior to their use of medication, 25% of people in their IOP programs dropped out. After they started using medication, only 5% dropped out.
How long should treatment with buprenorphine be continued?

Duration of treatment with buprenorphine is controversial.

- Some physicians use it as a detox agent for ± 3-5 days.
  - **But there is a >90% relapse rate.**
- Some physicians use it for short-term treatment, i.e. ± 1-3 months.
  - **But there is a 70-80% relapse rate.**
  - Similar to the fact that there is a 70-80% relapse rate after completion of a 28-day inpatient rehab program.
Why such high relapse rates?

• Long-term substance abuse causes structural and functional changes in the brain, i.e. the brain is damaged.
• The brain is an organ that takes a long time to heal. Some people say 6-10 months. Some people say 9-12 months.
• There is a large amount of evidence showing that it usually takes a brain at least a year or longer to heal.
• Most authorities, therefore, recommend continuing treatment with buprenorphine for at least a year.
• This allows time for the damage to heal and time to learn new behaviors and new coping and life skills.
“Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Buprenorphine in Office-Based Treatment of Opioid Addiction”¹

- “Except in patients whose addictive disorders are of brief duration, the best outcomes occur with long-term medication maintenance with methadone or buprenorphine accompanied by appropriate psychosocial intervention.”
- “The optimum duration of maintenance is unclear, but may involve long-term or even lifetime medication use.”
- “This is similar to the treatment of other chronic diseases, such as hypertension, diabetes, or asthma.”
- “...the goal is not to “get off” the buprenorphine, but rather to achieve maximal function both at home and at work.”

Common Misconceptions about Suboxone (buprenorphine)

- It’s just trading one addiction for another.
- It’s just trading one narcotic for another.
- You’re now “hooked” on Suboxone.
- If you’re taking Suboxone, you’re still “dirty.”
- You’re not really “clean” until you stop taking Suboxone.
- It’s just a “crutch.”
- It’s no different from Methadone.
- Once you start taking Suboxone, you’ll never be able to get off.
- The doctor wants to keep you on Suboxone so he can keep making money off of you.
“Buprenorphine is a medication used to treat opioid addiction. This is like taking medication to control diabetes or heart disease. It is NOT the same as substituting one addictive drug for another. Used properly, the medication does NOT create a new addiction. It helps to manage your addiction so that the benefits of recovery can be maintained.”

Since buprenorphine blocks other opioids, what do I do for pain control if I break my leg or have to have elective surgery?
Acute pain: Illness or injury

- Carry a wallet card.
- There are several options for pain control:
  - Non-opioid pain medication (e.g. Toradol, ibuprofen)
  - Regional block (e.g. epidural, suprascapular)
  - Possible admission to hospital for pain control with potent opioids that can over-ride buprenorphine (e.g. IV fentanyl) with monitoring of respiratory status.
- Wait 1 to 2 days or so and the buprenorphine blockade will be reduced or gone. Can then use any analgesic necessary (e.g. Morphine, Percocet).
- Follow up with buprenorphine prescribing physician for possible further pain management and close monitoring.
- When opioid pain coverage is no longer needed, get back on buprenorphine under direction of physician.
Elective procedures:
Surgery, Dental, Tests, etc.

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**Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy**

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*From Boston University Medical Center, Boston, Massachusetts, and University of California, Los Angeles, School of Nursing, Los Angeles, California.*

**Abstract**

More patients with opioid addiction are receiving opioid agonist therapy (OAT) with methadone and buprenorphine. As a result, physicians will more frequently encounter patients receiving OAT who develop acutely painful conditions, requiring effective treatment strategies. Undertreatment of acute pain is suboptimal medical treatment, and patients receiving long-term OAT are at particular risk. This paper acknowledges the complex interplay among addictive disease, OAT, and acute pain management and describes 4 common misconceptions resulting in suboptimal treatment of acute pain. Clinical recommendations for providing analgesia for patients with acute pain who are receiving OAT are presented. Although challenging, acute pain in patients receiving this type of therapy can effectively be managed.
Elective procedures: Surgery, Dental, Tests, etc.

- Inform buprenorphine prescribing physician about procedure well ahead of time so plans can be made.
- No more than mild pain anticipated:
  - If opioids will not be needed during the procedure for sedation/anesthesia or for post-op pain management, continue buprenorphine as usual. Can supplement with a non-opioid pain medication such as ibuprofen if needed for mild pain.
- Mild to moderate pain of relatively short duration anticipated:
  - May be able to continue buprenorphine as usual and supplement with ibuprofen or a full opioid agonist such as morphine or hydrocodone or oxycodone if needed. This can provide pain relief without causing euphoria. Stop full agonist when no longer needed. Should not result in any withdrawal symptoms.¹

Elective procedures: Surgery, Dental, Tests, etc. (cont.)

- **Severe pain anticipated:**
  - If severe post-op pain is anticipated, stop buprenorphine 1-2 days before the procedure. The physician may provide you with opioid coverage (e.g. morphine or oxycodone) before surgery to prevent or lessen any possible withdrawal symptoms that might otherwise occur. Can now use a full agonist opioid such as morphine or hydrocodone or oxycodone for pain management.
  - As before, follow up with buprenorphine prescribing physician for possible further pain management and close monitoring.
  - When opioid pain coverage is no longer needed, get back on buprenorphine under direction of physician.

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Special Populations/Scenarios
Pregnancy and Opioid Dependence
WHO Guidelines for the identification and management of substance use and substance use disorders in pregnancy

Selected Recommendations

1. Pregnant women on opioids should be encouraged to use opioid maintenance treatment where available rather than attempting opioid detoxification.

2. Pregnant patients with opioid dependence should be advised to continue or commence opioid maintenance therapy with either methadone or buprenorphine.

3. Mothers with substance use disorders should be encouraged to breastfeed unless the risks clearly outweigh the benefits.

4. Breastfeeding women using alcohol or drugs should be advised and supported to cease alcohol or drug use; however, substance use is not necessarily a contraindication to breastfeeding.

5. Mothers who are stable on opioid maintenance treatment with either methadone or buprenorphine should be encouraged to breastfeed unless the risks clearly outweigh the benefits.
ACOG/ASAM Recommendations

- Referral to methadone treatment gold standard but consider buprenorphine treatment
- Tapering methadone or buprenorphine may lead to relapse
- Abrupt discontinuation may lead to preterm labor, fetal distress or fetal demise
- Patients who are stable should be compatible with breastfeeding
- Neonatal abstinence syndrome is expected and treatable
Use of Buprenorphine for the Management of Chronic Pain
Buprenorphine was originally developed in the UK in 1978 as an IV pain medication.

- It is still used for IV, IM and transdermal pain control in Europe.
- It is used by veterinarians in an oral form for the control of pain.
Buprenorphine was originally developed in the UK in 1978 as an IV pain medication.

- It is still used for IV, IM and transdermal pain control in Europe.
- It is used by veterinarians in an oral form for the control of pain.
- In lower doses, buprenorphine has very high potency for control of pain: 1 mg of buprenorphine is equal in potency to 15 to 40 mg of injected morphine.
- At the present time, sublingual buprenorphine is not approved by the FDA for the treatment of pain in the US.

However, buprenorphine is used quite extensively on an "off-label" basis for the management of chronic pain.
CHRONIC PAIN MANAGEMENT

Suboxone is an opioid and an effective pain medication. It has been used for this purpose for many years -- mostly used in its injectable form. Suboxone is now available in the United States as an oral medication. It is fifteen times more potent than injected morphine. The medication is different from other opioids so the client usually feels more "clear headed" when taking Suboxone. An evaluation for chronic pain management will be made by the Program's physicians to determine if Suboxone is the appropriate medication for treatment.
Closing Thoughts

• Regardless of the area of medicine in which you practice, odds are very high that you will at some point have interactions with individuals who have some kind of substance use disorder.

• You can choose to treat them as if they’re “less than” as, unfortunately, many of our colleagues continue to do.

• Or, if they’re already in active treatment/recovery, you can choose to be supportive and acknowledge their positive accomplishments. A simple “atta boy” or “atta girl” can go an awful long way and can provide benefits to all parties... to the patient... to the clinician... and to the patient/clinician relationship built on mutual trust and respect.

• If appropriate, you can reach out to their addiction treatment provider to coordinate their care and thus improve the overall quality of the care and service you’re able to deliver.

• If it appears that the individual is still actively engaged in his or her substance abuse, a “brief intervention” or SBIRT may certainly fall on the deaf ears of denial but it may possibly provide just enough motivation for that individual to seek treatment.
  • www.suboxone.com
  • www.vivitrol.com
If you’re thinking about getting help for your addiction problem but don’t know where to start

Or

If you just want to ask some questions and get more information about what might be available,

Check out these websites:

www.suboxone.com
www.vivotrol.com

Enter your zip code and all providers in that area will be listed. They can supply you with information about treatment programs, including medication assistance, counseling, finances, insurance, etc.