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Medication Assisted Treatment: Medications for Opioid Use Disorder:

Part 3-Part 4

Common Abbreviations:
ASAM – American Society of Addiction Medicine
CNS – Central Nervous System
OTP – Opioid Treatment Provider
OUD – Opioid Use Disorder
PDMP – Prescription Drug Monitoring Program
REMS - Risk Evaluation and Mitigation Strategy
SAMHSA – Substance Abuse and Mental health Services Administration
SUD – Substance Use Disorder
WHO – World Health Organization

Part 3 – Pharmacotherapy for Opioid Use Disorder

1. The process of initial dosing with medication for OUD treatment until the patient reaches a state of stability is known as:
    a. Induction
    b. Medically supervised withdrawal
    c. Stabilization
    d. Steady state

2. Individuals that develop a tolerance to methadone may have _____ associated with using other opioids.
    a. Higher abuse liability
    b. Cross-tolerance
    c. Intrinsic activation
    d. Bioavailability

3. Which of the following is **not** an example of an opiate?
    a. Codeine
    b. Thebaine
    c. Morphine
    d. Fentanyl

4. About how many half-lives does it take to reach a steady state if a drug is continued at the same dose?
    a. 1
    b. 3
    c. 5
    d. 6

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5. Drugs with a lower mu-opioid receptor affinity may displace drugs with a higher mu-opioid receptor affinity.
   a. True
   b. False

6. The risk of respiratory arrest for buprenorphine is _____ the risk for respiratory arrest for methadone.
   a. lower than
   b. the same as
   c. higher than

7. How long does the FDA approved buprenorphine implants (Probuphine) last once they are placed?
   a. 30 days
   b. 90 days
   c. 6 months
   d. 12 months

8.. _____ is a monthly injection formulation of buprenorphine?
   a. Sublocade
   b. Vivitrol
   c. Probuphine
   d. Suboxone

9. Prescribers should make their OUD prescribing decisions based on which of the following:
   a. Psychiatric history
   b. Pregnancy status
   c. Patients' occupation
   d. All of the above should be taken into consideration.

10. Which of the following is **not** a factor that may contribute to difficulty achieving and maintaining abstinence from opioids?
   a. Neuroplastic changes in the brain
   b. Financial security
   c. Exposure to high-risk environments
   d. Short-term direct and indirect mu-opioid receptor agonist effects.

11. Medically supervised withdrawal is appropriate when patients:
   a. Have only used opioids for pain as prescribed.
   b. Are entering a controlled environment that disallows opioid agonists.
   c. Have attempted opioid agonist maintenance therapy but have been noncompliant with their treatment plan.
   d. Medically supervised withdrawal is never appropriate.

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12. Which of the following medications may be appropriate for patients in medically managed opioid withdrawal that are experiencing irritability?
    a. Metoclopramide
    b. Trazodone
    c. Diphenhydramine
    d. Clonidine

13. The intrinsic activity of buprenorphine is a partial opioid agonist which means:
    a. There is no opioid effect.
    b. The opioid effect increases as the dose increases.
    c. The opioid effect increases as the dose increases, but only up to a certain point.
    d. The opioid effect increases up to a certain point, but then decreases rapidly.

14. What is the difference between Zubsolv and Bunavail?
    a. The medications are identical, but made by different pharmaceutical companies.
    b. Zubsolv is buprenorphine only; Bunavail is buprenorphine and naloxone.
    c. Zubsolv is a sublingual film; Bunavail is a tablet.
    d. Zubsolv is a sublingual tablet; Bunavail is a buccal film.

15. Which formulation of methadone is most commonly used for pain relief, outside of OTPs?
    a. Dispersible tablets
    b. Tablets
    c. Liquid concentrate
    d. Powder

16. What is the average half-life of methadone?
    a. 5 hours
    b. 16 hours
    c. 24 hours
    d. 59 hours

17. Methadone induction should begin at a low dose and increase gradually with daily monitoring because:
    a. Patients are unlikely to have fully quit using illicit opioids while they are being induced.
    b. Release from tissue reservoirs can lead to a rapidly increasing half-life leading to increasing toxicity.
    c. Patients need to be in active opioid withdrawal before they are induced on methadone.
    d. Release from tissue reservoirs can lead to increasing serum plasma levels and toxicity, even if the daily methadone dose is not change.

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18. Pick the best answer that best describes the following sentence: “Methadone is approximately 70 to 80 percent bioavailable when patients take it orally for OUD”.
    a. 70 to 80 percent of methadone ingested is metabolized during the first half-life.
    b. 70 to 80 percent of methadone ingested reaches the blood stream.
    c. 70 to 80 percent of methadone ingested binds to the mu-opioid receptors in the body.
    d. All of the above

19. Which of the following is **not** an admission criteria for OTPs?
    a. Providing voluntary, written informed consent.
    b. Have a history of at least 1 year of opioid addiction before admission.
    c. Two documented unsuccessful, medically supervised withdrawals or treatments without OUD medication in a 12-month period.
    d. Being currently “opioid addicted”.

20. Which of the following information is necessary to assess benzodiazepine use in patients seeking medications for OUD?
    a. Prior overdoses
    b. Withdrawal history
    c. Intent of use.
    d. All of the above

21. Due to the risk of prolonged QTc intervals associated with high methadone doses, which of the following risk factors should be assessed during intake:
    a. Prior overdoses
    b. Patient history of use of cocaine and methamphetamines
    c. Patient history of injecting short-acting opioids
    d. Psychiatric comorbidity

22. Antiretroviral medications can inhibit CYP450 activity and decrease methadone metabolism, causing symptoms of overmedication.
    a. True
    b. False

23. Which of the following is **not** a possible side effect of methadone?
    a. Drowsiness
    b. Constipation
    c. Tremors
    d. Edema

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24. In which phase of treatment do providers determine whether or not a patient is appropriate for admission?
    a. Induction
    b. Assessment
    c. Screening
    d. Case management

25. What are the essential components of a medical assessment in determining if a patient is appropriate for methadone?
    a. Check the state PDMP, take the patient's history, conduct a physical exam, obtain laboratory results
    b. Check the state PDMP, assess the patient's psychosocial history, refer for laboratory testing, observe the patient's vital signs.
    c. Obtain a full trauma history, obtain a urine drug screen, check the patient's criminal record, conduct a physical exam
    d. Conduct a physical exam, obtain laboratory results, check the patient's criminal record for active warrants, check the state PDMP

26. Which of the following candidates **would not** be considered appropriate for methadone treatment?
    a. Pregnant women
    b. Patients that have been unsuccessful with methadone in the past
    c. Patients who responded well to methadone in the past.
    d. None of the above; all of these candidates would be appropriate.

27. When is the highest risk of overdose for a patient receiving methadone for OUD?
    a. Tapering off of a stable dose.
    b. The first two weeks of treatment.
    c. Initiating a concurrent benzodiazepine prescription
    d. The first month of treatment

28. What is the most appropriate initial dose of methadone for a patient that is taking antifungal medications?
    a. 5mg to 10mg
    b. 7mg to 12 mg
    c. 10 mg to 20mg
    d. 10mg to 30mg

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29. If a patient is given 30mg of methadone per day for the first few days of induction, the serum level on day 3 would reflect:
    a. 30mg from the third day's dose, 15mg remaining in the body from the second day's dose, 7.5mg remaining in the body from the first day's dose, for a total of 52.5mg
    b. 30mg from the third day's dose, 10mg remaining in the body from the second day's dose, 5mg remaining in the body from the first day's dose, for a total of 35mg
    c. 30mg from the third day's dose, 30mg remaining in the body from the second day's dose, 30mg remaining in the body from the first day's dose, for a total of 90mg
    d. 30mg from the third day's dose, 20mg remaining in the body from the second day's dose, 10mg remaining in the body from the first day's dose, for a total of 60mg

30. Patients that miss more than four doses of methadone should be:
    a. Discharged from treatment due to noncompliance.
    b. Given the same dose that they were given prior to missing their dose.
    c. Reassessed, given a substantially decreased dose and built back up gradually.
    d. Given a higher dose to quickly manage their withdrawal symptoms.

31. Which of the following is **not** a reason to adjust a patient's methadone dose once he/she reaches an adequate dose?
    a. Other members of the patient's group report better results at a different dose.
    b. To alleviate unpleasant side effects
    c. A new diagnosis of sleep apnea
    d. Concurrent illicit opioid or other drug or alcohol use.

32. How many take-home doses of methadone can a patient be given after 1 year of compliance with OTP requirements?
    a. 1 dose
    b. 3 doses
    c. Up to 2 weeks of doses
    d. Up to 1 month of doses

33. If a patient is in the process of tapering off of methadone and he/she begins to experience cravings, the provider can offer:
    a. To discontinue dose reduction.
    b. To begin XR-NTX after an appropriate period of opioid abstinence.
    c. To switch to buprenorphine to complete the dose reduction.
    d. All of the above.

34. What is the best evidence that a patient is stable on their dose of methadone?
    a. Patient experiences no withdrawal symptoms for 24 hours.
    b. Euphoria from self-administered opioids is blunted or blocked.
    c. Patient no longer requests dosage adjustments.
    d. Both A and B

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35. How long should a patient wait to be given naltrexone after taking long-acting opioids?
    a. 2-4 days
    b. 7-10 days
    c. 10-14 days
    d. There is no reason to wait to administer naltrexone after taking long-acting opioids.

36. Repeated administration of XR-NTX causes accumulation of naltrexone and its metabolites, lasting between 10 and 15 days.
    a. True
    b. False

37. Patients that attempt to override the opioid blockade provided by XR-NTX with high opioid doses:
    a. Are protected from overdose due to the high affinity of XR-NTX with the mu-opioid receptor.
    b. May cause overdose.
    c. Do not have sufficient family support to enter into recovery.
    d. Are likely using other illicit substances beside opioids.

38. What is a “Naloxone challenge”?
    a. Administering naloxone to a patient, either intravenously or subcutaneously, to evaluate a patient’s opioid dependence and risk of precipitated withdrawal.
    b. Providing a patient or their family with a prescription for naloxone for overdose prevention.
    c. Administering naloxone to a patient that is in respiratory arrest from an opioid overdose.
    d. The most appropriate way to begin a medically supervised withdrawal protocol.

39. The laboratory tests that should be run on a patient that is seeking treatment with XR-NTX:
    a. are identical to the laboratory tests run on a patient seeking methadone.
    b. are a drug and alcohol test and a pregnancy test.
    c. include a kidney function test in addition to the tests required for a patient seeking methadone.
    d. there are no laboratory tests needed as the medication does not produce any opioid effect.

40. Which patients are not appropriate candidates for XR-NTX treatment?
    a. Patients that have been abstinent from opioids for at least 1 week.
    b. Patients that are not able to attend frequent OTP visits.
    c. Patients that are in an external monitoring program.
    d. Patients that are pregnant.

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41. Informed consent for all medications for OUD should provide the patient with:
    a. The risks and benefits for the medications for OUD.
    b. The risks and benefits of non-medication treatments, including counseling.
    c. Their OUD diagnosis and the nature of the disorder.
    d. All of the above.

42. Which of the following is a potential side effect of XR-NTX treatment?
    a. Constipation
    b. Nausea
    c. An open wound at the injection site.
    d. Analgesia

43. Patients that wish to discontinue XR-NTX treatment that are not yet stable should be:
    a. Encouraged to attempt recovery without the benefit of medication.
    b. Discouraged because of the high rate of return to illicit opioid use.
    c. Required to be admitted for medically supervised withdrawal.
    d. Encouraged to attend peer support meetings.

44. How long does oral naltrexone block opioid-induced euphoria?
    a. 28-30 days.
    b. 4-5 days.
    c. 1-2 days.
    d. 12-24 hour.

45. Which patients are **not** appropriate for oral naltrexone?
    a. Patients that have taken heroin extensively.
    b. Patients that are leaving prison but are unwilling to take XR-NTX or opioid agonist therapy.
    c. Patients that cannot afford XR-NTX.
    d. Patients that have high levels of monitoring and negative consequences of nonadherence.

46. To increase adherence to an oral naltrexone, providers can suggest:
    a. Regular naloxone challenges to be given at the office.
    b. Directly observed administration either by a provider or a member of the patient's social network.
    c. Coordinating with the patient's employer to inform them of the patient's presenting problems.
    d. Strict consequences for positive drug tests.

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47. Buprenorphine extended-release injection (Sublocade) received FDA approval for the treatment of OUD disorder in what year?
    a. 2002
    b. 2013
    c. 2016
    d. 2017

48. What is the principal difference between Suboxone and Zubsolv?
    a. Suboxone has a longer half-life than Zubsolv.
    b. Zubsolv has greater bioavailability than Suboxone.
    c. Suboxone has treater bioavailability than Zubsolv.
    d. There is no difference; they are both buprenorphine/naloxone combination products.

49. What is the recommended once-daily maintenance dose range for Bunavail?
    a. 4mg/1mg to 24mg/6mg
    b. 1.9mg/0.71mg to 17.2mg/4.2mg
    c. 2.1mg/0.3mg to12.6mg/2.1mg
    d. 4mg to 24mg

50. How long does Probuphine remain effective once it is administered?
    a. Up to 28 days
    b. Up to 48 hours
    c. Up to 9 months
    d. Up to 6 months

51. How is buprenorphine excreted?
    a. In urine and feces.
    b. In sweat.
    c. In urine only.
    d. In bile.

52. Buprenorphine has more clinically relevant drug interactions than methadone.
    a. True
    b. False

53. Patients need to be informed to store buprenorphine in a secure location in their home because:
    a. There is a risk of diversion and misuse.
    b. Unintentional pediatric exposure can be life threatening or fatal.
    c. Insurance companies will not pay for replacement doses for lost or stolen medications.
    d. Both a and b.

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54. Which of the following is **not** advice to offer pregnant women to reduce neonatal abstinence syndrome severity?
    a. Avoiding smoking during pregnancy.
    b. Providing frequent skin-to-skin contact in the first week after birth.
    c. Stay compliant with their buprenorphine/naloxone combination product.
    d. Request rooming-in with the child.

55. Grapefruit juice may potentially _____ blood levels of buprenorphine.
    a. Decrease
    b. Increase
    c. Nullify
    d. Impact

56. Serotonin syndrome is a serious medical condition that can include fever, dilated pupils, tremor, sweating, and change in mental status. There is a slight risk of this happening when buprenorphine is combined with:
    a. anticonvulsants
    b. statins
    c. antidepressants
    d. antiretrovirals

57. Which of the following is **not** a potential side effect of buprenorphine?
    a. Vomiting
    b. Blurred vision
    c. Constipation
    d. Suicidal ideation

58. The REMS for buprenorphine indicates that a Clinical Opioid Withdrawal Scale score of _____ is typically adequate to ensure that a patient will avoid the risk of precipitated withdrawal.
    a. 10
    b. 12
    c. 15
    d. 17

59. If a patient has a history of using diverted buprenorphine, it is recommended:
    a. that the patient be referred to an OTP for methadone treatment.
    b. that the patient be considered for XR-NTX only.
    c. that the patient be assessed for buprenorphine treatment, as this is a potential indicator of inability to access treatment.
    d. that the provider attempt to gain information on the original source of the buprenorphine and report the prescriber to the appropriate authorities.

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60. Patients that are beginning buprenorphine treatment should only be initialed in an inpatient hospital setting.
    a. True
    b. False

61. Patients that are switching from methadone to buprenorphine should:
    a. generally be started with office-based induction.
    b. are safe to start their buprenorphine at home 12 hours after the last methadone dose.
    c. start their buprenorphine within 6-12 hours of their last methadone dose.
    d. are at high risk for overdose and should only begin induction if they are being treated as an inpatient.

62. Which patients may be appropriate for buprenorphine induction that are not currently physically dependent on opioids?
    a. Patients that are experiencing additional cravings due to an increase in stressors.
    b. Patients who have been incarcerated o in other controlled environments.
    c. Patients with chronic pain that are not being successfully treated with NSAIDS.
    d. All of the above

63. If a patient's withdrawal symptoms are managed on buprenorphine but he or she is still endorsing cravings:
    a. The patient is medication seeking and at risk of using illicit opioids.
    b. The patient's buprenorphine dose likely needs to be increased.
    c. The patient may be referred to counseling to learn how to reduce and manage cravings.
    d. The patient likely needs to split up their medication into two separate doses; morning and evening.

64. Transmucosal buprenorphine monoproduct:
    a. cannot yet be recommended for pregnant women due to insufficient safety data.
    b. provides pregnant women with additional safety due to needing only monthly injections.
    c. is contraindicated for pregnant women due to the risk to the fetus.
    d. is not as effective for women with OUD as transmucosal buprenorphine with naloxone.

65. What is the typical first dose of transmucosal buprenorphine for patients experiencing withdrawal from methadone?
    a. 8mg
    b. 4mg
    c. 2mg
    d. 1mg

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66. How often should a provider see a patient that has received buprenorphine implants?
    a. No less than weekly
    b. No less than monthly
    c. Every six weeks
    d. At six months

67. What is the best marker that a patient is making progress in treatment?
    a. The length of time that buprenorphine treatment is needed.
    b. The amount of medication required, with lower doses being preferable.
    c. When a patient is fully abstinent from opioid agonist therapy.
    d. When a patient is making progress towards their specific goals.

68. Which marker of recovery is the best indicator of sustained remission upon discontinuing buprenorphine?
    a. Full-time employment.
    b. Involvement in mutual help programs.
    c. Effective coping skills.
    d. There is no guarantee of continued abstinence.

69. If a patient has successfully tapered off of buprenorphine completely, what kind of support should be offered to them?
    a. A post-tapering monitoring and support plan.
    b. XR-NTX
    c. A follow-up appointment six months after completion
    d. Both a and b.

70. Patients OUD that are using benzodiazepines intravenously:
    a. Should be referred to a medically supervised benzodiazepine withdrawal program before being treated with buprenorphine or XR-NTX in an office-based setting.
    b. Are not appropriate for treatment of their OUD in an office-based setting.
    c. Should begin a gradual outpatient medically supervised benzodiazepine withdrawal as they begin medication for their OUD.
    d. Should begin talk therapy for their underlying anxiety issues prior to being treated for their OUD.

71. Providers of office-based treatment of OUD with medication should coordinate:
    a. wraparound services, primary care, and mutual support services.
    b. behavioral health care and psychiatry.
    c. behavioral health, primary care, and wraparound services.
    d. primary care.

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72. Patients should be automatically discharged from treatment if they do not discontinue illicit drugs after a month of buprenorphine treatment.
    a. True
    b. False

73. Brief supportive counseling can optimize medical management of OUD in an office-based setting and should include:
    a. Providing mindfulness training to manage cravings.
    b. Providing empathic listening and nonjudgmental discussion of triggers or increased cravings.
    c. Providing vouchers for support services, such as child care or vocational training.
    d. Helping patients process their trauma history.

74. Which of the following is a marker of engagement in recovery support meetings?
    a. Attending a regular “home” group.
    b. Working with a sponsor.
    c. Doing service work at meetings.
    d. All of the above.

75. What of the following is **not** an indicator that a patient is ready to come to the office less than weekly?
    a. Responsible handling of medication.
    b. Several weeks of abstinence from illicit opioids.
    c. Discovering a new prescription for a benzodiazepine from the PDMP.
    d. Adherence to appointments and treatment plan.

76. If a patient has a positive urine drug screen after initiation of their OUD medication indicates:
    a. Treatment is not effective for the individual and they should be discharged.
    b. A need to reassess the patient and make revisions to the treatment plan.
    c. That a patient requires a higher dose of their OUD medication.
    d. That the patient is likely diverting their OUD medication.

77. How many patients can a physician see after 1 year of prescribing buprenorphine to 30 active patients?
    a. 30 active patients
    b. up to 100 active patients if they apply to increase their limit.
    c. up to 275 active patients if they apply to increase their limit.
    d. Both a and b

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78. A diversion control plan:
    a. Includes informing patients that diversion causes negative views of treatment and discrimination against people with OUD.
    b. Ensuring that patients are able to safely store buprenorphine in their homes.
    c. Provides measures to reduce diversion and assigns specific responsibility to medical and administrative staff members for carrying out these measures.
    d. Both a and b

79. In order to ensure safety in office-based OUD treatment settings, the TIP expert panel recommends:
    a. Having injectable or intranasal naloxone onsite.
    b. Having security guards on-site.
    c. Having crash carts available.
    d. Providing all staff with de-escalation training.

80. For patients on buprenorphine for OUD that are admitted to the hospital with mild-to-moderate pain:
    a. Treat with higher-than-usual full agonist opioids.
    b. Divide the patient's usual buprenorphine dose into three times per day.
    c. Prescribe NSAIDS.
    d. Discontinue buprenorphine and prescribe full agonist opioids.

81. If a patient is admitted to the hospital for acute medical reasons, but may benefit from initiating medications for OUD:
    a. Their medical condition should be treated and then the patient should be referred to an outpatient provider.
    b. The patient should receive XR-NTX immediately.
    c. The patient may be initiated on buprenorphine only.
    d. The patient may be initiated on buprenorphine or methadone.

Part 4 – Partnering Addiction Treatment Counselors with Clients and Healthcare Professionals

82. How does a peer support specialist differ from a participant at a peer support meeting?
    a. There is no difference.
    b. A peer support specialist is employed in a clinical setting to provide experiential knowledge to the treatment team.
    c. A peer support specialist has skills learned in formal training in addition to lived experience in addiction.
    d. A peer support specialist has lived addiction and mental illness experience that treatment staff often lack.

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83. The sum of internal resources that an individual can draw upon to begin and sustained recovery from SUDs is known as:
    a. Psychosocial support
    b. The maintenance stage of change
    c. Recovery capital
    d. Recovery support

84. Clients that develop a tolerance and physical dependence to their medication prescribed for OUD, but no other behavioral symptoms of OUD:
    a. have traded one drug for another.
    b. are still addicted to opioids.
    c. are considered to be in remission.
    d. are not in recovery.

85. Addiction counseling can help clients live a self-directed, purposeful life by assisting patients to:
    a. Build a set of techniques to resist drug use.
    b. Improve interpersonal skills
    c. Replace substance use with constructive, rewarding activities.
    d. All of the above.

86. Cognitive-behavioral therapy in conjunction with medical management and buprenorphine may work best for clients:
    a. That are genuinely ready to change their lives.
    b. Whose OUD was primarily linked to misuse of prescription opioids.
    c. Whose OUD involved only heroin.
    d. That have not been successful with methadone maintenance therapy.

87. A recovery-oriented approach to treatment for OUD acknowledges that many OUD clients will have complex issues that may decrease quality of life, such as mental distress, poor diet, and lack of social support.
    a. True
    b. False

88. Person-centered care means that:
    a. The provider determines the amount, duration, and scope of services the clients receive.
    b. The providers are the expert in planning, developing and monitoring care that is unique to the individual client.
    c. Care is holistic and respects and responds to the client's cultural, linguistic, and socioenvironmental needs.
    d. The client is works with the professionals that program determines to be the best fit.

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89. One way that treatment providers can help clients develop and support positive relations with their families is to:
    a. Support clients in mending relationships with loved ones, even if they still use substances.
    b. Suggest that clients invite family and friends into treatment for codependency.
    c. Encourage clients to seek out new intimate relationships that support recovery.
    d. Help clients to cut ties with individuals who still use drugs or enable clients' drug use.

90. Trauma-informed care:
    a. requires treatment providers to realize the significance of trauma and its impact on the therapeutic alliance.
    b. Encourages clients to begin dealing with childhood trauma as soon as they begin treatment.
    c. Encourages clients to seek out recovery from traumas suffered during their opioid misuse as separate from other traumas they have experienced.
    d. Both a and c

91. Opioid use leads to an above-normal release of _____ in the brain, swamping the natural reward pathway and turning the brain strongly toward continued use.
    a. endorphins
    b. dopamine
    c. glutamate
    d. serotonin

92. The counselor's role in the counselor-prescriber alliance is to:
    a. Encourage the patients to take their medications appropriately.
    b. Develop the treatment plan for the patient, including determining if the patient's medication is at the appropriate dose.
    c. Review the patient's lab results with them and help them process their feelings about them.
    d. Ensure that the patient is well-informed about potential side effects of their OUD medications.

93. Unfortunately, there can be an anti-medication bias in mutual help meetings. One way counselors can help patients manage this issue is to:
    a. Mandate meeting attendance to ensure the community has the opportunity to meet patients that are stable on OUD medications.
    b. Recruit volunteers and peer support specialists to help patients find supportive meetings.
    c. Encourage clients to disclose their medication status to the entire meeting in order to promote rigorous honesty.
    d. Recommend online group meetings only.

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94. Clients that are in group therapy at one location but receive their OUD medication from another provider should:
    a. Obtain a release of information for both providers to communicate with each other, in accordance with state and federal laws.
    b. Be discouraged from discussing their counseling with their medication provider to avoid a breach in confidentiality.
    c. Be discharged from counseling if they refuse to sign a release of information to their medication provider.
    d. Openly communicate to improve the care of their shared patients.

95. When running a SUD therapy group that includes both patients taking OUD medications and those that are not, it is crucial to:
    a. Let the patients decide how much information to disclose about their OUD medications.
    b. Encourage patients to use group time to evaluate the pros and cons of medications for OUD.
    c. Reframe negative comments about OUD medications as judgmental behavior.
    d. Discourage patients from discussing the role of OUD medications in their recovery.

96. If a patient that is receiving medications for OUD discusses issues of chronic pain with their counselor, the counselor should:
    a. Advocate for the patient to receive better pain management to the prescriber.
    b. Direct the patient to a healthcare professional for assessment of pain and medical treatment as necessary.
    c. Instruct the patient in adjunct methods for pain relief.
    d. Both b and c