NAADAC'S LIFE-LONG LEARNING SERIES

Medication-Assisted Recovery: What Every Addiction Professional Needs to Know

presented by

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
www.naadac.org
Workshop Objectives

1) Participants will learn how substance use disorders develop in the brain and how this scientific research corresponds to pharmacotherapy.

2) Participants will learn about the current FDA-approved pharmacotherapies for alcohol and opioid dependence.

3) Participants will be able to introduce pharmacotherapy as a treatment option for clients at each Stage of Change.
The purpose of today’s educational webinar is to provide addiction and other helping professionals with *useful, unbiased information concerning pharmacotherapies* so your clients are afforded the best available resources and options for their treatment.

Not all clients will be best treated with pharmacotherapy, and most certainly, some of them will.
Section One:
Current Climate of Pharmacotherapy and Addiction Treatment
Prevalence of Substance Use Disorders

- In 2009, 22.5 million people aged 12 or older were either abusing or dependent on one or more substances, which is 8.9% of the general population.

- Of those people, 18.7 million were abusing alcohol and more than 2.2 million were abusing opioids.
  - 1,854,000 abused pain relievers.
  - 399,000 abused heroin.

Source: 2009 National Survey on Drug Use and Health
In 2009, only 4.3 million people aged 12 or older received treatment for drugs or alcohol. (2.6 million in a specialty facility)

Source: 2009 National Survey on Drug Use and Health

Prevalence of Opioid Dependence Treatment

- Alcohol: 2,894
- Marijuana: 1,243
- Cocaine: 787
- Pain Relievers: 739
- Stimulants: 517
- Heroin: 507
- Hallucinogens: 443
- Tranquilizers: 421

**Opioid Total**

739,000
+ 507,000
= 1,246,000
Relapse is Prevalent

Traditional evidence-based therapeutic approaches are highly effective.

BUT with a relapse rate of 40 to 60 percent within the first 12 months of completing addiction treatment, more interventions are required.

Over the past decade, the treatment of substance use disorders has entered into a new phase in which medications can play a vital role in helping someone recover.
Medication-Assisted Recovery

As we have learned more about brain chemistry and how addiction develops, more sophisticated pharmacological interventions have become available.

- NAADAC feels it is important for addiction counselors to be as familiar with pharmacotherapies as possible.

- Often, counselors see the client the most and are in the best position to recognize danger signs, abnormal side effects and to monitor compliance.

- The time is upon addiction professionals to educate themselves to provide the best evidence-based practices available to their clients.
Medication-Assisted Recovery

- Medications are a part of treatment, but only one part.

- Medications should always be used in conjunction with bio-psycho-social-spiritual therapy.

- Medications support the therapeutic process. Modern science has identified several changes that take place in a dependent’s brain. These changes do not instantaneously correct themselves after a client stops drinking/using. The client can think more clearly without so many physiological distractions taking away from counseling objectives.

- We are familiar with the use of medications in the treatment of many diseases, including substance use disorders.

- To reflect current terminology, “medications” are available by prescription and are used to treat an illness, disorder or disease; whereas, “drugs” are illicit psychoactive substances that are used to achieve a high.
The goal of addiction treatment is always to assist a client in stopping the compulsive use of drugs or alcohol and progress to living a normal, functional life.

Addiction creates a host of negative effects to the dependent client, his or her family and friends and society as a whole.

When considering medication management, the risk of continued use, the possible side effects and the benefits of the medication must be discussed.
Medication-Assisted Recovery

- The single most accurate predictor of successful treatment outcome is the length of time in treatment. Pharmacotherapies can:
  - help clients remain in treatment longer
  - achieve complete abstinence
  - help prevent relapse
  - reduce frequency and amount of consumption
  - help them continue to stay committed to meeting their treatment goals and maintain long-term recovery.

- Pharmacotherapies are effective. Clinical data suggest that clients perform better in treatment when psycho-social-educational-spiritual therapy is combined with appropriate pharmacotherapies.

- Medications can serve as a tool to initiate treatment.
Medication-Assisted Recovery

- Clients are now able to view and hear advertisements concerning new medications available via the Internet, television, print and radio. They can even request their own prescriptions from their doctor without consulting with their counselor.

- SAMHSA, NIAAA and NIDA all recommend that counselors and prescribers consider using medications to help treat alcohol and opioid dependence.

- Medications are not appropriate for everyone. Some may prove beneficial to your clients and some may not; however, every medication discussed in today’s webinar will be beneficial to someone, perhaps even just one particular client.
When developing a treatment plan for a client that may or may not include pharmacotherapies, consider the following:

- Information gained during the assessment
- Role of the prescriber
- Fits with the client
- Current level and type of substance abuse
- Treatment compliance
- Current medications
- Ability to pay
Section Two: Addiction is a Brain Disease
Four Legs of Addiction

Substance use disorders consists of four equally important facets, but often, special attention is given to one or more of these areas, but not all.

All four legs of the chair are required to “support” the client, and if one leg is missing, the chair will be unstable and unable to accomplish its goal.
Holistic Treatment

Treatment is most successful when the services are comprehensive.

Comprehensive and effective treatment should visually resemble the following diagram:

Substance Use Disorders are Diseases

Substance use disorders are brain diseases mostly characterized by a person’s inability to control his or her thoughts or intake of a substance.

A substance use disorder develops after a substance is repetitively consumed and the brain readjusts to its consistent presence.

Research shows that adaptations in neuronal functioning occur regardless of whether a person is taking legitimate medication for pain relief, consuming five beers as a first time drinker or injecting heroin on the streets.
Modern medicine, sound research techniques and sophisticated brain imaging technology have solidified two main facts to support the idea that all addictions are diseases:

1. A definitive and unique pattern of behavioral and physiological symptoms has been identified for substance use disorders.

2. A definitive and unique pattern of neurobiological adaptations that take place in the brain has been identified for substance use disorders.
Clinical Symptoms of Substance Use Disorders

1. A definitive and unique pattern of behavioral and physiological symptoms has been identified for alcohol dependence.

Substance use disorders manifests themselves similarly in most people and have a predictable series of symptoms.

Classifications in both the *DSM-V* and *ICD-10* mark substance use disorders as diseases that contain:

- craving
- tolerance
- loss of control
- physical dependence
Neurobiological Adaptations

2. A definitive and unique pattern of neurobiological adaptations that take place in the brain has been identified for substance use disorders.

Decades of research and brain imaging technology allow us to visually identify the impact substances have on the brain and its functioning.

- Autopsies and PET analysis reveal that alcohol dependents have smaller brains than their non-alcohol dependent counterparts.
Section Three:
FDA-Approved Pharmacotherapies for Alcohol and Opioid Dependence
FDA-Approved Pharmacotherapies

Alcohol Dependence

1951 Antabuse® (disulfiram)
1994 ReVia®/Depade® (naltrexone)
2004 Vivitrol® (naltrexone for extended-release injectable suspension)
2006

Opioid Dependence

1964 Methadose®/Dolophine® (methadone)
1984 ReVia®/Depade® (naltrexone)
1993 LAAM
2002 Subutex®/Suboxone® (buprenorphine)
2010

Campral® (acamprosate)

Vivitrol® (naltrexone for extended-release injectable suspension)
Disulfiram General Facts

- **Generic Name:** disulfiram
- **Marketed As:** Antabuse®
- **Purpose:** Discourages drinking by making the client physically sick when alcohol is consumed.
- **Is it being used?:** Not as much as it used to be; there are interactions with many everyday products; compliance is a concern.
**Disulfiram Administration**

Amount: one tablet  
Method: mouth  
Frequency: once a day

Can be crushed, diluted or mixed with food.

Abstinence Requirements: must be taken at least 12 hours after last consumption of alcohol

Contraindications: use of alcohol; coronary artery disease; liver disease; & severe myocardial disease
How Does Disulfiram Work?

Disulfiram works by blocking the oxidation of alcohol.

Alcohol is broken down naturally in the body by a series of enzymes.

Disulfiram blocks one of these enzymes from working, causing a build-up of acetaldehyde.

Acetaldehyde is poisonous, and a build-up produces a series of effects.
How Does Disulfiram Work?

- throbbing in head and neck
- brief loss of consciousness
- throbbing headache
- lowered blood pressure
- difficulty breathing
- marked uneasiness
- copious vomiting
- nausea
- flushing
- sweating
- thirst
- weakness
- chest pain
- dizziness
- palpitation
- hyperventilation
- rapid heartbeat
- blurred vision
- confusion
- respiratory depression
- cardiovascular collapse
- myocardial infarction
- acute congestive failure
- unconsciousness
- convulsions
- death
Acamprosate General Facts

- **Generic Name:**
  acamprosate calcium

- **Marketed As:**
  Campral®

- **Purpose:**
  encourages sobriety by reducing post-acute withdrawal symptoms from alcohol dependence

- **Indication:**
  For the maintenance of abstinence from alcohol in clients with alcohol dependence who are abstinent at treatment initiation.
Acamprosate Administration

Amount: 2 tablets
Method: mouth
Frequency: three times a day

CanNOT be crushed or diluted, but can be mixed with food.

- Contraindications: severe renal impairment (creatinine clearance of ≤ 30 mL/min)
- Risk of Overdose: extremely remote, with the most severe side effect being diarrhea
Acamprosate Administration

- **Populations:**
  18 to 65 years old; not tested for other populations

- **Pregnancy:**
  Category C

- **Addictive Properties:**
  Has not been found to be addictive; no reports of deviation during the clinical trials

- **Recommended Length of Treatment:**
  Approved by the FDA for use up to one year
How Does Acamprosate Work?

There is an increase in GABA, a major inhibitory neurotransmitter (−), which overrides the excitatory signals (+) of glutamate neurotransmitters.

Because there are more inhibitory (−) signals than excitatory (+), the body generally slows down.

This makes sense -

Question: What are the side effects of alcohol use?

Answer: slurred speech, incoordination, confusion, drowsiness, impaired judgment
How Does Acamprosate Work?

Since excitatory glutamate signals (+) are overridden by inhibitory GABA signals (-), glutamate is not able to activate the NMDA receptors (glutamate receptors) as it usually does.

As a result, the NMDA receptors (glutamate receptors) respond by multiplying in hopes of receiving more activity since there are more of them to be activated.

This process is called upregulation.
How Does Acamprosate Work?

This method of upregulation works and the imbalance is corrected.

More alcohol is required to feel the same level of intoxication (tolerance).
How Does Acamprosate Work?

What happens when alcohol is not present:

1. Glutamate (+) behaves normally.

2. But there are more NMDA receptors due to upregulation, so there is more glutamate activity (+) than normal.

3. The normal balance between inhibitory and excitatory is altered, resulting in alcohol withdrawal.
How Does Acamprosate Work?

Symptoms such as...

- hallucinations
- dysphoria
- tremors/seizures
- mood disturbances
- insomnia
- anxiety

...can become a powerful motive for people to resume their drinking.

Mechanism of Action: glutamate receptor modulator
How Does Acamprosate Work?

- reduces glutamate activity by “monitoring” the amount of glutamate that can react at the NMDA receptors
- limits the amount of glutamate released by the neuron

Pre-Synaptic Neuron

Post-Synaptic Neuron

A = acamprosate

NMDA Receptor

= Glutamate

NAADAC’S Life-Long Learning Series presents Medication-Assisted Recovery: What Every Addiction Professional Needs to Know
**Results:** In all three studies, participants treated with acamprosate were able to maintain complete abstinence more frequently than those treated with placebo.
Scientific Research about Acamprosate

**Results:** In all three studies, participants treated with acamprosate had a greater reduction in the number of drinking days during the entire study than those treated with placebo.
Results: In all three studies, participants treated with acamprosate were able to regain complete abstinence after one relapse more frequently than those treated with placebo.
Naltrexone General Facts

- **Generic Name:** naltrexone hydrochloride
- **Marketed As:** ReVia® and Depade®
- **Purpose**
  1. To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol;
  2. To discourage opioid consumption by blocking opioid receptors

  - **Amount:** 1 tablet
  - **Method:** mouth
  - **Frequency:** once a day

**Abstinence requirements:** must be taken at least 7-10 days after last consumption of opioids; abstinence from alcohol is not required
Extended-Release Naltrexone General Facts

- **Generic Name:**
  naltrexone for extended-release injectable suspension

- **Marketed As:**
  Vivitrol®

- **Purpose:**
  (1) To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol; (2) to discourage opioid consumption by blocking opioid receptors

- **Abstinence requirements:**
  Must be taken at least 7-10 days after last consumption of opioids; must not be actively drinking at time of administration
Extended-Release Naltrexone Administration

Amount: one 380mg injection
Method: deep muscle in the buttock
Frequency: every 4 weeks

Must be administered by a healthcare professional and should alternate buttocks each month.

Should not be administered intravenously.

Risk of Overdose: unlikely; risk of overdose is dramatically decreased due to the fact that it has to be administered by a healthcare professional, and it is not released to the individual.
Extended-Release Naltrexone Administration

- **Addictive Properties:**
  Has not been found to be addictive; no reports of misuse during clinical trials.

- **Recommended Length of Treatment:**
  The FDA has not limited the amount of time a client can be prescribed extended-release naltrexone.

- **Populations:**
  18 to 65 years old; not tested for other populations

- **Pregnancy:**
  Category C
There is an increase in opioid activity in the arcuate nucleus, and then dopamine activity in the nucleus accumbens and the ventral tegmental area (VTA).

Dopamine in these areas makes us feel good, and we remember it!
How Does Naltrexone Work? - Alcohol

Now, you might be thinking...

“What would happen if we were able to simply reduce the effects of dopamine and then perhaps drinking alcohol would not feel as good?”

This is exactly what scientists have been working on for decades and fortunately, we have two medication formulations that address this exact issue.
Naltrexone is an opioid receptor antagonist and blocks opioid receptors.

By blocking opioid receptors, the “reward” and acute reinforcing effects from dopamine are diminished, and alcohol consumption is reduced.
How Does Naltrexone Work? - Opioids

There is an increase in opioid stimulation in the nucleus accumbens and the ventral tegmental area (VTA), and dopamine is released.

Dopamine in these areas makes us feel good, and we remember it!
Naltrexone is an opioid receptor antagonist and blocks opioid receptors when opioids are consumed.

1) Sits on the receptor and blocks activity

2) Diminishes the “reward” and acute reinforcing effects from dopamine
How Does Naltrexone Work?

How often do you feel your clients take their prescribed medication when it is not administered by a treatment provider?

- 100% of the time
- 99% to 75% of the time
- 74% to 50% of the time
- 49% to 50% of the time
- 24% to 0% of the time

Which pharmacotherapy do you think has the highest compliance rates for taking the medication as prescribed?

- acamprosate
- disulfiram
- naltrexone
- extended-release naltrexone
Scientific Research about Extended-Release Naltrexone

Clinical trials results:

- Patients treated with extended-release naltrexone had significantly greater reductions in heavy drinking days (3.1 days) during the entire study than those treated with placebo (6.0 days).

- Patients with a seven-day abstinence period prior to treatment initiation had even significantly greater reductions in the number of heavy drinking days (0.2 days) during the entire study than those treated with placebo (2.5 days).

  - Significantly more patients (36%) were able to maintain complete abstinence from opioids than those who were injected a placebo (23%).

  - Significantly more patients being treated with extended-release naltrexone remained in the study/treatment than those treated with placebo.
Methadone General Facts

- **Generic Name:** methadone hydrochloride
- **Marketed As:** Methadose® and Dolophine® (among others)
- **Purpose:** To discourage illicit opioid use due to cravings or the desire to alleviate opioid withdrawal symptoms.
- **Class:** agonist

  - **Amount:** maintenance dose of 80 to 120mg
  - **Method:** mouth
  - **Frequency:** once a day

- **Abstinence requirements:** must be abstinent from opioids long enough to experience mild to moderate opioid withdrawal symptoms.
Buprenorphine General Facts

- **Generic Name:** buprenorphine hydrochloride
- **Marketed As:** Subutex® and Suboxone®
- **Purpose:** To discourage illicit opioid use due to cravings or the desire to alleviate opioid withdrawal symptoms.
- **Class:** partial agonist
Abstinence requirements: Client needs to be abstinent from opioids long enough to experience mild to moderate opioid withdrawal symptoms.

Both Subutex and Suboxone are administered as a single film or tablet dose sublingually in a range of 4mg to 24mg per day.

Tablets or film should be placed under the tongue until they are completely dissolved.
**How Does Buprenorphine Work?**

**Agonists** activate the opioid receptors. - A key that fits into a lock, turns it and opens the door all the way.

**Partial agonists** can fit the lock and turn, but the door only opens half way.

**Antagonists** bind to the receptor but, unlike agonists, they do not activate it. - A key that fits into the lock but is not able to unlock it. Instead, it simply sits in the lock and prevents any other key from unlocking the door and activating the receptor.
How Does Buprenorphine Work?

- **Opiate Effect**
  - Full Agonist (methadone, heroin, oxycodone)
  - Partial Agonist (buprenorphine)
  - Antagonist (naloxone, naltrexone)

- **Dose of Opiate**

- **Death**
How Does Buprenorphine Work?

Buprenorphine works in two ways:

1) Prevents opioid withdrawal symptoms by providing mild agonist effects.

2) Occupies opioid receptors so illicit opioids will have no effect.
How Does Buprenorphine Work?

Think of buprenorphine as the “schoolyard bully” and a guard at the same time.

If a client has recently consumed opioids, such as heroin, when a high dose of buprenorphine is taken, the heroin that has bonded to opioid receptors is “kicked off” and replaced with buprenorphine.

Further, if an opioid dependent client consumes opioids while buprenorphine is in their system, the illicit opioids are unable to bind to the receptors, and the dependent will not experience the desired effects.
How Does Buprenorphine Work?

- Even though buprenorphine has a short half-life, it has a long duration of action.

- Besides half-life, the duration of action of a substance is also determined by receptor affinity, meaning the strength with which a substance binds to a receptor.

- Buprenorphine has a very high affinity for opioid receptors, and it will continue to occupy the receptors for 24 to 72 hours, depending on the administered dose.
Buprenorphine is considered a safe option available for medication-assisted treatment for opioid dependence for two reasons:

1) Buprenorphine’s agonist effects level off as the dose increases, making it difficult for clients to overdose. This phenomenon is referred to as the “ceiling effect.”

The characteristic of opioid agonists that is the most dangerous to the consumer is the potential side effect of life-threatening respiratory suppression as the dose increases. Respiratory suppression with buprenorphine is kept to a minimum and does not increase with dose.
2) Buprenorphine is available in the United States in two different preparations:

- **Subutex** - contains only buprenorphine

- **Suboxone** - contains both buprenorphine and naloxone

Suboxone is the preferred method of buprenorphine treatment because it deters clients from using the medication inappropriately or selling it illicitly.
Safety Profile

- Naloxone is an opioid receptor antagonist that is commonly used to help revive clients who have an opioid overdose by “kicking off” any opioids that are occupying opioid receptors.

- Since naloxone is not as easily absorbed through the oral tissues, a sublingual dose of Suboxone will provide a full dose of buprenorphine and only a small, non-effective dose of naloxone.

- If Suboxone is administered intravenously, the naloxone will override the effects of buprenorphine and the opioid dependent client will experience full-blown withdrawal symptoms.
Dosage Instructions for Buprenorphine

There are four phases associated with medication-assisted recovery for opioid dependence:

- induction
- stabilization
- maintenance
- medically-assisted withdrawal
Buprenorphine General Facts

- **Populations:**
  16 to 65 years old; not tested for other populations

- **Pregnancy:**
  Category C

- **Addictive Properties:**
  Chronic administration produces physical dependence; has a high abuse liability and does produce withdrawal symptoms when the medication is ceased abruptly or tapered down too quickly.

  Because of buprenorphine’s mechanism of action and the preparation of Suboxone, the potential for abuse is drastically reduced.
**Scientific Research about Buprenorphine**

**Results:** Participants treated with a high dose of buprenorphine consumed opioids significantly less than participants treated with 1mg of buprenorphine.

* The 8mg and 16mg groups were statistically significant from the 1mg group.
Without question, medication interventions are extremely effective and beneficial to the client in early, as well as long-term, recovery.

However, it is imperative that pharmacotherapies are matched with some form of evidence-based therapeutic counseling to elicit sustained behavior change.
Section Four: Incorporating Pharmacotherapies into Treatment
Assessing Readiness to Change

When an addiction professional first interacts with a substance dependent client, the client may not be ready to stop using illicit drugs and/or alcohol.

Even clients expressing the desire to stop using will have ambivalent feelings about the change process.

In order for clients to experience sustained behavior change, they must voluntarily desire for their lives to be different.
Typically, people change voluntarily only when...

- ...they become interested in or concerned about the need for change

- ...they become convinced that the change is in their best interests or will benefit them more than cost them

- ...they organize a plan of action that they are committed to implementing

- ...they take the actions that are necessary to make the change and sustain the change
Assessing Readiness to Change

However, clients enter treatment at varying stages of readiness for treatment and openness to counseling. Some are eager, and some are looking for the door as soon as they sign in.

And experience has shown that some treatment interventions are better suited for particular types of clients, while others are best used at specific time periods during the treatment process.
The Stages of Change Model identifies six independent stages of behavior and thinking that clients can experience during the treatment process.

By identifying which stage of change a client is currently in, addiction professionals can better understand the treatment needs of that client and which treatment options are most appropriate.
Stages of Change Model

- **Precontemplation** - The client is not ready to change. He has little or no thought or interest in changing the behavior.

- **Contemplation** - The client is thinking about change. He is assessing the risks and benefits of changing.

- **Preparation** - The client is ready to change. He is getting ready to make the change and tests the waters by creating a plan of action.

- **Action** - The client is making the change and is incorporating the action plan.

- **Maintenance** - The client is sustaining the change. They continue the action plan until the change has been integrated into the client's lifestyle.

- **Relapse** - The client slips back into previous behavior. He must reenter the cycle of change at a point that is appropriate given the new level of readiness to change.
“In a representative sample across more than fifteen high-risk behaviors, it was found that fewer than 20% of a problem population are prepared for action at any given time. And yet, more than 90% of behavior change programs are designed with this 20% of the population in mind.”

- Prochaska, Norcross and DiClemente, 1994
Why Don’t People Change?

- They are not convinced of the problem or the need for change — *unmotivated*

- They are not committed to making a change — *unwilling*

- They do not have an actual or perceived ability to make a change — *unable*
Motivation, willingness and ability to change all belong to the client.

The tasks of the counselor is to help the client find the internal motivation to change, make the decision to change and take the action needed to travel the road of recovery.

Pharmacotherapies can help with this.
## Stages of Change Model

<table>
<thead>
<tr>
<th>Stage</th>
<th>What is the patient feeling/doing?</th>
<th>What can the counselor do?</th>
<th>Are medications appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>not ready to change - the patient has little or no thought or interest in changing the behavior</td>
<td>raise ambivalence – increase the patient’s perception of risks and problems with current behavior</td>
<td>if the patient does not believe that they have a problem with alcohol then they probably will not be open to taking medication; however, knowing there are medications that could help may create an interest in treatment and offer hope</td>
</tr>
<tr>
<td>Contemplation</td>
<td>thinking about change - the risks and benefits of change are assessed by the patient</td>
<td>tip the decisional balance – evoke reasons for change and risks of not changing; strengthen the patient’s self-efficacy for behavior change</td>
<td>could promote the consideration of possible sobriety and support the notion that change is possible; patients can view medications as another tool to help them achieve their goals</td>
</tr>
<tr>
<td>Preparation</td>
<td>getting ready to make change - the patient gets ready to change and tests the waters by creating a plan of action</td>
<td>help the patient to determine the best course of action to take in seeking change; develop a plan</td>
<td>can be a part of a patient’s individualized treatment plan; schedule and regimen can promote the patient’s commitment to the plan and set a timeframe for initiating the plan</td>
</tr>
</tbody>
</table>
# Stages of Change Model

<table>
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<tbody>
<tr>
<td>action</td>
<td>making the change – the patient makes steps to change</td>
<td>help the patient implement the plan; use skills; problem-solve; support self-efficacy</td>
<td>positive effects from medication can reinforce initial success of treatment; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
<tr>
<td>maintenance</td>
<td>sustaining the change – the patient continues the action plan until change has been integrated into the patient’s lifestyle</td>
<td>help the patient identify and use strategies to prevent relapse; resolve associated problems</td>
<td>can prevent relapse; can support stabilization and resolution of other problems during psychosocial therapy sessions; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
<tr>
<td>relapse</td>
<td>slipping back into previous behavior – the patient goes back to the behavior and must reenter the cycle of change</td>
<td>help the patient recycle through the stages of contemplation, preparation and action, without becoming stuck or demoralized because of relapse and identify the triggers leading to relapse</td>
<td>can support the patient’s commitment to change; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
</tbody>
</table>
RECAP: How Can Pharmacotherapy Interact with the Change Process?

- **Precontemplation** – offer hope, create interest
- **Contemplation** – influence pros for change, sobriety sampling, support efficacy
- **Preparation** – choice and commitment, part of comprehensive plan, set date
- **Action** – support initial success, reduce initial physical reactions, reduce craving
  - **Maintenance** – prevent relapse, support stabilization and resolution of other problems
Additional Resources:
www.naadac.org/education

Pharmacotherapy: Integrating New Tools into Practice

New Innovations with Opioid Treatment: Buprenorphine

Medication Management for Addiction Professionals: Campral Series

Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy

New Horizons: Integrating Motivational Styles, Strategies and Skills with Pharmacotherapy

www.naadac.org/education
Thank You for Participating!

Feel free to ask questions.

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