Questions Asked During the Live Webinar Broadcast on 9/19/12

Q: Where should Vivitrol fit in treatment, as it has no addictive properties?
A: It should be a primary treatment modality in partnership with all of the other parts of the needed tool set that we discussed for all alcoholic patients and many opiate patients that choose not to be on Suboxone. After any opiate addict stops Suboxone, after 14 days they should be put on Vivitrol for at least a year. In my opinion all alcoholic patients should be on Vivitrol.

Q: Why is the reason Antabuse is not being used as other meds?
A: It is very dangerous to drink alcohol when you are on it, life threatening in some cases. Also, patients can just stop it when they want to drink. Mainly not used because of this danger and because we have so many better choices now.

Q: why didn't you talk about cocaine?
A: Not enough time. Happy to do another webinar to talk about cocaine, methamphetamine and benzdiazepines

Q: what should I treat first? Depression or alcohol craving (with naltrexone)
A: You should treat both simultaneously, one with an antidepressant and alcohol with Vivitrol and then add all of the other tools that we discussed, on the Enterhealth/NIH comprehensive treatment diagram

Q: What do you mean you are "punished" if you take too much suboxone?
A: It puts you in opiate withdrawal. Not life threatening, but very very uncomfortable.

Q: What are the success differences between the addicted individual treated with medications and the individuals treated without any meds?
A: In general medications give you about and additional 30% long term success. But you need to individualize the treatment to the specific patient. I think you always want to use the anti addiction meds when appropriate

Q: What about patients who are currently taking methadone and would like to try Vivitrol to help them with alcohol dependence, do they have to stop methadone or can they take both?
A: They have to stop methadone within a detox program and then wait 14 days and then start Vivitrol. It works very well. We do it all of the time here at Enterhealth Ranch.

Q: What about process addictions?
A: I don’t know the science behind them. So I won’t comment authoritatively. If they have co-occurring alcohol and drug and/or psych all of those should be treated simultaneously.
Q: Since brain is healing x 12 mos., when should neuropsych testing be used? Multiple testing? How to manage high cost testing.
A: Neuropsych testing probably after about 15-30 days from a screening standpoint then full testing if indicated at about 30-45. Maybe follow up testing 6 months to a year after that.

Q: Jeffery Schwartz’s with OCD suggests that "talking Therapy" has value for neurogenesis in so far as it serves as coaching for mindfulness training. What do you think of this approach?
A: I think that individual, group and family therapy as well as 12 step/SMART recovery all helps to build healthy coping skills in an addict. They need to be heavily focused on individual therapy. Therapy should always be given only as part of a comprehensive approach which overall heals the brain. Not sure which component is more important though.

Q: Is there any such integrated treatment for those dependent on cocaine or amphetamine?
A: Yes, the same comprehensive approach works great with both stimulant classes.

Q: Is there evidence that there are antioxidants in the body that can offset the carcinogen properties of cannabis? Some research says yes, correct?
A: I have never heard this. Pot is very toxic period!! It should be avoided like the plague. If addiction develops it should be taken just as seriously as any other substance class addiction

Q: Is the MJ risk of heart attack age sensitive: does it increase with age?
A: No it stays constant, but as you age the CV system becomes more at risk. Also MJ risk increases depending on what it is treated, cut and processed with.

Q: In utilizing cutting edge science what different approach should one utilize considering Brain Neurochemistry?
A: Everything that I discussed today. Addiction and its treatment is all about neurochemistry

Q: If the receptor is blocked for pharmaceutical opiates, will it also be blocked for endogenous opiates?
A: No, surprisingly the endogenous opiates seem to work just fine, thankfully. You can still enjoy life.

Q: How do I pay for Vivitrol for cash pay or Medicare patients?
A: I would go to Vivitrol.com and call the 800# and they will help you with that? I think that they still have a discount program for Cash patients, not sure. I don’t know about Medicare.

Q: How about patients addicted to methamphetamine - you did not mention
A: They are treatable with the same comprehensive approach that I discussed for alcohol and opiates. We don’t have any great medication protocols to treat them, but there are
some that are good to try. Feel free to go to www.enterhealth.com and ask them about the Methamphetamine treatments.

Q: Do you have any recommendations for people working in rural areas? How do we approach the medical community to get on board with seeing addiction as a medical disease?

A: To start, I would have your PCP read the Healing the Addicted Brain book then they will be able to work better in partnership with the family. If the patient needs to go to residential have them come to Enterhealth and then we will work with the PCP before they leave to set all of that up. At the end of the day, it will be the patients family that creates change within the rural system. Also, you might try working with some of the younger MD’s as they may be more open to the more science-based approach that I described.

Q: Can talk therapy and treatment that is cortex focused guide the limbic system and give it "commands"? Can the cortex direct human ability of exercising free will?

A: We don't know for sure. There really is no reason that you would not use all of the tools that we have to treat this lifethreatening disease. I would not split hairs but rather use everything that could possibly help the patient and their family.

Q: A physician told me that patients who need opiates for pain control will not become addicted, but rather dependent upon it for pain control. From addiction treatment perspective, what is your (Dr. Urschel) response to that?

A: if a patient has no history of addiction there is a good chance that proper opiate use for the treatment of chronic pain will NOT result in addiction. Pain needs to be treated comprehensively just like addiction or any other chronic disease. Many pain patients on opiates have physical tolerance but not addiction. I do talk about this issue in my book Healing the Addicted Brain