# Understanding The Disease of Addiction

## What is addiction?

Addiction is a long-lasting (chronic) disease of the brain. Addiction to substances such as drugs and alcohol may be called substance use disorder. It affects how your brain learns and works. Your genes and your environment can affect your risk for addiction. A family history of addiction also raises your risk. But anyone can have an addiction. Although breaking an addiction can be challenging, it can be done.

## How does addiction affect my brain?

Whether you start using drugs or alcohol is your choice. But once your brain is exposed to the addictive substance, your brain begins to change. These brain changes overpower your self-control. This happens because the substance overexcites the brain's reward center. The substance mimics the brain's own natural feel-good chemicals. The brain is rewired into believing that the substance is a good thing and that you need it to survive. Over time, you no longer find pleasure in other things you once enjoyed. The addiction is more powerful. Even after "detoxing" off a substance the brain changes remain, and it will be an ongoing journey to resist these substances.

## How do you treat the disease of addiction?

The only way to get over an addiction is to stop using the substance. There is hope in recovery from addiction. You can relearn how to find pleasure in other things again. But your brain will always be at risk for addiction. Addiction is very powerful. So, you often will need ongoing comprehensive medical and psychotherapy help and social support for long-term success.

Addiction is a chronic condition. It's common for people who are recovering from addiction to start using the substance again (called a relapse). This doesn't mean that treatment doesn't work. Just like other chronic health conditions, addiction requires ongoing treatment that changes as the person's needs change.

# An Overview of The Levels of Care and Treatment Tiers

Treatment is provided at various levels based on the medical and psychosocial needs of the patient. These levels include Outpatient, Intensive Outpatient, and Aftercare (Case Management). General program length is approximately 18-24 months. Provider visits and therapy frequency is individualized and at the discretion of the multidisciplinary treatment team.

## Tier 1: Intake, Evaluation, and Induction

In conjunction with the medical practitioners, assessments are performed to determine the level of treatment needs and appropriate for treatment. Case management will also begin to coordinate care with outside providers and key individuals in the patient's environment. Additionally, the treatment clinicians begin to place appropriate referrals to address overall physical, mental, and social health determinants.

- Intake Assessment
- Screening for Opioid use disorder (DSM Screening Tool)
- Case Management Evaluation – identify readiness and barriers to treatment.
- Motivational Interview – to determine motivation for beginning treatment.
- ASAM Assessment to determine most appropriate level of care.
- ASI – to determine the problem severity profile and address physical, mental, and social health determinants.

### Induction

Once a patient has been evaluated and determined to be appropriate for admission to the facility programs, medical induction is focused on optimal medication utilization to address withdrawal and ongoing maintenance treatment for identified substance use disorders. This is typically done over two (2) days with observed dosing as part of the MAT (Medication Assisted Treatment Program). The overall goal of Induction is beginning stabilization.

- Collect Urine Drug Screens (UDS)
- Conduct Clinical Opioid Withdrawal Scale (COWS) to determine level of withdrawal.

## Tier 2: Stabilization

During Tier 2, the treatment clinicians continue to work with the patient to achieve wellness and recovery by providing structure treatment services through individual counseling, group counseling, and case management. The intensity of these services depends on the severity and acuity of addiction in the patient. Often, patients will vacillate between levels of care until they complete the Tier.

The medical practitioners continue to manage and optimize medications until patients have greatly reduced the use of their drug of abuse, no longer has cravings, and is experiencing few to no side effects. Together, with the treatment clinicians, a recommendation will be made on the level of care, frequency of drug screens, and treatment planning to facilitate patient success towards established goals.

- The focus of this Tier is to increase patient stabilization, moving toward overall functional improvement.
- 14-day prescriptions
- Weekly peer support meeting attendance
- UDS every visit
- Every two weeks individual sessions

## Tier 3: Maintenance and Aftercare

During this Tier, we believe that continuing care is an essential part of the recover process. As part of this process, the patient will work together with Peer Support Services and the Case Manager bi-weekly.

The patient will attend the following:

- Individual counseling sessions 1 x monthly (45-60 minutes)
- Case Management 2 x monthly (30-minute sessions)
- UDS every 30 days during Individual therapy session
- Group therapy 1 x month
- 30-day prescriptions

If the patient relapses or needs increased support, return to Tier 2 or Tier 3 for additional care.

# FACTS ABOUT BUPRENORPHINE

## What is Buprenorphine?

Buprenorphine is a medication used to treat opioid addiction.

Buprenorphine is one of three medications commonly used to treat opioid addiction. The other two are methadone and naltrexone. Cost varies for the different medications. You may need to take this into account when considering your treatment options.

The person who takes buprenorphine feels normal, not high. However, the brain thinks it is receiving the problem opioid, so withdrawal symptoms stay away. Buprenorphine also reduces cravings. If cravings continue to be a problem, your doctor will adjust your medication or help you find other ways to reduce them.

## How is Buprenorphine Taken?

You take buprenorphine as a pill that dissolves under the tongue. You do NOT chew or swallow it. There are two forms.

**Suboxone**® contains buprenorphine plus another medication called naloxone. The **naloxone** is added to prevent abuse—it brings on withdrawal in people who abuse buprenorphine by injecting it. **Subutex**® contains only buprenorphine. This form is prescribed if you should not take naloxone for any reason, such as if you are allergic to it or are pregnant.

The proper dose of buprenorphine is important. The program physician should be aware of all medications that each patient is taking, as some medications affect buprenorphine metabolism and stabilization; the buprenorphine dose may need to be adjusted. Blood levels of buprenorphine can be measured if there is any question about the proper dose. The policy of the program is that patients have the right to know the amount of their dose.

## What side effects may occur with Buprenorphine?

- Body aches, headaches, and cold- or flu-like symptoms
- Dizziness
- Constipation
- Sweating
- Sleep problems, including tiredness
- Upset stomach or vomiting
- Mood swings
- Serious side effects

**Important Information About Benzodiazepines and Whether or Not Medication Assisted Treatment (MAT) is the Best Treatment for You**

(Counselor to Review with Patient)

Safety while enrolled in medication assisted treatment (MAT) is everyone's responsibility. This begins with clinic staff, but also extends to patients and their close relatives and friends. Taking methadone or Suboxone along with unauthorized drugs is severely hazardous. Serious problems can result from the intake of multiple drugs such as alcohol, sedatives, or tranquilizers (benzodiazepines), hypnotics, and/or other opioids in addition to methadone or
Suboxone. When used alone, many of these drugs are relatively moderate depressants; however, when combined with methadone their effects can be magnified and add up to become lethal. Therefore, the obligation to be safe rather than sorry when it comes to methadone is of prime importance.

## Policy on Benzodiazepines

It is the policy of the Department that patients receiving medication assisted treatment approved medications be screened for benzodiazepine use and evaluated for benzodiazepine dependence. When there is a concern regarding benzodiazepine use, the program physician will evaluate the patient and formulate a plan. Patients who ignore the plan and continue to abuse benzodiazepines will be discharged from the program.

## Patients with A History of Benzodiazepine Abuse

Patients with a history of benzodiazepine abuse/addiction and persons taking prescription benzodiazepines will be screened for benzodiazepines (including clonazepam) for the duration of their treatment. For all other patients, the counselor and program physician will determine the frequency of benzodiazepine screening.

## Interference with Cognitive and Motor Performance

Since benzodiazepines and other sedative drugs have the potential to impair judgment, thinking or motor skills, we caution you against engaging in hazardous occupations requiring mental alertness, such as operating machinery or driving a motor vehicle when/if taking any of these medications while on methadone or Suboxone treatment. Also, the concurrent use of alcohol or other CNS-depressant drugs during benzodiazepine therapy can further increase
sedation and cause coordination problems while on medication assisted treatment (MAT). It is your responsibility to inform one of the MAT program physicians if you are taking any sedative drugs.

## Prescription Benzodiazepines

The program physician will assess the person's ability to participate in program, take the medication as prescribed and the medication's appropriateness with methadone or Suboxone. Patients will be asked to sign a written consent for release of information for each of their treating and prescribing physicians. The absence of this release disallows

the clinic physician to be able to safely prescribe methadone or Suboxone. Therefore, in this situation, refusal to
sign a written consent would be grounds for discharge from medication assisted treatment.
Persons who are taking prescription benzodiazepines that have been approved by the program physician must bring in the original prescription and all refilled prescriptions to be recorded in the clinic record. Failure to take the medication as prescribed and/or failure to register prescriptions in a timely fashion will be grounds for loss of take-home privileges and may result in discharge from medication assisted treatment.

## Higher Level of Treatment Care

Persons who abuse benzodiazepines during or after a benzodiazepine taper will be referred to a higher intensity of treatment. Persons who decline the appropriate level of intensity of treatment for benzodiazepine abuse/dependence and continue to abuse benzodiazepines will be tapered off methadone or buprenorphine and discharged from treatment.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

# ACOG COMMITTEE OPINION

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*(Replaces Committee Opinion Number 524, May 2012)*

**Committee on Obstetric Practice**
**American Society of Addiction Medicine**

*The Society of Maternal–Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.*

# Opioid Use and Opioid Use Disorder in Pregnancy

**ABSTRACT:** Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. To combat the opioid epidemic, all health care providers need to take an active role. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, it is essential that screening be universal. Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care, opioid misuse, and untreated opioid use disorder. Multidisciplinary long-term follow-up should include medical, developmental, and social support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome by a pediatric care provider. Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

## Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.

# PREGNANCY:

## Methadone and Buprenorphine

**Some women are surprised to learn they got pregnant while using heroin, Oxycontin, Percocet or other pain medications that can be misused (known as opioid drugs). You, along with family and friends, may worry about your drug use and if it could affect your baby.**

**Some women may want to "detox" as a way to stop using heroin or pain medicines. Unfortunately, studies have shown that 8 out of 10 women return to drug use by a month after "detox." Therefore, most doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.**

### HOW SAFE IS IT TO TAKE METHADONE OR BUPRENORPHINE (SUBUTEX®) DURING PREGNANCY?

- In the right doses, both methadone and buprenorphine stop withdrawal, reduce craving, and block effects of other opioids.
- Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
- Based on many years of research studies, neither medicine has been associated with birth defects.
- Babies born to women who are addicted to heroin or prescription opioids can have temporary withdrawal or abstinence symptoms in the baby (Neonatal Abstinence Syndrome or NAS). These withdrawal symptoms (NAS) also can occur in babies whose mothers take methadone or buprenorphine
- Talk with your doctor about the benefits versus the risks of medication treatment along with the risks of not taking medication treatment.

### IS METHADONE OR BUPRENORPHINE A BETTER MEDICATION FOR ME IN PREGNANCY?

- A pregnant woman and her doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
- If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

### HOW CAN I GET STARTED ON METHADONE OR BUPRENORPHINE?

- Depending where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
- Methadone may only be given out by specialized clinics while buprenorphine may also be available from your primary care physician or obstetrician if they have received special training.
- Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

### WHAT IS THE BEST DOSE OF METHADONE OR BUPRENORPHINE DURING AND AFTER PREGNANCY?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

- The "right" dose will prevent withdrawal symptoms without making you too tired.
- The right dose depends on how your body processes the medications.
- In pregnancy, you process these medications more quickly, especially in the last several months and this affects what dose you need.
- The dose of methadone usually needs to increase with pregnancy – especially in the third trimester and you may need to take methadone more than once a day.
- There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.
- The dose does not seem to determine how much NAS a baby will have.
- After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause sedation. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. *For further information, please see brochure Childbirth, Breastfeeding and Infant Care; Methadone and Buprenorphine.*