Dear Reader,

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

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

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

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

Sincerely,

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

Your bravery and perseverance are the inspiration for this book.

ACKNOWLEDGMENTS

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

www.truenorthmedical.com
What is Suboxone®?

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

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

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

Figure 1. Opioid Dependence Causes Changes in the Brain

Non-Opioid-Dependent and Opioid-Dependent Brain Images

The lack of red in the opioid-dependent brain shows that long-term opioid use reduces dopamine receptor concentrations in the brain. Low dopamine receptor levels impair a variety of neurological processes including pleasure, motivation, memory and learning.

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

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

Figure 2. Similarities to Other Chronic Diseases

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Drug Dependence</th>
<th>Diabetes, Asthma, and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well studied</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Chronic disorder</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Predictable course</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Effective treatments</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Heritable</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires continued care</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires adherence to treatment</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Requires ongoing monitoring</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Influenced by behaviour</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Tends to worsen if untreated</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>


How can someone know if they are opioid dependent?

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

Image 1. The 6 C’s

1. **LOST CONTROL**
   Opioids are taken in larger amounts or over a longer period than intended.

2. **CRAVINGS**
   There is a strong and constant desire for opioids.

3. **UNABLE TO CUT DOWN**
   Unsuccessful efforts to cut down or control opioid use.

4. **COMPULSIVE USE**
   A great deal of time is spent in activities necessary to obtain opioids, use opioids, or recover from opioids.

5. **PHYSICAL AND SOCIAL CONSEQUENCES**
   Important social, occupational, or recreational activities are given up or reduced because of opioid use.

6. **CONTINUED USE DESPITE HARM**
   Continued use of opioids despite knowledge of having a physical or mental problem that won’t go away and that is likely to have been caused or made worse by the opioid (for example, continuing to use opioids despite severe side effects or a dangerously high dosage).
Why do people find it so hard to stop using opioids?

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

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

Image 2. Opioid Dependence Causes Changes in the Brain

Cortex
(complex mental tasks, like math)

Thalamus
(unconscious activities)

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

No

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

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

How can Suboxone® help people with opioid dependence?

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

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

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

**“HIGH AFFINITY” for the opioid receptor**

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

In the course of recovery from opioid dependence, many people relapse (start using opioids again) at some point and consume an opioid that is not part of their treatment program. If a person relapses while taking buprenorphine, the opioids cannot reach the opioid receptor. It is important to understand, while Suboxone® reduces the risk of opioid overdose in the event of a relapse, that does not mean the risk is zero, especially if opioids are combined with other drugs or alcohol.
This means that there is far less euphoria or “high” with the relapse. This lack of euphoria helps reduce the risk of further relapse. Also, because the opioids have trouble getting to the receptor during relapse, it reduces the risk of accidental overdose or death during relapses.

Figure 3. Buprenorphine Blocks Opioid Receptors

As therapy begins:
1. A person is in a mild-to-moderate state of withdrawal (-) as the opioid of dependence begins to leave the receptors.
2. Buprenorphine attaches to receptors as the other opioid leaves the person’s system. Withdrawal symptoms start to get better because buprenorphine is filling up the receptors. In addition, buprenorphine reduces cravings.
3. Buprenorphine firmly attaches to the receptors and blocks other opioids from attaching. With adequate maintenance doses, buprenorphine fills most receptors. Buprenorphine has a long duration of action, so its effect doesn’t wear off quickly.


2 “LOW ACTIVITY” at the opioid receptor

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

3 “SLOW DISSOCIATION” from the opioid receptor

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

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

Figure 4. Patient Taking An Opioid Three Times A Day

Figure 5. Patient Taking Suboxone® Once Daily
“CEILING EFFECT” at the opioid receptor

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

Are Suboxone® and buprenorphine the same thing?

No

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

Why does Suboxone® contain both buprenorphine and naloxone?

Each Suboxone® tablet contains:
- Buprenorphine (also known as Subutex®), plus
- Naloxone (also known as Narcan®)

Tablets come in two strengths and in each strength the ratio of buprenorphine to naloxone is 4:1:
- 2 mg buprenorphine / 0.5 mg naloxone
- 8 mg buprenorphine / 2 mg naloxone

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

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

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

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

Tips

The proper way to take Suboxone® is to place the tablet under the tongue and let it dissolve. This is referred to as “sublingual” (under the tongue) administration.

If Suboxone® is administered in some other way (for example, if it is snorted or injected), it can lead to a very uncomfortable episode of withdrawal. This is because of the naloxone in the Suboxone® tablet. If Suboxone® is used sublingually, the naloxone portion of the tablet cannot enter the bloodstream and therefore is not activated. However, if a Suboxone® tablet is snorted or injected, the naloxone portion of the tablet can enter the bloodstream and cause withdrawal.
**Starting on Suboxone®**

**Are there people who should avoid Suboxone®?**

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

**Image 4. People Who Should Avoid Suboxone®**

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

- Allergy to Suboxone®/naloxone
- Serious liver problems
- Serious breathing problems
- Paralytic ileus (intestinal blockage)
- Decreased level of consciousness
- Inability to provide informed consent
- Possibly elevated transaminases (liver enzymes) beyond 3–5x the upper limit of the normal range

Avoiding “precipitated withdrawal”

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

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

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

In most cases, between 4 mg and 8 mg of Suboxone® is given on the first day. It is usually increased by about 4 mg per day until opioid withdrawal symptoms stop. There is no single dose that is the right dose for everyone. Doses vary from person to person and even the same individual may need different doses at different times in their life. Most people stabilize on doses between 8 mg and 16 mg. The Suboxone® product monograph states that all Suboxone® doses are to be observed by a pharmacist (with the exception of weekends and holidays) for at least the first two months of treatment, in order to ensure safe usage. This is why daily attendance at the pharmacy is required at the start of Suboxone® treatment.
There is a lot more to opioid recovery than simply taking a medication. Many studies have shown that outcomes are better in individuals who make lifestyle changes and seek out counselling. Counselling resources vary depending on where people live. People on Suboxone® should be encouraged to speak to their doctor, pharmacist and other members of their treatment team about counselling resources in their area. They may also want to check out some of the resources listed in the back of this booklet. Counselling and medication work better together than either of these treatments does on its own.

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

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

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

Image 5. Common CNS Depressants

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

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

Suboxone® maintenance treatment

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

What to do if Suboxone® is not working

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

- **Consider getting more counselling.**
  Counselling has been shown to help with both the physical (pain, aches, sweats) and emotional (cravings, depression) struggles that many people experience during opioid recovery.

- **Talk to your doctor about whether or not a second illness (like untreated depression or post-traumatic stress disorder) might help explain the lack of response to treatment.**
  Untreated illnesses like depression or PTSD can often interfere with the response to Suboxone® treatment. There are a number of safe and effective (non-addictive) medications as well as non-medication treatments for these conditions.

- **Consider switching to a different treatment.**
  Sometimes people who do not respond well to Suboxone® respond better to another medication, such as methadone.

- **Consider switching to a new treatment provider or a different Suboxone® program.**
  Studies have shown that the location of a Suboxone® clinic and the services the Suboxone® clinic provides can be just as important (and sometimes more important) than the medication itself.

- **Consider making other lifestyle changes that may help with your recovery.**
  Sometimes making changes in other areas of your life, such as exercising more or reducing your use of other drugs or alcohol, can help make your Suboxone® work more effectively for you.
Common issues during maintenance

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

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

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

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

**Pregnancy and breast-feeding**
Until recently, methadone was considered the standard of care for pregnant women who were opioid dependent. However, this view is now changing among many of the specialists who work with opioid-dependent patients who are pregnant or breast-feeding. In view of the rapidly changing recommendations in this area, we strongly advise any patient who is pregnant and/or breast-feeding to discuss their treatment options with a doctor who specializes in this area.
Figure 9. Constipation Treatment/Prevention for Patients on Suboxone®
Follow this treatment plan in the order written for treatment and then withdraw treatments in reverse order when improved.

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

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

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

3. RESTORALAX® OR LAX-A-DAY®
1 teaspoon daily or twice daily. Alternately, Lactulose® syrup can be used, 2 to 4 tablespoons daily; although this is probably the most effective stool softener it can make you more gassy.

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

4. STIMULANT LAXATIVE DAILY
Senokot®, 2 tablets every night before bed or Milk of Magnesia®, 1 to 2 tablespoons nightly.

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

5. GLYCERINE SUPPOSITORY

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

6. FLEET OR TAP WATER ENEMA
Try to hold water in for 10 to 20 minutes, if possible.

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

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

Figure 10. Sleep Hygiene

TAKE CARE OF YOUR BODY:

DO NOT DRINK CAFFEINE
No more than 1 or 2 caffeinated beverages a day and no tea, coffee, or cola after 4 o’clock. Avoid alcohol as it interferes with sleep.

DO NOT GO TO BED HUNGRY
Have a light and healthy snack but do not eat a big or spicy meal late in the evening.

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

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

HAVE A REGULAR BEDTIME ROUTINE
A regular bedtime routine teaches your body when it’s time to go to sleep.

• Have a soothing drink like camomile (herbal) tea or a milky drink.
• Have a bath, or a routine of washing your face and brushing your teeth before bed.
• Go to bed at the same time each night.
• When in bed think of nice things (for example, think of 5 nice things that happened that day — such as a nice conversation, seeing the sunshine, or hearing nice music on the radio).
• Do a relaxed breathing exercise (place one hand on your stomach and the other on your chest then deliberately slow your breathing; breathe deeply in your stomach instead of high in your chest).
• Try to wake up at the same time every day, even if this is tiring to begin with.
When to taper
Opioid dependence is a chronic (long-term) disease and many of the changes that occur in patients with opioid dependence can make it very difficult for them to function normally if they stop their Suboxone®. The figure below (Figure 11) shows the many striking similarities between chronic illnesses like Type 2 diabetes and opioid dependence.

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

**INDIVIDUAL WITH TYPE 2 DIABETES**

- Individual receptors no longer respond normally to the body’s natural production of insulin.

**INDIVIDUAL WITH OPIOID DEPENDENCE**

- Opioid receptors no longer respond normally to the body’s natural production of opioids (endorphins).

While some patients manage to reverse their illness to the point where they no longer require additional insulin, many do not.

While some patients manage to reverse their illness to the point where they no longer require additional opioids, many do not.
While it is impossible to predict with certainty who will do well with a taper and who will not, we do know that people who have been on opioids for a longer period of time (2 years or more) tend to do better than those who are only on Suboxone® for a shorter period of time.

Figure 12. Chance of Successful Long-Term Recovery

![Graph showing the percentage chance of successful long-term recovery over years in treatment.](image)

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

Figure 13. Tapering Readiness Inventory

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

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been abating from other opiates and illegal drugs, such as cocaine and speed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think you are able to cope with difficult situations without using drugs?</td>
<td></td>
<td></td>
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<tr>
<td>Are you employed or in school?</td>
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<tr>
<td>Are you staying away from contact with users and illegal activities?</td>
<td></td>
<td></td>
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<tr>
<td>Have you gotten rid of your drug paraphernalia (needles, syringes, cotton, etc.)?</td>
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<td></td>
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<tr>
<td>Are you living in a neighbourhood that doesn’t have a lot of drug use, and are you comfortable there?</td>
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<td></td>
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<tr>
<td>Are you living in a stable family neighbourhood?</td>
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<tr>
<td>Do you have non-user friends that you spend time with?</td>
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<tr>
<td>Do you have friends or family who would be helpful to you during a taper?</td>
<td></td>
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<tr>
<td>Have you been participating in counselling that has been helpful?</td>
<td></td>
<td></td>
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<tr>
<td>Does your counsellor think you are ready to taper?</td>
<td></td>
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<tr>
<td>Do you think you would ask for help when you are feeling bad during a taper?</td>
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<tr>
<td>Have you stabilized on Suboxone®?</td>
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<tr>
<td>Have you been on Suboxone® for a long time?</td>
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<tr>
<td>Are you in good mental and physical health?</td>
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<td></td>
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<tr>
<td>Do you want to get off Suboxone®?</td>
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</table>
After tapering — what comes next?
As with most chronic illnesses, relapses are quite common. In the long term, as many as 30-50% of individuals who successfully taper off Suboxone® will eventually relapse and need to go back on their medication. The following tips (Image 6) may help reduce this risk of relapse. If relapse does occur, please see a doctor right away. Studies show that the sooner people get back on treatment, the better their chances of a good early recovery.

Image 6. Avoiding Relapse
For people who have tapered off Suboxone®, the following tips may help you avoid relapse.

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

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

Government of Canada National Anti-Drug Strategy
www.nationalantidrugstrategy.gc.ca/

Canadian Centre on Substance Abuse
www.ccsa.ca/

National Council on Alcoholism and Drug Dependence, Inc.
http://ncadd.org/

Project Cork
http://www.projectcork.org/

National Institute on Drug Abuse (U.S.)
www.nida.nih.gov/

Centre for Addiction and Mental Health
www.camh.net

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