

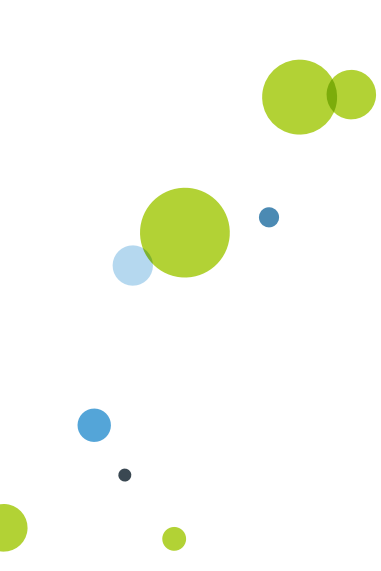
^N **SUBOXONE[®]:**

A Handbook for Patients

Chris A. Cavacuiti, MD



^N ***Suboxone[®]***
(buprenorphine and naloxone)



This handbook is dedicated to all the people we have met who are living with opioid dependence.

Your bravery and perseverance are the inspiration for this book.

ACKNOWLEDGMENTS

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Dear Reader,

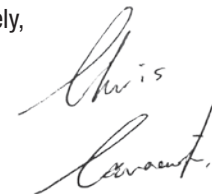
The aim of this book is to help people better understand how opioids work and why Suboxone® can be an effective treatment for opioid dependence.

The contributors to this book have all dedicated their careers to helping people who are facing challenges around their use of opioids. What medical science and our clinical experience tell us is that opioids are incredibly powerful medications for relieving pain, capable of performing tremendous good as well as significant harm.

As any chronic opioid user will attest, trying to manage the use of opioids on a long-term basis is a challenging and complicated process. Finding reliable and evidence-based information on the treatment options available for opioid-related problems is very difficult as well.

We wrote this handbook to help answer some of the challenging and complex questions that people face when it comes to managing their opioid use and hope it will provide you with valuable insights and information. This should also be used as an aid towards having frank and honest discussions with your doctor and other treatment providers, but should not replace those crucially important conversations.

Sincerely,

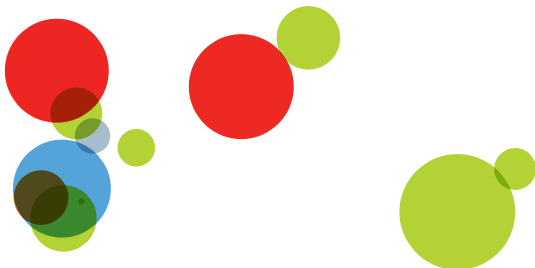


To order additional copies of this Handbook or for a free PDF download of the Handbook, please visit the TrueNorth Medical Centre website:

www.truenorthmedical.com

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What is Suboxone®?

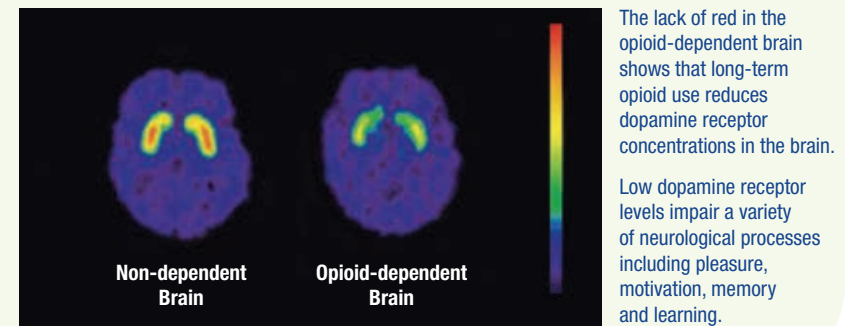
Suboxone® is the brand name for a tablet that is used to treat individuals who are experiencing problems related to opioids. The tablet is designed to be used sublingually (meaning that the tablet is placed under the tongue and is left there until it dissolves). Each Suboxone® tablet contains: **buprenorphine and naloxone**

Suboxone® was approved in the USFDA (United States Food and Drug Administration) as a treatment for opioid dependence in 2002. In 2007, Health Canada approved Suboxone® for the treatment of opioid-related disorders. Before we can understand how Suboxone® works as a treatment for opioid dependence, it is important to understand how long-term opioid use can cause changes in the brain.

When someone has been taking opioids on a daily basis for a long time (more than a few months), it causes significant and long-lasting changes in how their brain works. These changes are often referred to as “neuroadaptation.” Neuroadaptation means that the neurons (brain cells) “adapt” to the constant presence of opioids in the brain. The most obvious examples of neuroadaptation are tolerance and withdrawal. Tolerance is when the body needs more and more of a drug to achieve the same effect as before. Withdrawal is when the body experiences symptoms such as aches, pain, sweating, nausea, or diarrhea when an opioid dose is missed. Tolerance and withdrawal are both hallmark features of opioid dependence.

Figure 1. Opioid Dependence Causes Changes in the Brain

Non-Opioid-Dependent and Opioid-Dependent Brain Images



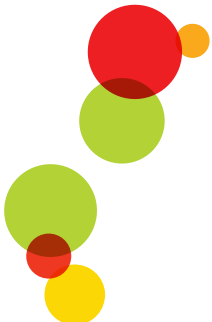
Source: Wang GJ et al. *Neuropsychopharmacology* 1997;16(2):174-182.



About the Author

Dr. Chris Cavacuiti, BA, MD, CCFP, MHSc, ASAM, FCFP has been practicing addiction medicine for more than 15 years. He is an Addiction Medicine Consultant at St. Michael's Hospital and the Casey House HIV/AIDS Hospice. He is the Medical Director for the Methadone and Suboxone® programs at the TrueNorth Medical Centres.

Dr. Cavacuiti is an Assistant Professor in the Department of Family and Community Medicine at the University of Toronto. He was the lead author and editor of *Principles of Addiction Medicine: The Essentials* which was published in 2011 by the American Society of Addiction Medicine. He has published several peer-reviewed articles in the field of addiction medicine.



Many people blame themselves for developing an opioid dependence. It is important to understand that the characteristic brain changes that are seen in long-term opioid users occur regardless of the reason for opioid use. These brain changes occur not only in people who use opioids recreationally, but also in people who take opioids for pain. In fact, if opioids are given to laboratory animals, we see exactly the same brain changes that we see in humans. Opioid dependence is a chronic illness, meaning it can last a long time or may even be something that patients struggle with for life — like asthma, diabetes or high blood pressure.

These brain changes begin within a matter of days or weeks once people start taking opioids. They can occur even when people take low or infrequent doses of opioids. Once these brain changes occur, they are extremely difficult to reverse.

Figure 2. Similarities to Other Chronic Diseases¹⁻³

Characteristics	Drug Dependence	Diabetes, Asthma, and Hypertension
Well studied	✓	✓
Chronic disorder	✓	✓
Predictable course	✓	✓
Effective treatments	✓	✓
Heritable	✓	✓
Requires continued care	✓	✓
Requires adherence to treatment	✓	✓
Requires ongoing monitoring	✓	✓
Influenced by behaviour	✓	✓
Tends to worsen if untreated	✓	✓

Source: 1. McLellan AT et al. *Addiction* 2005;100(4):447–458. 2. McLellan AT et al. *JAMA* 2000;284(13):1689–1695. 3. McLellan AT. *Addiction* 2002;97(3):249–252.

How can someone know if they are opioid dependent?

Along with tolerance and withdrawal, most people with opioid dependence report problems with “The 6 C’s.”

Image 1. The 6 C’s

- **1 LOSS OF CONTROL**
Opioids are taken in larger amounts or over a longer period than intended.
- **2 CRAVINGS**
There is a strong and constant desire for opioids.
- **3 UNABLE TO CUT DOWN**
Unsuccessful efforts to cut down or control opioid use.
- **4 COMPULSIVE USE**
A great deal of time is spent in activities necessary to obtain opioids, use opioids, or recover from opioids.
- **5 PHYSICAL AND SOCIAL CONSEQUENCES**
Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- **6 CONTINUED USE DESPITE HARM**
Continued use of opioids despite knowledge of having a physical or mental problem that won’t go away and that is likely to have been caused or made worse by the opioid (for example, continuing to use opioids despite severe side effects or a dangerously high dosage).

Why do people find it so hard to stop using opioids?

Some basic knowledge of how the human brain works can help explain why quitting opioids is such a difficult process. The human brain can be divided into two areas (see [Image 2](#)). The first area contains the “deeper brain structures” like the brain stem and thalamus. We can think of this as the area that controls the more basic “primitive” or “unconscious” activities of our body, like breathing. These deep brain structures can be found in all vertebrates (animals with backbones). Humans (and to a lesser extent, other “smart” animals like chimpanzees) have a second area of the brain called the cortex. This is the part of the brain that is involved in complex mental tasks like talking or doing math.

The brain changes that occur with chronic opioid use take place in the more primitive parts of the brain associated with basic survival tasks (like breathing). There is very little conscious control over what happens in these deeper brain structures. Being smart and successful does not help a person hold their breath for a longer period, because breathing is a deep brain structure activity. Similarly, being smart and successful does not help a person quit opioids because opioid dependence involves deep brain structure activity.

Image 2. Opioid Dependence Causes Changes in the Brain



Do these brain changes only happen in people who buy opioids “on the street” and take them recreationally?

No

The brain changes that occur with long-term opioid use happen regardless of why they are used and who is providing them. Just because opioids are prescribed does not necessarily mean they are safe. Above and beyond the risk of addiction, opioids are associated with many other risks including breathing problems, constipation, fractures, low testosterone, and sleep apnea. Death and illness from prescription opioid use have now reached extremely high rates. Between 1999 and 2007, unintentional deaths due to overdose in the United States more than doubled, mainly because of increases in overdoses caused by using prescription opioids. In Ontario, the mortality rate from prescription overdose deaths (27.2 deaths per million people) is more than twice the Ontario mortality rate from HIV (12 deaths per million people).

Studies also show that opioids become less safe as the dose gets higher. For example, people who are prescribed doses of morphine that are greater than 100 mg per day are at much higher risk of unintentional overdose and death than those on lower doses.

Image 3. Commonly Used Prescription Opioids

OPIOID	BRAND NAMES of drugs containing this opioid
Codeine	Tylenol* #1, #2, #3
Fentanyl	Duragesic*
Morphine	MS Contin*, Statex*, Kadian*
Hydromorphone	Hydromorph Contin*, Dilaudid*
Hydrocodone	Vicodin*
Oxycodone	Percocet*, OxyContin*, OxyNEO*



* All trademarks are the property of their respective owner(s)

How can Suboxone® help people with opioid dependence?

Opioids work by activating receptors in the brain called “opioid receptors.” When an opioid receptor is activated, it causes a number of brain changes including a feeling of pleasure, reduced pain and stress, slower heart rate and slower breathing.

Suboxone® tablets contain an opioid called “buprenorphine.” Buprenorphine works by activating the opioid receptors in the brain. However, buprenorphine has a number of unique characteristics that make it very different from other opioids, like those listed on page 6. Compared with other opioids, buprenorphine is different in four important ways:

- 1 **HIGH AFFINITY for the opioid receptor**
- 2 **LOW ACTIVITY at the opioid receptor**
- 3 **SLOW DISSOCIATION from the opioid receptor**
- 4 **CEILING EFFECT at the opioid receptor**

1 “HIGH AFFINITY” for the opioid receptor

“High affinity” means if buprenorphine and another opioid (like morphine or oxycodone) are both competing to try and bind with an opioid receptor, then buprenorphine wins. This is due to buprenorphine’s stronger affinity, or attraction, to the opioid receptors. Therefore, if someone was to take buprenorphine at the same time as another opioid, such as morphine, there is far less effect from the other opioid, as it is mainly buprenorphine acting on the opioid receptors.

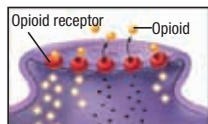
In the course of recovery from opioid dependence, many people relapse (start using opioids again) at some point and consume an opioid that is not part of their treatment program. If a person relapses while taking buprenorphine, the opioids cannot reach the opioid receptor.

tips

It is important to understand, while Suboxone® reduces the risk of opioid overdose in the event of a relapse, that does not mean the risk is zero, especially if opioids are combined with other drugs or alcohol.

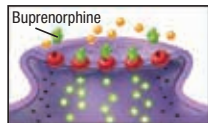
This means that there is far less euphoria or “high” with the relapse. This lack of euphoria helps reduce the risk of further relapse. Also, because the opioids have trouble getting to the receptor during relapse, it reduces the risk of accidental overdose or death during relapses.

Figure 3. Buprenorphine Blocks Opioid Receptors

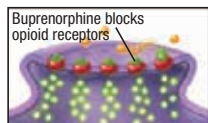


As therapy begins:

1. A person is in a mild-to-moderate state of withdrawal (-) as the opioid of dependence begins to leave the receptors.



2. Buprenorphine attaches to receptors as the other opioid leaves the person's system. Withdrawal symptoms start to get better because buprenorphine is filling up the receptors. In addition, buprenorphine reduces cravings.



3. Buprenorphine firmly attaches to the receptors and blocks other opioids from attaching. With adequate maintenance doses, buprenorphine fills most receptors. Buprenorphine has a long duration of action, so its effect doesn't wear off quickly.

Source: 1. Johnson RE et al. *Drug Alcohol Depend.* 2003;70(2 Suppl):S59-S77. 2. Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Suboxone in the Treatment of Opioid Addiction.* Treatment Improvement Protocol Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004. 3. Bickel WK, Amass L. *Exp Clin Psychopharmacol.* 1995;3(4):4.

2 “LOW ACTIVITY” at the opioid receptor

“Low activity” means that buprenorphine activates the opioid receptor in a less powerful way compared with other opioids. Buprenorphine has enough activity at the opioid receptor to relieve aches, pains, sweating and other opioid withdrawal symptoms, but not enough to make people euphoric or “high.” Also, the more activity an opioid has, the more habit-forming it is. Because of buprenorphine’s “low activity” compared to other opioids, people who take buprenorphine can gradually become less physically dependent on opioids over time.

3 “SLOW DISSOCIATION” from the opioid receptor

“Slow dissociation” means buprenorphine takes a lot longer to separate from the opioid receptor and as a result stays in the body much longer than other short-acting opioids. This means that buprenorphine can be taken just once a day (and in some cases even once every 2 to 3 days). Many other opioids stop working after 4 to 6 hours. The “slow

dissociation” also means that the levels of buprenorphine in the brain stay much steadier than other opioids.

A steady drug level keeps patients from experiencing intoxication (which happens when opioid levels go too high) or withdrawal (which happens when drug levels go too low).

Figure 4. Patient Taking An Opioid Three Times A Day

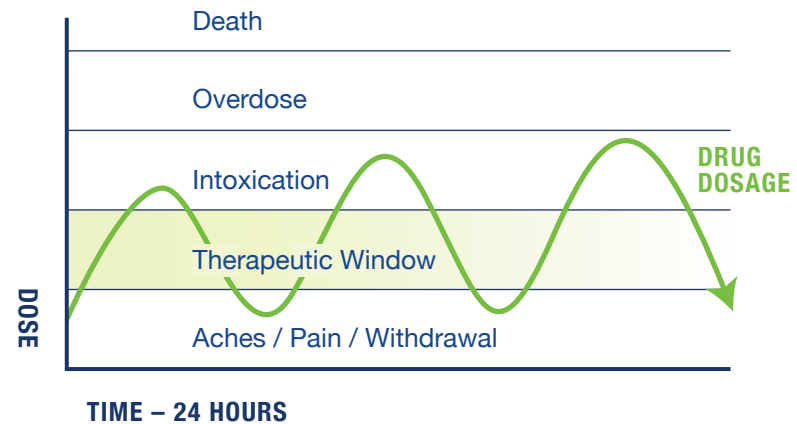
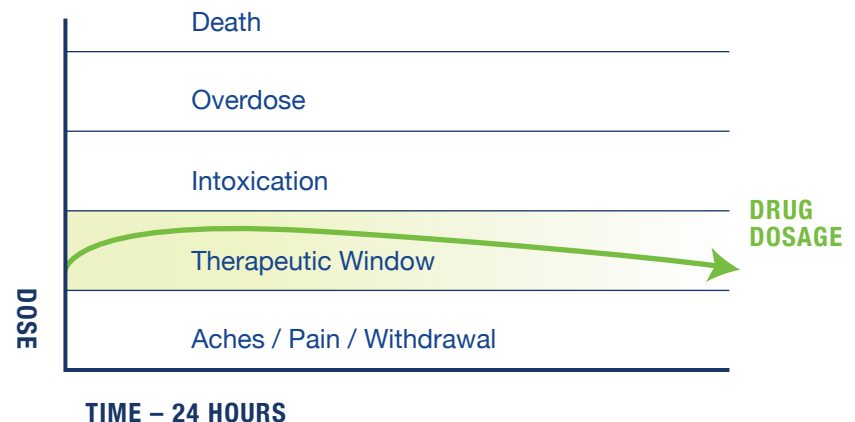


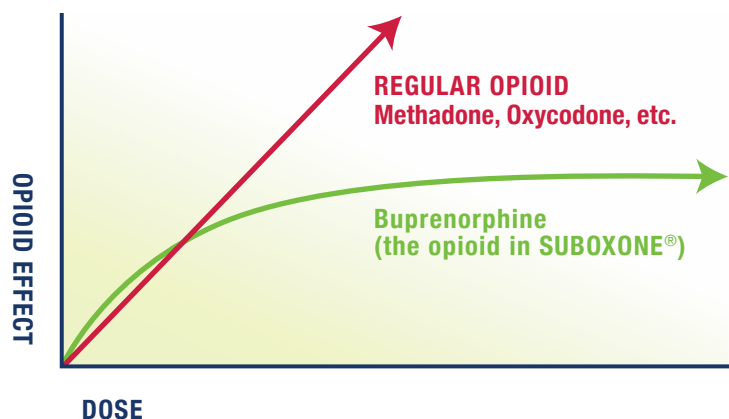
Figure 5. Patient Taking Suboxone® Once Daily



4 “CEILING EFFECT” at the opioid receptor

“Ceiling effect” means that above and beyond a certain point (somewhere around 16 mg of buprenorphine in most cases) giving more buprenorphine does not lead to significantly more activity at the opioid receptor. With most opioids (like methadone or oxycodone), higher doses result in greater effect.

Figure 6. “Ceiling Effect” at the Opioid Receptor



Are Suboxone® and buprenorphine the same thing?

No

Suboxone® is a combination tablet with two ingredients: buprenorphine and naloxone.

Why does Suboxone® contain both buprenorphine and naloxone?

Each Suboxone® tablet contains:

- Buprenorphine (also known as Subutex®), plus
- Naloxone (also known as Narcan®)

Tablets come in two strengths and in each strength the ratio of buprenorphine to naloxone is 4:1:

- 2 mg buprenorphine / 0.5 mg naloxone
- 8 mg buprenorphine / 2 mg naloxone

Buprenorphine is the medicinal ingredient in the tablets. Naloxone is included within the tablets to prevent misuse of Suboxone®.

Naloxone is what is called an “opioid antagonist” — it reverses the effects of opioids. It is the rescue medication given to patients in the emergency department if an opioid overdose is suspected. If someone who is opioid dependent injects naloxone, it will cause sudden and severe withdrawal.

Is there a type of Suboxone® that does not contain naloxone?

In Canada, Subutex® (which contains only buprenorphine without any naloxone) is only available through the Health Canada Special Access Program. Access to Subutex® is only available for special situations where the naloxone portion of the Suboxone® tablet might be dangerous, such as pregnancy.

tips

The proper way to take Suboxone® is to place the tablet under the tongue and let it dissolve.

This is referred to as “sublingual” (under the tongue) administration.

If Suboxone® is administered in some other way (for example, if it is snorted or injected), it can lead to a very uncomfortable episode of withdrawal.

This is because of the naloxone in the Suboxone® tablet. If Suboxone® is used sublingually, the naloxone portion of the tablet cannot enter the bloodstream and therefore is not activated. However, if a Suboxone® tablet is snorted or injected, the naloxone portion of the tablet can enter the bloodstream and cause withdrawal.

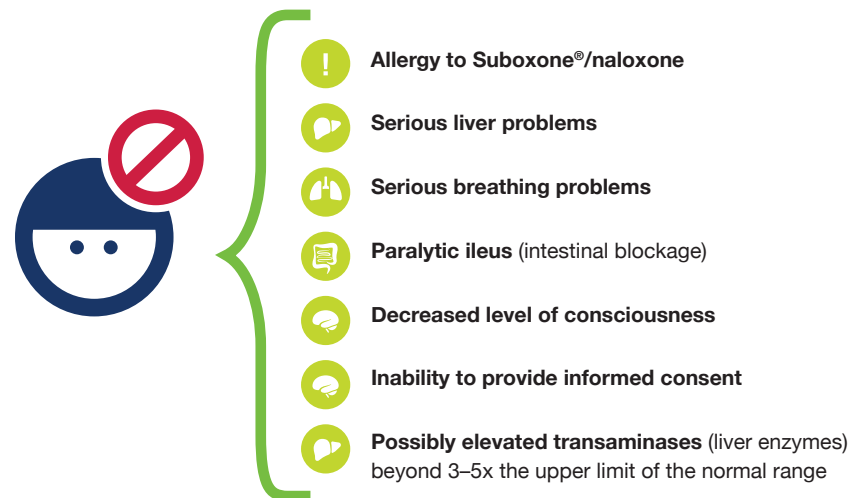
Starting on Suboxone®

Are there people who should avoid Suboxone®?

As previously noted, Suboxone®'s relatively low activity at the opioid receptor makes it safer than most other opioids. However, there are still some people (**Image 4**) who should be especially careful about starting Suboxone®.

Image 4. People Who Should Avoid Suboxone®

According to the Centre for Addiction and Mental Health, these are some of the most common reasons Suboxone® should not be started:



Source: CAMH. Suboxone/naloxone for opioid dependence: clinical practice guideline. 2012. Accessed at http://knowledge.camh.net/primary_care/guidelines_materials/Documents/Suboxone_naloxone_gdlns2012.pdf.

Avoiding “precipitated withdrawal”

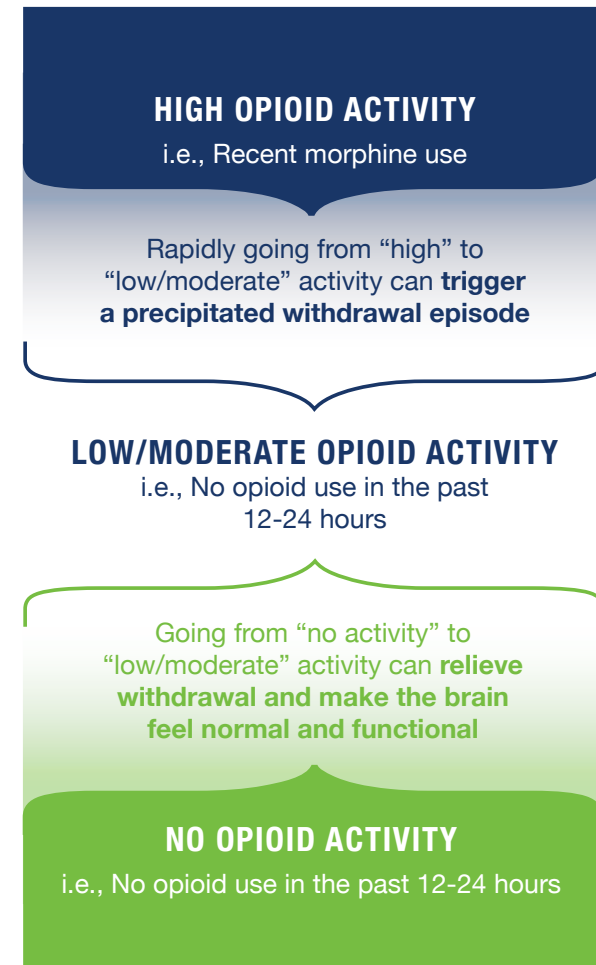
“Precipitated withdrawal” occurs when someone has a lot of opioids (such as heroin, oxycodone or methadone) in their system when they take their first Suboxone® dose. Remember that Suboxone® has “high affinity” but “low activity” at the opioid receptor (see pages 7 to 8). Suboxone®’s “high affinity” at the opioid receptor allows it to force other opioids off the receptor. Rapidly replacing a lot of very strong opioids with a weaker opioid like Suboxone® can trigger withdrawal.

The way to avoid an episode of “precipitated withdrawal” is for a patient to already be in withdrawal when taking the first dose of Suboxone®. Because different opioids last for different lengths of time, it is important that patients be open and honest with their doctor about the opioids they are taking. Depending on the particular opioids an individual is using, they may need to be in withdrawal for as little as 12 to 24 hours, or as long as 2 to 3 days before taking their first Suboxone® dose (see Figure 7).

How do people know when they are on the “right dose”?

In most cases, between 4 mg and 8 mg of Suboxone® is given on the first day. It is usually increased by about 4 mg per day until opioid withdrawal symptoms stop. There is no single dose that is the right dose for everyone. Doses vary from person to person and even the same individual may need different doses at different times in their life. Most people stabilize on doses between 8 mg and 16 mg. The Suboxone® product monograph states that all Suboxone® doses are to be observed by a pharmacist (with the exception of weekends and holidays) for at least the first two months of treatment, in order to ensure safe usage. This is why daily attendance at the pharmacy is required at the start of Suboxone® treatment.

Figure 7. Length of Time Before Starting Suboxone®



tips

TIPS FOR TAKING YOUR SUBOXONE® DOSE

- Make sure your mouth is clean and moist before you take your dose.
- Avoid smoking (anything) for 15 to 30 minutes before your dose.
- Avoid caffeine, diuretics and medications that dry out your mouth before your dose.
- If you are thirsty before your dose, water is your best choice.
- Don't take your dose for at least 15 to 30 minutes after cleaning your teeth or using a mouthwash.
- If your mouth feels dry, try drinking a glass of water or chewing some gum a few minutes before your dose.
- Sucking on an ice cube can help moisten your mouth and reduce the bitter taste of the tablet.
- To avoid accidentally swallowing your dose, try not to talk while you are waiting for your dose to dissolve.
- Make sure that the Suboxone® has entirely dissolved before drinking anything.

Safety issues

The use of central nervous system (CNS) depressants (**see Image 5**) significantly decreases the safety of Suboxone®. One recent study looked at 137 people who died while taking Suboxone®. Benzodiazepines and/or other CNS depressants were also present in 99.3% (136/137) of cases. Because of the dangers of combining Suboxone® with other drugs, urine drug testing is a frequent and important component of most Suboxone® treatment programs.

Image 5. Common CNS Depressants



- **Alcohol**
- **Anticholinergics** (atropine, scopolamine, etc.)
- **Anticonvulsants** (carbamazepine, valproic acid, etc.)
- **Antihistamines** (diphenhydramine, etc.)
- **Antipsychotics** (haloperidol, quetiapine, etc.)
- **Antitussives** (dextromethorphan, etc.)
- **Benzodiazepines** (diazepam, clonazepam, etc.)
- **Barbituates** (phenobarbital, pentobarbital, etc.)
- **Cannabinoids** (marijuana, dronabinol, nabilone, etc.)
- **Hypnotics** (zolpidem, zopiclone, etc.)
- **Muscle relaxants** (baclofen, cyclobenzaprine, etc.)

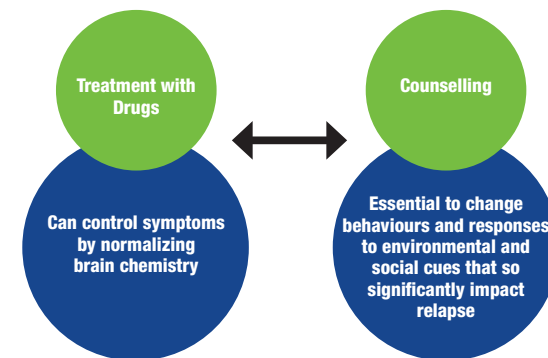
The role of counselling and lifestyle change

“Patients should be assessed for a broad array of biopsychosocial needs in addition to opioid use and addiction, and should be treated, referred, or both for help in meeting all their care needs, including medical care, psychiatric care, and social assistance.”

Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Suboxone in Office-Based Treatment of Opioid Addiction.

There is a lot more to opioid recovery than simply taking a medication. Many studies have shown that outcomes are better in individuals who make lifestyle changes and seek out counselling. Counselling resources vary depending on where people live. People on Suboxone® should be encouraged to speak to their doctor, pharmacist and other members of their treatment team about counselling resources in their area. They may also want to check out some of the resources listed in the back of this booklet. Counselling and medication work better together than either of these treatments does on its own.

Figure 8. Components of Treatment: Treatment with Drugs and Counselling^{1,2}



Both are necessary to normalize brain chemistry, change behaviour, and reduce risk for relapse; neither alone is sufficient.

Source: 1. McLellan AT et al. *Addiction* 1998;93(10):1489-1499. 2. McLellan AT et al. *JAMA* 1993;269(15):1953-1959.



Suboxone® maintenance treatment

While it would be great if people could just take Suboxone® for a few days or weeks and then stop, the evidence tells us that this approach almost never works and that the majority of people who use Suboxone® short-term end up relapsing. Recovery rates are much better among patients who stay on Suboxone® for a long time (months to years). Longer term Suboxone® therapy is often referred to as “Suboxone® maintenance treatment.”

What to do if Suboxone® is not working

While Suboxone® can be helpful to a lot of people, it does not work for everyone. When someone finds that their Suboxone® is not working as well as they had hoped, there are various options that might help.

- **Consider getting more counselling.**
Counselling has been shown to help with both the physical (pain, aches, sweats) and emotional (cravings, depression) struggles that many people experience during opioid recovery.
- **Talk to your doctor about whether or not a second illness (like untreated depression or post-traumatic stress disorder) might help explain the lack of response to treatment.**
Untreated illnesses like depression or PTSD can often interfere with the response to Suboxone® treatment. There are a number of safe and effective (non-addictive) medications as well as non-medication treatments for these conditions.
- **Consider switching to a different treatment.**
Sometimes people who do not respond well to Suboxone® respond better to another medication, such as methadone.
- **Consider switching to a new treatment provider or a different Suboxone® program.**
Studies have shown that the location of a Suboxone® clinic and the services the Suboxone® clinic provides can be just as important (and sometimes more important) than the medication itself.
- **Consider making other lifestyle changes that may help with your recovery.**
Sometimes making changes in other areas of your life, such as exercising more or reducing your use of other drugs or alcohol, can help make your Suboxone® work more effectively for you.



Common issues during maintenance

Constipation

While constipation is less common with Suboxone® than it is with other opioids, it is still a fairly common occurrence. The constipation treatment plan (**Figure 9**) can often help people avoid this problem.

Ongoing or increased cravings

Unless these cravings are accompanied by lots of other signs and symptoms of physical withdrawal, this is usually more a sign of physical or emotional stress rather than an inadequate dose.

Generally speaking, ongoing or increased cravings are better managed with more intense counselling or lifestyle changes (exercise, yoga, meditation, etc.) rather than through dosage adjustments.

Insomnia

Sleep issues are a common problem in opioid recovery. While sleep medications often help in the short term, they usually end up making the problem worse in the long term. See **Figure 10** for a list of non-medication techniques to help you improve your sleep.

Pregnancy and breast-feeding

Until recently, methadone was considered the standard of care for pregnant women who were opioid dependent. However, this view is now changing among many of the specialists who work with opioid-dependent patients who are pregnant or breast-feeding. In view of the rapidly changing recommendations in this area, we strongly advise any patient who is pregnant and/or breast-feeding to discuss their treatment options with a doctor who specializes in this area.

Figure 9. Constipation Treatment/Prevention for Patients on Suboxone®

Follow this treatment plan in the order written for treatment and then withdraw treatments in reverse order when improved.



1

HIGH FIBRE DIET

Beans, lentils, chick peas, pears, bananas, fibre-rich bread, bran buds (All-Bran*), oat bran or consider Metamucil*, 1 tablespoon twice daily.



2

DRINK ENOUGH WATER

6 glasses daily – or any liquids will count (but do not count caffeinated or alcoholic beverages).

If no benefit then consider adding a stool softener daily...



3

RESTORALAX* OR LAX-A-DAY*

1 teaspoon daily or twice daily. Alternately, Lactulose* syrup can be used, 2 to 4 tablespoons daily; although this is probably the most effective stool softener it can make you more gassy.

If no benefit after 2 to 3 days add to the above...



4

STIMULANT LAXATIVE DAILY

Senokot*, 2 tablets every night before bed or Milk of Magnesia*, 1 to 2 tablespoons nightly.



5

GLYCERINE SUPPOSITORY

If no benefit after 2 to 3 days add to the above...

FLEET OR TAP WATER ENEMA

Try to hold water in for 10 to 20 minutes, if possible.



6

If at any time there is ongoing bleeding or severe pain, please call your doctor.

* All trademarks are the property of their respective owner(s).

Figure 10. Sleep Hygiene

TAKE CARE OF YOUR BODY:



DO NOT DRINK CAFFEINE

No more than 1 or 2 caffeinated beverages a day and no tea, coffee, or cola after 4 o'clock. Avoid alcohol as it interferes with sleep.



DO NOT GO TO BED HUNGRY

Have a light and healthy snack but do not eat a big or spicy meal late in the evening.

HAVE A REGULAR BEDTIME ROUTINE

A regular bedtime routine teaches your body when it's time to go to sleep.

- Have a **soothing drink** like chamomile (herbal) tea or a milky drink.
- Have a bath, or a **routine** of washing your face and brushing your teeth before bed.
- Go to **bed at the same time each night**.
- When in bed think of **nice things** (for example, think of 5 nice things that happened that day — such as a nice conversation, seeing the sunshine, or hearing nice music on the radio).
- Do a **relaxed breathing exercise** (place one hand on your stomach and the other on your chest then deliberately slow your breathing; breathe deeply in your stomach instead of high in your chest).
- Try to **wake up at the same time every day**, even if this is tiring to begin with.



PHYSICAL EXERCISE

Brisk activity (especially in the late afternoon) can help make your body tired and help you sleep. Try to do some exercise every day.

SLEEP ONLY AT NIGHTTIME

Do not have daytime naps, no matter how tired you feel. Naps keep the problem going by making it harder for you to get a full night of sleep the next night.





MAKE YOUR BEDROOM A PLEASANT PLACE TO BE:

- Keep it clean and tidy.
- Introduce pleasant smells such as a drop of lavender oil onto the pillow.
- Get extra pillows.
- Make sure that your home feels safe to you (for example, doors are locked and windows are closed).



COPING WITH BAD DREAMS:

Some people don't like relaxation before going to sleep, or are scared of letting go. If that is you, try these preparation techniques instead:

- **Prepare yourself** in case you have bad dreams by thinking of a bad dream then think of a different ending for it. Practice this new ending many times before going to sleep.
- Before going to sleep **prepare to reorient yourself** when you wake from a bad dream.
- Remind yourself that you are at home, that **you are safe**. Imagine your street, buses, and local shops.
- Put a **damp towel or a bowl of water** by the bed to splash your face, or place a special object by the bed, such as a photograph or a small, soft toy.
- When you wake up from a bad dream, **move your body** if you can and reorient yourself immediately (touching a special object, wetting your face, going to a window, talk to yourself in a reassuring way).

YOUR BED IS FOR SLEEPING IN:

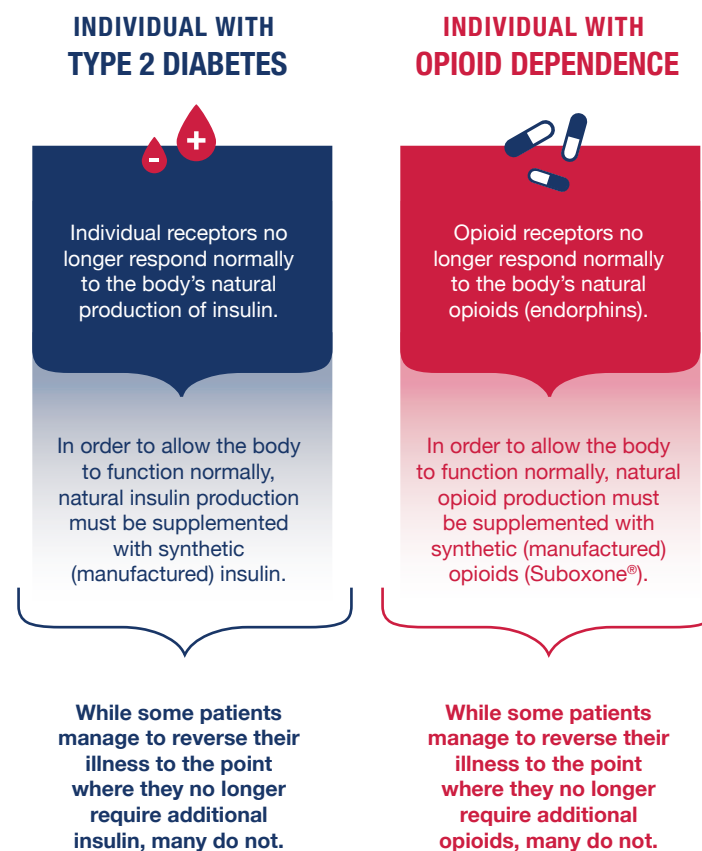
- If you cannot sleep after 30 minutes, get up and do another activity elsewhere such as reading or listening to music (try to avoid TV as it can wake you up).
- After 15 minutes return to bed and try to sleep again. If you still can't sleep after 30 minutes get up again.
- Repeat this routine as many times as necessary and only use your bed for sleeping in.

Tapering Suboxone®

When to taper

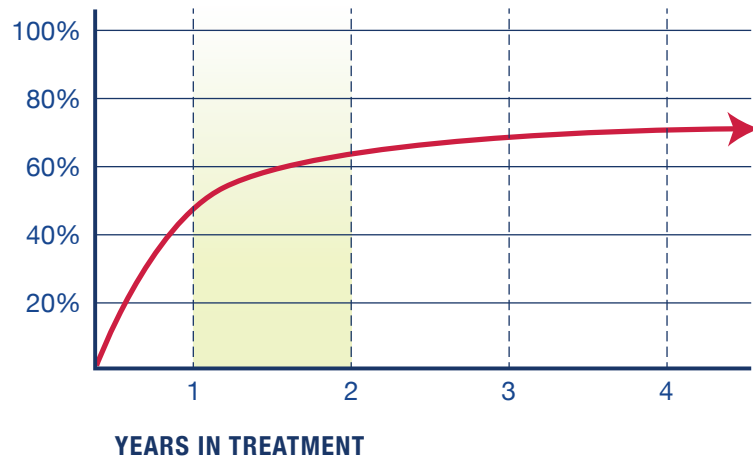
Opioid dependence is a chronic (long-term) disease and many of the changes that occur in patients with opioid dependence can make it very difficult for them to function normally if they stop their Suboxone®. The figure below (**Figure 11**) shows the many striking similarities between chronic illnesses like Type 2 diabetes and opioid dependence.

Figure 11. The Similarities Between Type 2 Diabetes and Opioid Dependence



While it is impossible to predict with certainty who will do well with a taper and who will not, we do know that people who have been on opioids for a longer period of time (2 years or more) tend to do better than those who are only on Suboxone® for a shorter period of time.

Figure 12. Chance of Successful Long-Term Recovery



Some organizations also use the “Tapering Readiness Inventory” (Figure 13) to help people decide if they are ready to stop their Suboxone®. It may be helpful to complete this inventory and discuss the results with your treatment team before making any decisions about tapering.

Figure 13. Tapering Readiness Inventory

Instructions: The purpose of this inventory is to help you decide if you are ready to discontinue Suboxone® at this time. The more questions you can honestly answer by checking “yes,” the greater the likelihood that you are ready to taper from your medications. Consider that each “no” response represents an area that you probably need to work on to increase the odds of a successful taper and recovery. Check the appropriate response.

1	Have you been abstaining from other opiates and illegal drugs, such as cocaine and speed?	☐ YES	☐ NO
2	Do you think you are able to cope with difficult situations without using drugs?	☐ YES	☐ NO
3	Are you employed or in school?	☐ YES	☐ NO
4	Are you staying away from contact with users and illegal activities?	☐ YES	☐ NO
5	Have you gotten rid of your drug paraphernalia (needles, syringes, cotton, etc.)?	☐ YES	☐ NO
6	Are you living in a neighbourhood that doesn't have a lot of drug use, and are you comfortable there?	☐ YES	☐ NO
7	Are you living in a stable family neighbourhood?	☐ YES	☐ NO
8	Do you have non-user friends that you spend time with?	☐ YES	☐ NO
9	Do you have friends or family who would be helpful to you during a taper?	☐ YES	☐ NO
10	Have you been participating in counselling that has been helpful?	☐ YES	☐ NO
11	Does your counsellor think you are ready to taper?	☐ YES	☐ NO
12	Do you think you would ask for help when you are feeling bad during a taper?	☐ YES	☐ NO
13	Have you stabilized on Suboxone®?	☐ YES	☐ NO
14	Have you been on Suboxone® for a long time?	☐ YES	☐ NO
15	Are you in good mental and physical health?	☐ YES	☐ NO
16	Do you want to get off Suboxone®?	☐ YES	☐ NO

After tapering — what comes next?

As with most chronic illnesses. Relapses are quite common. In the long term, as many as 30-50% of individuals who successfully taper off Suboxone® will eventually relapse and need to go back on their medication. The following tips (**Image 6**) may help reduce this risk of relapse. If relapse does occur, please see a doctor right away. Studies show that the sooner people get back on treatment, the better their chances of a good early recovery.

Image 6. Avoiding Relapse

For people who have tapered off Suboxone®, the following tips may help you avoid relapse.



- 1 **Identify** environmental cues and stressors that act as triggers for relapse.
- 2 **Learn** to identify and manage negative emotional states.
- 3 **Work** toward a more balanced lifestyle.
- 4 **Develop** skills to cope with stressful life events.
- 5 **Understand** and manage cravings.
- 6 **Learn** to identify and interrupt lapses and relapses.
- 7 **Develop** a recovery support network, such as joining a self-help group.
- 8 **Utilize** clinical resources available to patients, such as counselling.

Source: Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Suboxone in Office-Based Treatment of Opioid Addiction.



Other Resources

Government of Canada National Anti-Drug Strategy

www.nationalantidrugstrategy.gc.ca/

Canadian Centre on Substance Abuse

www.ccsa.ca/

National Council on Alcoholism and Drug Dependence, Inc.

<http://ncadd.org/>

Project Cork

<http://www.projectcork.org/>

National Institute on Drug Abuse (U.S.)

www.nida.nih.gov/

Centre for Addiction and Mental Health

www.camh.net

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