



STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE - 032

SUBSECTION EFFECTIVE DATE

POLICY/PROCEDURE

02/10/2017

Orientation Materials for Clients

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

Each person seeking care at the COE will be oriented to services and practices at the program.

PROCEDURE

Each new client will be given the following on admission to the COE:

Orientation/Orientation Packet for Clients: Welcome, How services are provided and expectations; (e.g.: 6 month stabilization, referral, return if problems occur that community providers cannot address, etc), tox screening, pill counts, participation in treatment, family participation, services: medical, psychiatric, substance use disorders, tobacco cessation, education/vocation, clinic attendance policy, privacy, releases of information, clinic contact information, Medication card, overdose risk and naloxone overdose reversal kits

Welcome to the Eleanor Slater Center of Excellence for the Treatment of Opioid Use Disorder!

This program is set up to help people who have developed problems with opioids—heroin or prescription pain medicines—to get the treatment they need and to be able to get into recovery. We will work with you using treatment approaches that have been shown to help others with these problems recover from their addiction.

The Center of Excellence is here to help you get the treatment you need as quickly as possible, to make services available in one place that will help you to regain your health and move on with your life. This program includes medical examinations, access to testing for illnesses such as HIV and viral hepatitis, there is mental health care available if needed, and we provide treatment for opioid use disorder and will help with other substance problems if needed. The program also includes counseling—with your assigned counselor and group counseling. There are other therapeutic interventions available including family therapy, groups that provide information on the risks with drug use, medication groups, help with looking for work or going to school, and other activities that will address areas that we find people using our services identify as needs.

Recovery from addiction is difficult and will require a big effort on your part. There are requirements for the treatment that include regular visits to the program and participation in the therapies including medications and drug screening. We will work with you on your individual needs and will develop a plan that is tailored to you. We invite you to ask any questions you have at any time over the course of your treatment.

Treatment in this program is not long term. We expect that people will complete their care at the Center of Excellence within 6 months. We will work with you to find a healthcare provider in your community where you can continue to get your medication and any other therapies you may need. If you want to continue in group therapy at our program after you finish your treatment here, we can help you to do that and will ask you to give us permission to speak with the healthcare provider who is continuing your care so that we can let them know how you are doing in our program.

We look forward to working with you!

The Center of Excellence Staff

Methadone

What it is

Methadone is a long-acting opioid medication that reduces cravings and withdrawal symptoms. It usually comes in liquid form, is taken orally, and dispensed daily.

What it does

Methadone satisfies the areas of the brain that opioids act on, calms withdrawal symptoms, and reduces drug cravings. It can block the euphoric effects of short-acting opioids, such as heroin.

People taking a prescribed dose of methadone that is right for them feel normal, can continue to work, and can usually perform tasks like driving.

Because methadone controls withdrawal symptoms and blocks cravings, people who are addicted to opioids tend to stick with it. This allows them to build a life in recovery and avoid the hazards and problems that come with illegal drug use.

Where do you get it?

Methadone is usually given daily. It can be dispensed only at licensed, federally-regulated opioid treatment programs. Limited take-home dosing may be permitted, and can become more frequent for those doing well in long-term treatment. The provider can explain the guidelines about "take-home medication."

Cost

Methadone is typically the least expensive of the three Medication Assisted Treatment (MAT) options. However, the real cost to an individual varies depending on the state where the person lives, health insurance coverage, and other factors. The provider will have information about real cost and payment options.

Who it works for

Methadone can work for people who have made other unsuccessful attempts to stop. It is a recommended treatment for opioid use disorder during pregnancy.

Research outcomes

Methadone has been in use for many years. It is the best-studied approach to MAT for opioid use disorder. Research shows that methadone treatment can be highly effective when combined with counseling and recovery support.

Starting methadone

Methadone can be started at any time. There is no need to wait for withdrawal symptoms to begin after the last use. However, providers will not start methadone treatment with anyone who seems to have just used or who appears intoxicated.

After the first dose of methadone, people typically stay at the clinic for a few hours. The doctor or nurse usually checks on them regularly to watch their reaction. If withdrawal symptoms are a problem, 2–4 hours after the first dose another small dose may be given. The goal is to find the dose that controls withdrawal symptoms with the fewest side effects by beginning low and increasing slowly.

Side effects

Most people have some side effects from methadone such as constipation, sleepiness, and sweating. Long-term use of methadone may cause sexual side effects and heart problems.

Warnings

Some warnings are listed below. For complete information, visit the websites at the end of this section.

- Highest risk of overdose at start of treatment.
- High risk of overdose when combined with benzodiazepines (Valium, Ativan, Xanax).
- High risk of overdose when combined with other substances, including alcohol.
- Increased risk of serious heart problems and sudden cardiac death.

- Risk of driving impairment at the start of treatment or during dosage adjustments.
- May affect ability to get a commercial driver's license (CDL) in some states.

To reduce the risk of heart problems, experts recommend:

1. You know about the heart risks;
2. You are screened for heart health and history;
3. You may get heart tests as part of your treatment program; and
4. If a problem is found, the methadone dose should be lowered or stopped.

All medications can interact with alcohol, other prescription and over-the-counter medications, as well as vitamins, herbs, and supplements. If you use alcohol or other drugs in addition to opioids, your situation may be more complex. Talk to your doctor about all the medications and substances you use. To learn more about medication interactions, visit: [Avoiding Drug Interactions](#).

Risks to others

All medications should be stored in a locked cabinet out of reach of children or pets. Doses tolerated by some individuals can cause serious harm, even death, to others. Medications should only be taken by the person they were intended for. Excess medication should be disposed of properly. More information on how to dispose of excess medication where you live, and where you can drop off unused medicine during annual take-back days can be found [here](#).

How long do I need to take it?

The decision about how long to take methadone is an individual choice people discuss with their treatment provider. Most of the time, methadone treatment for less than 90 days has little effect. People who take it a year or more have the best rates of success.

Some take methadone for many years. Others choose to taper off very gradually with the help of their treatment providers. Some research shows that many people return to drug use when they stop taking methadone. This is one reason people stay on methadone maintenance for a long time. It is best to

periodically assess the need for ongoing treatment with your doctor or counselor.

There is withdrawal from methadone when it is stopped quickly. Methadone withdrawal is less intense than heroin withdrawal, but it lasts longer. Withdrawal symptoms can be reduced by slowly cutting down the methadone dose over a number of months.

Pregnancy

Methadone has been used for years to safely treat opioid problems during pregnancy. As with any treatment, there are some risks; but they are not nearly as high as the risks pregnant women with untreated opioid use disorder may face. Infants born to mothers treated with methadone during pregnancy are at risk for withdrawal symptoms, sometimes severe enough to require medication and delay discharge from the hospital. These symptoms can be monitored and are easily managed in most hospitals, and there is no evidence of permanent effects. Women are encouraged to breastfeed, although trace amounts of methadone may be found in breast milk. Researchers agree that these low levels are not a cause for concern, and that the benefits of breastfeeding for the infant far outweigh any risk.

HIV/AIDS

Structured methadone programs may be beneficial for people who are being treated with HIV medications. Methadone doses may need to be adjusted for those on certain medications. It can interact with some of the drugs that are used to treat HIV. Talk with your doctors about your situation.

Hepatitis and liver disease

Methadone is usually safe for people with hepatitis unless the liver is functioning very poorly. It has been used safely in combination with interferon by people undergoing treatment for hepatitis. Talk with your doctors about your situation.

Pain

Methadone can be used with other opioid medications prescribed for pain. Dosage is watched carefully due to overdose risk. Methadone for maintenance therapy is only taken once a day, which is not enough to control pain.

People who use methadone for MAT may have a high tolerance for opioid pain medications. They may not get relief from their pain at typical dosages. They can benefit from working with a doctor experienced with managing pain in people with histories of opioid use disorder.

Legal issues

- Methadone does not affect the ability to get a driver's license, as long as the person is not using illegal drugs or abusing prescription medications.
- Methadone may affect eligibility for commercial driver's licenses in some states.
- People receiving methadone treatment are protected by confidentiality laws and anti-discrimination laws as long as they are not using illegal drugs or abusing prescribed medications.
- Methadone may show up on a drug screen.
- An employer legally cannot fire you for being treated with methadone as long as you can document that it is prescribed as part of your medical treatment.
- People involved with the criminal justice system often have a difficult time getting methadone while in jail or prison, or while under court supervision.

For more information

More information on methadone

www.nlm.nih.gov/medlineplus/druginfo/meds/a682134.html

FDA approved package inserts and product labeling:

<https://www.dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=human&query=METHADONE>

How To Use Methadone Safely

http://dptbeta.samhsa.gov/methadonesafety/text_publications/follow_directions_brochure.aspx

Methadone Treatment for Pregnant Women

store.samhsa.gov/product/Methadone-Treatment-for-Pregnant-Women/SMA09-4124

Know Your Rights: Rights for People on MAT

www.lac.org/doc_library/lac/publications/Know_Your_Rts_-_MAT_final_9.28.10.pdf

Buprenorphine

What it is

Buprenorphine is usually taken daily and must be dissolved under the tongue. It should never be chewed or swallowed. It has lower abuse potential and can have milder withdrawal symptoms than methadone. It does not have the same level of euphoric effects or as great of an overdose risk as other opioid drugs.

Buprenorphine is widely available in a formula that contains added naloxone, which discourages abusing or injecting it. It also is made in a formula with just the single drug and no added naloxone, which is sometimes used for Medication Assisted Treatment (MAT) with pregnant women and people who are switching from methadone.

What it does

Both forms of buprenorphine control withdrawal symptoms and block cravings. People taking a prescribed dose of buprenorphine that is right for them, feel normal, can continue to work, and can usually perform tasks like driving.

Where do you get it?

Doctors can complete a required training and certification process that allows them to prescribe buprenorphine to treat opioid use disorder. They can prescribe buprenorphine to patients they see in their office or for clients in treatment programs. At the beginning of treatment, patients seen at a doctor's office usually have frequent appointments, are referred to attend counseling, and are monitored to ensure they are making satisfactory progress. Then they may receive a prescription to take at home.

Cost

Buprenorphine is typically more expensive than Methadone, but less expensive than Naltrexone. However, the real cost to an individual varies depending on the state where the person lives, health insurance coverage, and other factors. The provider will have information about real cost and payment options.

Who it works for

Most guidelines suggest people with shorter, less extensive histories of heavy opioid use may be good candidates for treatment with buprenorphine. It also works for more severe opioid use disorder and for people who decide to switch from methadone. It offers a safe and effective alternative for those unable to get to an opioid treatment program on a regular basis and for pregnant women seeking treatment. It works best for people who are able to adhere to a treatment plan and take the medication as directed.

Research outcomes

Since buprenorphine was approved for MAT only a few years ago, in comparison to methadone, there are fewer long-term studies of safety and effectiveness. So far the research suggests that long-term treatment with buprenorphine is safe and very effective when combined with counseling and recovery support. Several recent studies on buprenorphine have shown it can be used to safely treat opioid use disorder during pregnancy. This research also suggests that although infants born to mothers treated with buprenorphine are at-risk for withdrawal, their symptoms tend to be milder. They are less likely to require treatment with medications and have shorter hospital stays than infants born to mothers treated with methadone.

Starting buprenorphine

It is necessary to wait 12–24 hours after the last opioid use before starting buprenorphine in order to avoid uncomfortable symptoms.

After the first dose, people typically stay at the doctor's office or treatment center for a few hours while the doctor or nurse checks on them regularly to watch their reaction. If withdrawal symptoms are a problem, dosages can be adjusted.

Side effects

Most people have some side effects from buprenorphine such as headache, nausea, and constipation. Some people using buprenorphine for long-term MAT have reported sexual side effects or liver problems.

Warnings

Some warnings are listed below. For complete information, see the list of websites at the end of this section.

- Moderate risk of overdose.
- High risk of overdose when combined with benzodiazepines (Valium, Ativan, Xanax).
- High risk of overdose when combined with other substances, including alcohol.
- Possible risk of liver damage.
- Risk of driving impairment at the start of treatment or during dosage adjustments.
- May affect ability to get a commercial driver's license (CDL) in some states.

All medications can interact with alcohol, other prescription and over-the-counter medications, as well as vitamins, herbs, and supplements. If you use alcohol or other drugs in addition to opioids, your situation may be more complex. Talk to your doctor about all the medications and substances you use. You can search for medication interactions at [Avoiding Drug Interactions](#).

Risks to others

All medications should be stored in a locked cabinet out of reach of children or pets. Doses tolerated by some individuals can cause serious harm, even death, to others. Excess medication should be disposed of properly. Medications should only be taken by the person they were prescribed for.

How long do I need to take it?

The decision about how long to take buprenorphine is made by the individual with their doctor. Most current research shows that the longer people are treated with buprenorphine, the more positive the results. Research shows that treatment lasting more than nine months decreases the chance of returning to drug use. It is safe to stay on buprenorphine for a long time. When they are ready, most people work with their doctor to slowly reduce the dose of buprenorphine. The withdrawal symptoms tend to be milder than symptoms people have when they discontinue methadone.

Pregnancy

Although there are fewer long-term studies available on buprenorphine treatment during pregnancy, so far a substantial amount of research has shown it can be used safely to treat women who are pregnant or breastfeeding. As with any treatment, there are some risks; but they are not nearly as high as the risks pregnant women with untreated opioid use disorder

may face. Infants born to mothers treated with buprenorphine during pregnancy are at risk for experiencing withdrawal, but the symptoms tend to be milder and may be easier to manage. These newborns are less likely to require medication for withdrawal symptoms and spend less time in the hospital than newborns whose mothers are treated with methadone. There is no evidence of any permanent effects, and current medical guidelines consider buprenorphine an option for pregnant women who prefer it, or are already taking it.

Use of buprenorphine only, in the single drug formula, has been studied in pregnant women. Compound formulas that contain naloxone are not recommended for pregnant women, since it has not been tested for safety.

HIV/AIDS

Buprenorphine may be used by people with HIV/AIDS. There are fewer interactions with HIV drugs than with methadone. It is possible that it may still interact with some HIV medications and require an adjusted dose. Talk with your doctors about your situation.

Hepatitis and liver disease

People with liver disease should check with their doctors before starting buprenorphine. It is possible it may contribute to liver damage, especially in people who already have a liver condition. Combination products containing naloxone should not be used if patients have severe liver impairment. Liver function tests are recommended before beginning buprenorphine. Studies have shown it can be used safely by people with hepatitis who are being treated with interferon. Talk with your doctors about your situation.

Pain

People who use buprenorphine for MAT often have a high tolerance to opioid pain medications. It can be difficult to relieve their pain at a typical dosage. Buprenorphine, in high doses, may decrease the effectiveness of other opioids used to manage pain. People with chronic pain who are using buprenorphine for MAT can benefit from working with a doctor who is experienced with pain management for people with histories of opioid use disorder.

Talk to your doctor if you need pain relief and are taking buprenorphine for MAT.

Legal issues

- Buprenorphine does not affect the ability to get a driver's license, as long as the person is not using illegal drugs or abusing prescription medications.
- Buprenorphine may affect eligibility for commercial driver's licenses in some states.
- People receiving buprenorphine treatment are protected by confidentiality laws and anti-discrimination laws as long as they are not using illegal drugs or abusing prescribed medications.
- Buprenorphine may show up on a drug screen.
- An employer legally cannot fire you for being treated with buprenorphine as long as you can document that it is prescribed as part of your medical treatment.
- People involved with the criminal justice system may have a difficult time getting buprenorphine while in jail or prison, or while under court supervision.

For more information

More information about buprenorphine

www.nlm.nih.gov/medlineplus/druginfo/meds/a605002.html

FDA approved package inserts and product labeling:

<https://www.dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=human&query=BUPRENORPHINE>

The Facts About Buprenorphine

www.store.samhsa.gov/product/The-Facts-about-Buprenorphine-for-Treatment-of-Opioid-Addiction/SMA14-4442

Know Your Rights: Rights for People on MAT

www.lac.org/doc_library/lac/publications/Know_Your_Rts_-_MAT_final_9.28.10.pdf

Naltrexone

What it is

Naltrexone blocks the ability of opioids to eliminate pain and induce euphoria. This removes the rewarding aspects of opioid use that result in a desire for more. It is available in an extended release injectable form that is administered every 30 days and in tablet form, taken once a day by mouth.

The extended release injection has been the most effective form of naltrexone for treating addiction. It has helped to prevent relapse when combined with counseling and other supportive services.

Naltrexone is an Medication Assisted Treatment (MAT) option for people who are able to get through the initial 7–10 days of withdrawal and are highly motivated to prevent a return to drug use. Risk of overdose is high for people who try to use large amounts of opioids to override naltrexone's blocking effects. There is also a high risk of overdose when people skip dosages or are at the end of a dosage cycle and go back to using the amount of opioids they used to tolerate.

What it does

Naltrexone is not a controlled substance and has no potential for abuse. People feel completely normal while taking it. When the pills were the only form of naltrexone available, people with a strong impulse to use simply stopped taking their pills, and the blocking effect no longer stood in the way. The extended release injection has been a much more successful treatment for opioid use disorder. Once it is administered, stopping the effects of medication is not an option until four weeks have passed. Recent studies of MAT with extended release, injectable naltrexone have consistently shown it reduces the chance of relapse and helps people remain abstinent from opioids. It also helps to reduce craving and to keep people in treatment longer.

However, if people addicted to opioids do not stop using them for 7-10 days before starting naltrexone, they risk bringing on withdrawal symptoms that can be quite severe. Naltrexone can also block the pain relieving effects of opioid medications. People with chronic pain problems, who sometimes need to take opioid medications, should keep this in mind when they consider their MAT options.

People have tried to override the blocking effect by taking large doses of opioids on top of naltrexone. This can result in fatal overdose. Overdose risk is high for people who return to opioid use after a period of treatment with naltrexone; in part, because their tolerance goes down while they are drug-free, and they cannot handle amounts they used to take.

Where do you get it?

Any qualified medical provider, doctor, nurse practitioner, or physician's assistant can administer injections in their offices or prescribe naltrexone pills. No special training is required. Naltrexone is not a controlled substance; there is no potential for abuse or for dependence.

Cost

The extended release injectable form of naltrexone is typically the most expensive MAT option. However, the real cost to an individual varies depending on the state where the person lives, health insurance coverage, and other factors. The provider will have information about real cost and payment options.

Who it works for

Naltrexone works well for highly motivated people who are able to stop opioid use for 7-10 days prior to beginning treatment. It is a good option for those who are eager to eliminate all opioids. The injectable form is helpful for people who have a hard time keeping up with daily pills. Since it is approved for treating alcohol problems as well, people taking naltrexone may find it also helps them avoid drinking. People who need to take opioid medications for chronic pain may not be good candidates for naltrexone.

Research outcomes

The extended release injectable form naltrexone was approved for treating opioid use disorder in 2010, so a limited number of long-term studies have been completed. Results so far suggest that the extended release injection, used in combination with counseling and other supports, reduces craving and helps prevent relapse. It helps people to maintain abstinence from opioid drugs and to stay in treatment longer.

Starting naltrexone

Naltrexone treatment for opioid use disorder cannot begin until at least 7–10 days after the last opioid use, without risking immediate and severe withdrawal symptoms. It does not help with detoxification from opioids or help withdrawal symptoms. Providers often request a urine sample to make sure people are free of opioids before starting naltrexone. Some providers administer a small amount of naltrexone or a related medication to test the response. If there is no adverse reaction they will administer the full dose by injection and check periodically, to make sure it is well tolerated, before patients leave the office or treatment center.

Side effects

Most people do not have many side effects from naltrexone, but soreness in the area of the injection is very common. Other side effects can include stomach pain or nausea, diarrhea, and difficulty sleeping.

Warnings

Some warnings are listed below. For complete information, see the list of websites at the end of this section.

- High risk of overdose if people use opioids to override blocking effect.
- Moderate to high risk of overdose due to lowered tolerance.
- Risk of causing severe withdrawal in opioid dependent patients who have not stopped using for 7-10 days.
- Risk of canceling pain relieving effects if opioid pain medication is given in a medical emergency.
- Risk of depression and suicidal thoughts.
- Risk of severe injection site reaction.

All medications can interact with alcohol, other prescription and over-the-counter medications, as well as vitamins, herbs, and supplements. If you use alcohol or other drugs in addition to opioids, your situation may be more complex. Talk to your doctor about all the medications and substances you use. To learn more about medication interactions, visit: [Avoiding Drug Interactions](#).

Risks to others

All medications should be stored in a locked cabinet out of reach of children or pets. Excess medication should be disposed of properly. Medications should only be taken by the person they were prescribed for.

How long do I need to take it?

Deciding how long to take naltrexone is an individual choice. Like other medications used for MAT, it is safe to stay on it for long-term treatment. There is no withdrawal from naltrexone. It can be stopped at any time. However, when a long-acting injection is given, it stays in effect for a 30-day period. Some research has shown that many people return to drug use when they stop taking naltrexone, skip doses, or are at the end of a dosing cycle. When this takes place, there is a risk of increased sensitivity to the effects of opioids and a heightened risk of overdose. Generally, people need to remain in treatment a minimum of 90 days in order to benefit.

Pregnancy

There is no research on safety of use during pregnancy or breastfeeding. It is not recommended to use naltrexone during pregnancy until there is more research about its safety.

HIV

Naltrexone is safe to use with HIV medications. There is low potential for HIV drug interactions.

Hepatitis and liver disease

People with a history of liver disease who are considering naltrexone should talk it over with their doctor. They often recommend liver function tests before treatment begins. Very large doses of naltrexone can cause liver damage, but studies show it is safe at the recommended dose, even for people with hepatitis who are taking Interferon. Talk with your doctor about your situation.

Pain

Naltrexone can keep opioid pain medications from working. It may bring on severe withdrawal symptoms in people physically dependent on opioid pain medication, unless they have stopped all opioids for at least 7-10 days beforehand. Non-opioid medications taken for pain relief can be used safely with naltrexone at all times. If you have chronic pain, and are considering naltrexone for MAT, talk with your doctor. If you use naltrexone for MAT and have to take opioid pain medication for medical reasons:

- Inform medical staff that you are using naltrexone.

- Stop taking naltrexone before starting to take a prescribed pain medication.
- Do not use naltrexone while using the pain medication.
- Restart naltrexone 7 days after the last dose of pain medication.

Legal issues

Naltrexone is not a controlled substance and legal issues are usually not a concern.

For more information

More about naltrexone

www.nlm.nih.gov/medlineplus/druginfo/meds/a609007.html

FDA approved package inserts and product labelling

[www.dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=human&query=NA
LTREXONE](http://www.dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=human&query=NA
LTREXONE)

The Facts about Naltrexone for Treatment of Opioid Addiction

[store.samhsa.gov/product/The-Facts-about-Naltrexone-for-Treatment-of-
Opioid-Addiction/SMA12-4444](http://store.samhsa.gov/product/The-Facts-about-Naltrexone-for-Treatment-of-
Opioid-Addiction/SMA12-4444)

**Department of Behavioral Healthcare, Developmental Disabilities
and Hospitals Center of Excellence for the Treatment of Opioid
Use Disorder**

INJECTABLE NALTREXONE TREATMENT AGREEMENT

Name:

I am requesting that my doctor provide injectable naltrexone (Vivitrol) treatment for
opioid _____ addiction. I freely and voluntarily agree to accept this
treatment

list drug(s)
agreement, as follows:

- (1) I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her staff.
- (2) I agree to conduct myself in a courteous manner in the physician's or clinic's office.
- (3) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not be able to see me and I will not be given medication until my next scheduled appointment.
- (4) I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the clinic.
- (5) I agree that my medication (or prescriptions) can only be given to me at my regular office visits.
- (6) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing injectable naltrexone (Vivitrol) with other medications, especially other pain medications (opioids) can be dangerous and can result in possible withdrawal symptoms.
- (7) I understand that misuse of benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), Clonopin (clonazepam) and/or other drugs of abuse including alcohol can endanger my recovery.
- (8) I understand that injectable naltrexone works by blocking the effects of any opioid I might take. I understand that taking opioids with naltrexone can be medically dangerous and that if I were to take too much opioid, I could have an opioid overdose which could be life-threatening.
- (9) I understand that medication alone is not sufficient treatment for my addictive disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my recovery.
- (10) I understand that there are alternatives to injectable naltrexone (Vivitrol) treatment for opioid addiction including:
 - a. medical withdrawal and drug-free treatment

b. buprenorphine/naloxone treatment

c. methadone treatment

My doctor will discuss these with me if I request this and will give me a referral to another program if needed.

Patient's Signature

Date

Witness Signature

Date

**Department of Behavioral Healthcare, Developmental Disabilities
and Hospitals Center of Excellence for the Treatment of Opioid
Use Disorder**

BUPRENORPHINE/NALOXONE TREATMENT AGREEMENT

Name:

I am requesting that my doctor provide buprenorphine/naloxone (Suboxone) treatment for opioid _____ addiction. I freely and voluntarily agree to accept this treatment

list drug(s)
agreement, as follows:

- (1) I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her staff.
- (2) I agree to conduct myself in a courteous manner in the physician's or clinic's office.
- (3) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not be able to see me and I will not be given any medication until my next scheduled appointment.
- (4) I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and could result in my treatment being stopped and referral to another treatment program.
- (5) I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal.
- (6) I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the clinic.
- (7) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
- (8) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
- (9) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone (Suboxone) with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), Clonopin (clonazepam) and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines. I also understand that I should not drink alcohol while taking this medication as the

combination could produce excessive sedation or impaired thinking or other medically dangerous events.

- (10) I agree to take my medication as the doctor, and his/her staff has instructed, and not to alter the way I take my medication without first consulting the doctor.
- (11) I understand that medication alone is not sufficient treatment for my addictive disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.
- (12) I understand that my buprenorphine/naloxone (Suboxone) treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.
- (13) I understand that there are alternatives to buprenorphine/naloxone (Suboxone) treatment for opioid addiction including:
 - a. medical withdrawal and drug-free treatment
 - b. naltrexone treatment
 - c. methadone treatment

My doctor will discuss these with me and provide a referral if I request this.

Patient's Signature

Date

Witness Signature

Date

Patient Information

BUPRENORPHINE/NALOXONE INDUCTION (Treatment Days 1-2):

Starting buprenorphine/naloxone (buprenorphine) is a process that will occur over several days. During this time, you will report to the clinic each morning to begin taking buprenorphine. Please read the information and guidelines below before your appointment for buprenorphine induction:

Guidelines for buprenorphine induction:

- You must not use any heroin or prescription pain medicine after 5:00 pm on the day before you are scheduled to start buprenorphine induction. You will be evaluated by clinic staff for signs and symptoms of opiate withdrawal on the morning of your appointment and you will not be given any medication if withdrawal symptoms are not seen.
- You must report to the Eleanor Slater Substance Recovery Clinic at your scheduled appointment time on your first day of buprenorphine induction. The clinic is located on the first floor of the Regan Building in the Outpatient Clinic area at 111 Howard Ave, Cranston, RI 02920.
- You should plan to stay at the clinic for up to 2-3 hours on the first day of buprenorphine induction. The second visit will last approximately 30 minutes – 1 hour.
- You should arrange for transportation to and from the clinic so that you will not need to drive yourself (ie. arrange to have a friend or family member give you a ride or plan to take public transportation).

If you have any questions, please call the clinic at 401 462-3456 for clarification and/or additional information.

MEDICATION GUIDE

VIVITROL® (viv-i-trol) (naltrexone for extended-release injectable suspension)

Read this Medication Guide before you start receiving VIVITROL injections and each time you receive an injection. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about VIVITROL?

VIVITROL can cause serious side effects, including:

1. Risk of opioid overdose.

You can accidentally overdose in two ways.

- VIVITROL blocks the effects of opioids, such as heroin or opioid pain medicines. **Do not** take large amounts of opioids, including opioid-containing medicines, such as heroin or prescription pain pills, to try to overcome the opioid-blocking effects of VIVITROL. This can lead to serious injury, coma, or death.
- After you receive a dose of VIVITROL, its blocking effect slowly decreases and completely goes away over time. If you have used opioid street drugs or opioid-containing medicines in the past, using opioids in amounts that you used before treatment with VIVITROL can lead to overdose and death. You may also be more sensitive to the effects of **lower** amounts of opioids:
 - after you have gone through detoxification
 - when your next VIVITROL dose is due
 - if you miss a dose of VIVITROL
 - after you stop VIVITROL treatment

It is important that you tell your family and the people closest to you of this increased sensitivity to opioids and the risk of overdose.

You or someone close to you should get emergency medical help right away if you:

- have trouble breathing
- become very drowsy with slowed breathing
- have slow, shallow breathing (little chest movement with breathing)
- feel faint, very dizzy, confused, or have unusual symptoms

2. Severe reactions at the site of the injection (injection site reactions).

Some people on VIVITROL have had severe injection site reactions, including tissue death (necrosis). Some of these injection site reactions have required surgery. Call your healthcare provider right away if you notice any of the following at any of your injection sites:

- intense pain
- the area feels hard
- large area of swelling
- lumps
- blisters
- an open wound
- a dark scab

Tell your healthcare provider about any reaction at an injection site that concerns you, gets worse over time, or does not get better by two weeks after the injection.

3. Sudden opioid withdrawal.

Anyone who receives a VIVITROL injection must not use any type of opioid (must be opioid-free) including street drugs, prescription pain medicines, cough, cold, or diarrhea medicines that contain opioids, or opioid dependence treatments, buprenorphine or methadone, **for at least 7 to 14 days** before starting VIVITROL. Using opioids in the 7 to 14 days before you start receiving VIVITROL may cause you to suddenly have symptoms of opioid withdrawal when you get the VIVITROL injection. **Sudden opioid withdrawal can be severe, and you may need to go to the hospital.**

You must be opioid-free before receiving VIVITROL unless your healthcare provider decides that you don't need to go through detox first. Instead, your doctor may decide to give your VIVITROL injection in a medical facility that can treat you for sudden opioid withdrawal.

4. Liver damage or hepatitis. Naltrexone, the active ingredient in VIVITROL, can cause liver damage or hepatitis.

Tell your healthcare provider if you have any of the following symptoms of liver problems during treatment with VIVITROL:

- stomach area pain lasting more than a few days
- dark urine
- yellowing of the whites of your eyes
- tiredness

Your healthcare provider may need to stop treating you with VIVITROL if you get signs or symptoms of a serious liver problem.

What is VIVITROL?

VIVITROL is a prescription injectable medicine used to:

- treat alcohol dependence. You should stop drinking before starting VIVITROL.
- prevent relapse to opioid dependence, **after** opioid detoxification.

This means that if you take opioids or opioid-containing medicines, you must stop taking them before you start receiving VIVITROL. **See "What is the most important information I should know about VIVITROL?"**

To be effective, treatment with VIVITROL must be used with other alcohol or drug recovery programs such as counseling. VIVITROL may not work for everyone.

It is not known if VIVITROL is safe and effective in children.

Who should not receive VIVITROL?

Do not receive VIVITROL if you:

- are using or have a physical dependence on opioid-containing medicines or opioid street drugs. **See "What is the most important information I should know about VIVITROL?"**

To see whether you have a physical dependence on opioid-containing medicines or opioid street drugs, your healthcare provider may give you a small injection of a medicine called naloxone. This is called a naloxone challenge test. **If you get symptoms of opioid withdrawal after the naloxone challenge test, do not start treatment with VIVITROL at that time.** Your healthcare provider may repeat the test after you have stopped using opioids to see whether it is safe to start VIVITROL.

- are having opioid withdrawal symptoms. Opioid withdrawal symptoms may happen when you have been taking opioid-containing medicines or opioid street drugs regularly and then stop.

Symptoms of opioid withdrawal may include: anxiety, sleeplessness, yawning, fever, sweating, teary eyes, runny nose, goose bumps, shakiness, hot or cold flushes, muscle aches, muscle twitches, restlessness, nausea and vomiting, diarrhea, or stomach cramps. **See "What is the most important information I should know about VIVITROL?"** Tell your healthcare provider if you have any of these symptoms before taking VIVITROL.

- are allergic to naltrexone or any of the ingredients in VIVITROL or the liquid used to mix VIVITROL (diluent). See the end of this Medication Guide for a complete list of ingredients in VIVITROL and the diluent.

What should I tell my healthcare provider before receiving VIVITROL?

Before you receive VIVITROL, tell your healthcare provider if you:

- have liver problems
- use or abuse street (illegal) drugs
- have hemophilia or other bleeding problems
- have kidney problems
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if VIVITROL will harm your unborn baby.
- are breastfeeding. It is not known if VIVITROL passes into your milk, and if it can harm your baby. Naltrexone, the active ingredient in VIVITROL, is the same active ingredient in tablets taken by mouth that contain naltrexone. Naltrexone from tablets passes into breast milk. Talk to your healthcare provider about whether you will breastfeed or take VIVITROL. You should not do both.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements.

Especially tell your healthcare provider if you take any opioid-containing medicines for pain, cough or colds, or diarrhea. **See "What is the most important information I should know about VIVITROL?"**

If you are being treated for alcohol dependence but also use or are addicted to opioid-containing medicines or opioid street drugs, it is important that you tell your healthcare provider before starting VIVITROL to avoid having sudden opioid withdrawal symptoms when you start VIVITROL treatment.

Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

How will I receive VIVITROL?

- VIVITROL is injected by a healthcare provider, about 1 time each month.
- VIVITROL is given as an injection into a muscle in your buttocks using a special needle that comes with VIVITROL.
- After VIVITROL is injected, it lasts for a month and it cannot be removed from the body.
- If you miss your appointment for your VIVITROL injection, schedule another appointment as soon as possible. **See "What is the most important information I should know about VIVITROL?"**
- Whenever you need medical treatment, be sure to tell the treating healthcare provider that you are receiving VIVITROL injections and mention when you got your last dose. This is important because VIVITROL can also block the effects of opioid-containing medicines that might be prescribed for you for pain, cough or colds, or diarrhea.
- Carry written information with you at all times to alert healthcare providers that you are taking VIVITROL, so that they can treat you properly in an emergency. Ask your healthcare provider how you can get a wallet card to carry with you.

What should I avoid while receiving VIVITROL?

Do not drive a car, operate machinery, or do other dangerous activities until you know how VIVITROL affects you. VIVITROL may make you feel dizzy and sleepy.

See "What are the possible side effects of VIVITROL?"

What are the possible side effects of VIVITROL?

VIVITROL can cause serious side effects, including:

- **See "What is the most important information I should know about VIVITROL?"**

- **Depressed mood.** Sometimes this leads to suicide, or suicidal thoughts, and suicidal behavior. Tell your family members and people closest to you that you are taking VIVITROL.

You, a family member, or the people closest to you should call your healthcare provider right away if you become depressed or have any of the following symptoms of depression, especially if they are new, worse, or worry you:

- You feel sad or have crying spells.
 - You are no longer interested in seeing your friends or doing things you used to enjoy.
 - You are sleeping a lot more **or** a lot less than usual.
 - You feel hopeless or helpless.
 - You are more irritable, angry, or aggressive than usual.
 - You are more or less hungry than usual or notice a big change in your body weight.
 - You have trouble paying attention.
 - You feel tired or sleepy all the time.
 - You have thoughts about hurting yourself or ending your life.
- **Pneumonia.** Some people receiving VIVITROL treatment have had a certain type of pneumonia that is caused by an allergic reaction. If this happens to you, you may need to be treated in the hospital. Tell your healthcare provider right away if you have any of these symptoms during treatment with VIVITROL:
 - shortness of breath or wheezing
 - coughing that does not go away
- **Serious allergic reactions.** Serious allergic reactions can happen during or soon after an injection of VIVITROL. Tell your healthcare provider or get medical help right away if you have any of these symptoms of a serious allergic reaction.
 - skin rash
 - swelling of your face, eyes, mouth, or tongue
 - trouble breathing or wheezing
 - chest pain
 - feeling dizzy or faint

Common side effects of VIVITROL may include:

- nausea. Nausea may happen after your first VIVITROL injection and usually improves within a few days. Nausea is less likely with future injections of VIVITROL.
- sleepiness
- headache
- dizziness
- vomiting
- decreased appetite
- painful joints

- muscle cramps
- cold symptoms
- trouble sleeping
- toothache

Tell your healthcare provider if you have any side effect that bothers you or that does not go away.

These are not all the side effects of VIVITROL. For more information, ask your healthcare provider or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about VIVITROL

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. This Medication Guide summarizes the most important information about VIVITROL. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about VIVITROL that is written for health professionals.

For more information about VIVITROL call 1-800-848-4876, Option #1 or go to www.vivitrol.com.

What are the ingredients in VIVITROL?

Active ingredient: naltrexone

Inactive ingredients: polylactide-co-glycolide (PLG)

Diluent ingredients: carboxymethylcellulose sodium salt, polysorbate 20, sodium chloride, and water for injection

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Manufactured and marketed by:

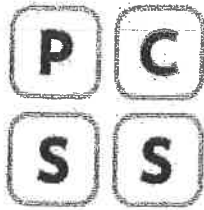
Alkermes, Inc.

852 Winter Street

Waltham, MA 02451-1420

Revised: July 2013

Alkermes® and VIVITROL® are registered trademarks of Alkermes, Inc.



TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Buprenorphine/Naloxone Maintenance Treatment Information for Patient

Buprenorphine/Naloxone Treatment for Opioid Addiction

Opioid medicines are used for three purposes: pain relief, severe coughing, and for the treatment of addiction to opioid drugs (heroin, prescription pain medicines). Buprenorphine is an opioid medication which has been used as an injection for treatment of pain while patients are hospitalized, for example for patients who have had recent surgery. It is a long acting medication, and binds for a long time to the "mif opioid receptor.

Buprenorphine/naloxone is a combination medication that can be used to treat opioid dependence (addiction). Patients only need to take the medication once daily and some will be able to take this medication less frequently (every other day or every third day). Buprenorphine is not absorbed very well orally (by swallowing) - so a sublingual (dissolve under the tongue) tablet and, more recently, a film containing the medicine that is also absorbed from under the tongue, has been developed for treatment of addiction. Buprenorphine/naloxone tablets also contain naloxone (Narcan) which is an opioid antagonist. Naloxone is poorly absorbed from under the tongue, but if the medication is injected, the naloxone will cause withdrawal symptoms. The reason that naloxone is combined with the buprenorphine is to help discourage abuse of this drug by injection.

Aside from being mixed with naloxone to discourage needle use, buprenorphine itself has a "ceiling" for narcotic effects (it is termed a "partial agonist") which makes it safer in case of overdose. This means that by itself, even in large doses, it doesn't suppress breathing to the point of death in the same way that heroin, methadone and other opioids could. These are some of the unusual qualities of this medication which make it safer to use outside of the usual strict methadone regulations at a clinic and, after stabilization, most patients would be able to take home up to one-four weeks worth of buprenorphine/naloxone at a time. However, this medicine can be dangerous and life-threatening overdose and death have occurred when buprenorphine is mixed with other drugs. It is important not to take street drugs with this medicine, not to drink alcohol to excess, and to tell your doctor that you are taking this drug so that they can be careful about prescribing other medicines with buprenorphine that might have an interaction that could be dangerous. It is up to you to make sure that you inform anyone who is prescribing medication for you of your addiction to opioids and your use of buprenorphine. Buprenorphine is also dangerous for children. It is very important that you keep this medication safely away from any children as life-threatening overdoses have occurred when children take this medicine.

Will Buprenorphine/Naloxone be useful for Patients on Methadone?

Methadone maintenance patients may be interested in whether this medication might help them. Unfortunately, because of the partial agonist nature of the medication, for some, it is not equivalent in maintenance strength to methadone. In order to even try buprenorphine/naloxone without going into major withdrawal, a methadone-maintained patient would have to taper down to 30 mg of methadone daily or lower. In some cases, buprenorphine may not be strong enough for patients used to high doses of methadone and may lead to increased cravings and the risk of a relapse to opiate use. If you are methadone-maintained and decide to try buprenorphine, please be aware of this risk, and keep the door open for resuming methadone immediately if necessary.

FOR MORE INFORMATION ABOUT MEDICATION ASSISTED TREATMENT

American Academy of Addiction Psychiatry (AAAP)

202-393-4484

www.pcssmat.org

- Web-Based Buprenorphine Training
- Live Buprenorphine Training Information
- Buprenorphine/methadone/injectable naltrexone News
- Governmental Agency Links
- CME modules and webinars

www.pcss-o.org

- Safe Opioid Prescribing
- Mentoring Program
- Phone app on safe opioid prescribing
- Treatment guidelines
- CME modules and webinars

SAMHSA

1-866-BUP-CSAT

www.buprenorphine.samhsa.gov

- Drug Addiction Treatment Act of 2000
- Physician Waiver Qualifications
- How to Request a Waiver Form
- Frequently Asked Questions
- For More Information
- Buprenorphine Trainings

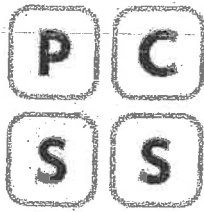
Medication Assisted Treatment

<http://www.samhsa.gov/medication-assisted-treatment>

So Remember:

- If you are offered buprenorphine (Suboxone) by a 'friend' and you are taking methadone or are addicted to heroin or prescription pain medicines, the buprenorphine in Suboxone will push the other opioids off of the receptors in your brain and you may have withdrawal and be very uncomfortable.
- If you dissolve and inject the buprenorphine/naloxone tablet or film; it may cause severe withdrawal because of the naloxone which is an opioid antagonist.
- If you are on methadone treatment and you wish to transfer to buprenorphine/naloxone (Suboxone), your dose has to be at 30 mg or less daily to switch.
- There have been deaths reported when buprenorphine is mixed with benzodiazepines (Xanax, Klonopin, Ativan, Halcion, Valium, Librium, Serax, etc). This has mainly occurred when the drugs are injected, but there is also risk in taking these drugs together in the way they are meant to be used. There is a risk of overdose when any narcotic drug is taken in combination with alcohol and/or other sedative drugs. If you drink excessively or take any of these drugs, either by prescription or on your own, buprenorphine may not be a good treatment for you.
- When you detox from opioids you lose tolerance or your ability to withstand the effects of opioids which puts you at risk for overdose. We will offer you a naloxone overdose antidote kit to provide emergency treatment should you experience an overdose.

If you have questions, ask your counselor or doctor or call the program at:



TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM

For Medication Assisted Treatment

Buprenorphine/Naloxone Maintenance Treatment Information for Opioid Dependence

Information for Family Members

Family members of patients who have been prescribed buprenorphine/naloxone for treatment of opioid addiction often have questions about this treatment.

What is an opioid?

Opioids are narcotics (medicines that are used to treat pain, cough or opioid addiction and which produce drowsiness, fuzzy thinking, and euphoria in some). Opioids are in the same family as opium, morphine, and heroin. This includes many prescription pain medications, such as Codeine, Vicodin, Lortab or Lorcet, Demerol, Dilaudid, Morphine, MSContin, Oxycontin, and Percodan or Percocet. Methadone and buprenorphine are also opioids. Buprenorphine is the opioid medicine in Buprenorphine/naloxone that treats opioid addiction

Why are opioids used to treat addiction?

Many family members wonder why doctors use buprenorphine to treat opiate addiction, since it is in the same family as heroin. Some of them ask "Isn't this substituting one addiction for another?" But the medications used to treat addiction to heroin and prescription pain medications - methadone and buprenorphine are longer-acting than other opioids like heroin and so are not "just substitution." Many medical studies since 1965 show that maintenance treatment with these long-acting opioids helps keep patients healthier, keeps them from getting into legal troubles, and helps to prevent them from getting other diseases such as Hepatitis and/or HIV/AIDS.

What is Buprenorphine/naloxone?

Buprenorphine/naloxone is a tablet or strip that combines the opioid medication, buprenorphine, and naloxone, a medication called an opioid antagonist, for treatment of opioid dependence.

Buprenorphine/naloxone is a medicine that is taken once daily by dissolving under the tongue.

Naloxone is inactive (poorly absorbed) when taken this way. However, naloxone when injected by someone whose body is physically dependent on opioids will produce opiate withdrawal. In this way, the naloxone helps to prevent abuse of buprenorphine/naloxone by injection.

What is the right dose of Buprenorphine/naloxone?

Family members of patients who have been addicted to heroin or prescription opioids have watched as their loved ones use a drug that makes them intoxicated or 'high' or have watched the painful withdrawal that occurs when the drug is not available. Sometimes the family has not seen the 'normal' person for years. They may have seen the patient misuse doctors' prescriptions for opiate narcotics to get "high". They are rightly concerned that the patient might misuse or take too much of the buprenorphine/naloxone prescribed by the doctor. They may watch the patient and notice that the patient seems drowsy, or stimulated, or restless, and think that the buprenorphine/naloxone will be just as bad as heroin or other prescription opioids that the patient is abusing.

Every opioid can have stimulating or sedating effects, especially in the first weeks of treatment. Once a patient is stabilized on the correct dose of buprenorphine, the patient should not feel "high," and there should be no excessive sleepiness or intoxication. The "right" dose of buprenorphine/naloxone is the

one that allows the patient to feel and act normally. Most patients will need 12/3 mg (buprenorphine/naloxone) to 16/4 mg of buprenorphine/naloxone daily to achieve relief of opiate withdrawal symptoms and craving. Most patients can be inducted onto the buprenorphine/naloxone and stabilized within a few days. Occasionally it may take a little longer to find the right dose (up to a few weeks). During the period of dose adjustment, the buprenorphine level in the buprenorphine/naloxone may be too high, or too low, which can lead to withdrawal, daytime sleepiness, or trouble sleeping at night. The patient may ask that family members help keep track of the timing of these symptoms, and write them down. Then the doctor can use all these clues to adjust the amount and time of day for the buprenorphine/naloxone dose.

Once the right dose is found, it is important to take it on time in a regular way (once daily), so the patient's body and brain can work well.

How can the family support good treatment?

Even though maintenance treatment for opioid addiction works very well, it is NOT a cure. This means that the patient will continue to need the stable dose of buprenorphine/naloxone, with regular monitoring by the doctor. This is similar to other chronic diseases, such as diabetes or asthma. These illnesses can be treated, but there is no permanent cure, so patients often stay on the same medication for a long time. The best way to help and support the patient is to encourage regular medical care, and encourage the patient not to skip or forget to take the medication.

- **Regular medical care**

Patients will be required to see the physician for ongoing buprenorphine/naloxone treatment at least every two to four weeks, once they are stable. If they miss an appointment, they may not be able to refill the medication on time, and may even go into withdrawal, which could be uncomfortable. The patient will be asked to bring the medication container to each visit, and may be asked to give urine, blood or breath samples at the time of the visit. Sometimes the patient may be called in randomly to have their pills counted and/or to give a urine sample to test for the presence of other drugs or alcohol. This is a regular part of drug abuse treatment and is done for the patient's safety and to make sure that they are getting the treatment needed.

- **Special Medical Care**

Some patients may also need care for other needle-related problems, such as hepatitis or HIV disease. They may need to go for blood tests or see several physicians for these illnesses.

- **Counseling**

Patients who are recovering from addiction need counseling and other psychosocial treatments. The patient may have regular appointments with an individual counselor or be involved in group therapy. These appointments are key parts of treatment, and work together with the buprenorphine/naloxone to improve success in treatment for addiction. Sometimes family members may be asked to join in family therapy sessions which also are geared to improve addiction care.

- **Meetings**

Most patients use some kind of recovery group to maintain their sobriety. It sometimes takes several visits to different groups to find the right "home" meeting. In the first year of recovery some patients go to meetings every day, or several times per week. These meetings work to improve success in treatment, in addition to taking buprenorphine/naloxone. Family members may have their own meetings, such as Al-Anon, or ACA, to support them in adjusting to life with a patient who has addiction.

- **Taking the medication**

Buprenorphine/naloxone medication is unusual because it must be dissolved under the tongue, rather than swallowed. Please be aware that this can take up to a few minutes. While the medication is dissolving, the patient will not be able to answer the phone, or the doorbell, or speak very easily. This means that the family will need to get used to the patient being "out of commission" for a few minutes whenever the regular dose is scheduled.

- **Storing the medication**

If buprenorphine/naloxone is lost or misplaced, the patient may skip doses or go into withdrawal, so it is very important to find a good place to keep the medication safely at home preferably in a locked cabinet or lock box - away from children or pets who can become seriously ill or even die if they accidentally take this medication. Always keep the medicine in the same location, so it can be easily found. The doctor may give the patient a few "backup" pills, in a separate bottle, in case an appointment has to be rescheduled, or there is an emergency of some kind. DO NOT put the buprenorphine/naloxone next to the vitamins, or the aspirin, or other over-the-counter medications, to avoid confusion. If a family member or visitor takes buprenorphine/naloxone by mistake, he or she should be checked by a physician or taken to an emergency department immediately as serious adverse reactions can occur if someone who does not usually take this medicine were to take it by mistake.

What does buprenorphine/naloxone treatment mean to the family?

It is hard for any family when a member finds out he or she has a disease that is not curable. This is true for addiction as well. When chronic diseases go untreated, they have severe complications which can lead to disability and death. Fortunately, buprenorphine/naloxone maintenance can be a successful treatment, especially if it is integrated with counseling and support for life changes that the patient has to make to remain sober.

Chronic disease means the disease is there every day, and must be treated every day. This takes time and attention away from other things, and family members may resent the effort and time and money that it takes for buprenorphine/naloxone treatment and counseling. It might help to compare addiction to other chronic diseases, like diabetes or high blood pressure. After all, it takes time to make appointments to go to the doctor for blood pressure checks, and it may annoy the family if the food has to be low in cholesterol, or unsalted. Most families can adjust to these changes when they consider that it may prevent a heart attack or a stroke for their loved one.

Another very important issue for family members to know about is that addiction can be partly inherited. Research is showing that some persons have more risk for becoming addicted than others and that some of this risk is genetic. So when one member develops opioid addiction, it means that other blood relatives should consider themselves "at risk" of developing addiction. It is especially important for young people to know that alcohol or drugs at parties might be dangerous for them, even more than for most of their friends.

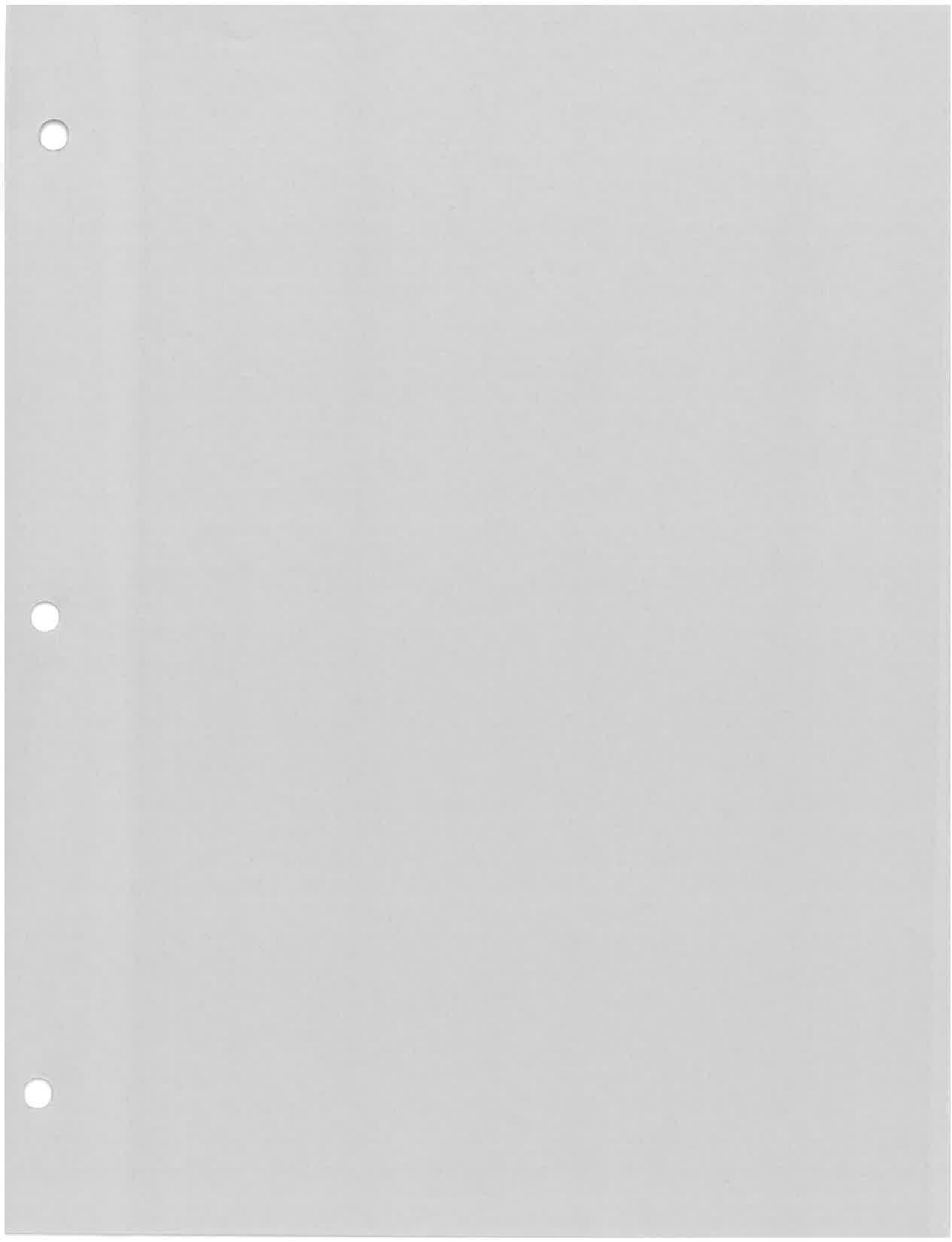
It is common for people to think of addiction as a weakness in character, instead of as a disease. Perhaps the first few times the person used drugs it was poor judgment. However, by the time the patient is addicted, using every day, and needing medical treatment, it should be considered to be a "brain disease" rather than a problem with willpower.

Sometimes when the patient improves and starts feeling normal, the family has to get used to the new "normal" person. The family interactions might have been all about trying to help this person in trouble, and now he or she is no longer in so much trouble. Some families can use some help themselves during this change and might ask for family therapy for a while.

In summary:

Family support can be very helpful to patients on buprenorphine/naloxone treatment. It helps if the family members understand how addiction is a chronic disease that requires ongoing care. It also helps if the family gets to know about how the medication works and how it should be stored at home to keep it safe. Family life might have to change to allow time and effort for "recovery work" in addiction treatment. Sometimes family members themselves can benefit from therapy.

Buprenorphine/naloxone (Buprenorphine/naloxone) Maintenance Treatment/Family Information Guide
Revised 09/25/10



STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE - 033

SUBSECTION EFFECTIVE DATE

02/10/2017

POLICY/PROCEDURE

Obtaining Informed Consent for Patient-Related Communications

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

Patient privacy will always be respected at the COE. Sharing of information with other clinicians/providers outside of the COE or its QSOs will only occur with informed consent of the patient and completion of a 42 CFR compliant Release of Information.

PROCEDURE

When patients are admitted to the COE, Releases of Information should be obtained in order to facilitate communication with significant others and/or treatment providers outside of the COE. In an ongoing manner, additional releases should be sought if, during the course of treatment, it becomes clear that information is needed from an outside person/agency to facilitate clinical care of the patient.

A release of information must also be obtained in order for any information about the patient's course of treatment in the COE to be released. Completed releases must be kept in the patient's medical record.

PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, (NAME OF PATIENT) authorize

(NAME OR GENERAL DESIGNATION OF PROGRAM
MAKING DISCLOSURE) to disclose to: _____ (NAME OF
PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE) the following
information:

(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE):

e.g.: my attendance and compliance in substance abuse treatment

The purpose of the disclosure authorized herein is to:

(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing
Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be
disclosed without my written consent unless otherwise provided for in the regulations. I also
understand that I may revoke this consent at any time except to the extent that action has been
taken in reliance on it, and that in any event this consent expires automatically as follows:

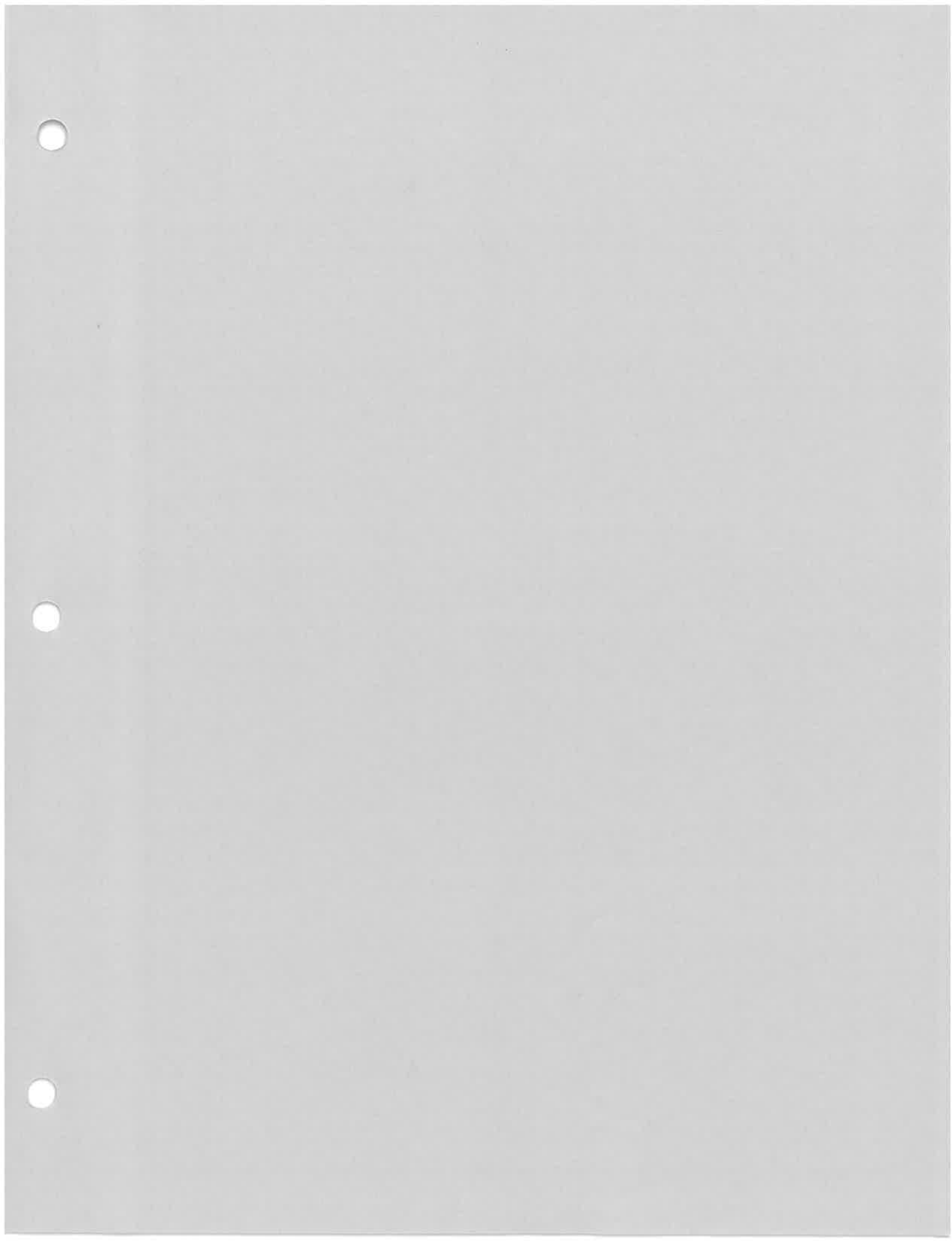
_____ or upon program discharge (SPECIFICATION OF THE DATE, EVENT,
OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

(Print Name) (Signature of Participant)

(Date)

DOB:

(Print Name) (Signature of Parent, Guardian or Authorized Rep. when required) (Date)



STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE - 034

SUBSECTION EFFECTIVE DATE

02/10/2017

POLICY/PROCEDURE

Patient Satisfaction Survey

AMENDMENT / REVISION HISTORY

Approved:

Amended:

POLICY

All patients at the COE will be asked to complete a Patient Satisfaction Survey after 2 months of treatment at the COE and again at discharge.

PROCEDURE

The Case Manager will request that patients complete a Satisfaction Survey at the time of completion of two months of treatment and at discharge. It should be explained to patients that this is a mechanism by which we try to improve the services offered at the program and we appreciate any feedback they wish to give us to help us to do a better job with our services.

**DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL
DISABILITIES AND HOSPITALS CENTER OF EXCELLENCE**

PATIENT SATISFACTION SURVEY

1. How would you rate the services you have received from the Center of Excellence?

- Excellent Good Fair Poor

2. Did you receive the type of service that you wanted?

- Yes, definitely. Yes, in general. No, not really. No, definitely not.

3. Has our program met your recovery needs?

- Yes, all (or almost all) of my needs were met. Most of my needs were met.
 A few of my needs were met. None of my needs were met.

4. If a family member or friend was in need of similar help, would you recommend our program to them?

- Yes, definitely. Yes, probably. No, probably not. No, definitely not.

5. How satisfied are you with the amount of help you received at the Center of Excellence?

- Very satisfied Mostly satisfied Not very satisfied Very dissatisfied

6. Have the COE's services helped you deal more effectively with your alcohol/drug problem (s)?

- Yes, very much. Yes, somewhat. No, not very. No, things are worse now.

7. In general, how satisfied are you with the services you received?

- Very satisfied Mostly satisfied Not very satisfied Very dissatisfied

8. In general, how satisfied are you with the comfort and cleanliness of our facility?

- Very satisfied Mostly satisfied Not very satisfied Very dissatisfied

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL
DISABILITIES AND HOSPITALS CENTER OF EXCELLENCE

9. Have our staff, including the receptionist/secretary, made you feel comfortable?

- Yes, definitely. Yes, mostly. No, not all the time. No, definitely not.

10. If you were to seek help again, would you come back to our facility?

- Yes, definitely. Yes, probably. No, I doubt it. No, definitely not.

11. Do you feel the services you received were non-discriminatory to your racial and/or ethnic background?

- Yes, definitely. Yes, mostly. No, not all the time. No, definitely not.

12. Do you feel that the services you received were sensitive to your preferred gender and sexuality?

- Yes, definitely. Yes, mostly. No, not all the time. No, definitely not.

Please provide the Center of Excellence with any additional comments that may assist us in better serving our patients: