Questions Asked During Live Webinar Broadcast on 07/31/2017

NOW What're We Supposed to Do? Evidence-Based Practices for Medication-Assisted Treatment

Presenter: Michael Bricker, MS, CADC II, LPC

Any studies focusing specifically on MAT in residential settings?

A: I haven't had time to do a full literature search, but the web is full of anecdotal references from various residential programs. Overall, they report great success. Of course the greatest benefit from residential treatment is everything ELSE they get, and a dosage and duration difficult to achieve in outpatient. I personally have used both oral and injected naltrexone in residential with positive results – especially treatment retention in the 2nd-3rd weeks.

I add "P" to the H.A.L.T.: Pain, Hungry, Angry, Lonely and Tired "PHALT"

A: A great idea, especially since many people wind up addicted due to mis-management of chronic pain! I use the ACT model with great success.

In Montana as well we have experienced good success in using Naltrexone for Methamphetamine addiction. Are there studies being done at NIDA to switch this from off-label to on-label?

A: There are several NIDA/NIH research studies underway or recently completed, and reported results are promising. Anecdotally, reports from treatment providers are very encouraging. If you're close to a college or university with a research department, they may have access to government databases with more information.

Regarding not imposing high expectations, don't people raise to the higher expectations?

A: Excellent observation! I've learned over the years that my patients never fail to live DOWN to my expectations of them! If I expect them to be a bunch of dishonest, malingering malcontents, they won't disappoint me. On the other hand, offering respect combined with reasonable but increasing expectations, proper support and encouragement works miracles.

When switching from Suboxone to Vivitrol how long do you wait before the injection? Do you began with Suboxone, then oral naltrexone, and move to Vivitrol?

A: Great question! That's a medical decision outside my scope of practice. My observation has been that waiting a few days (the serum half-life of buprenorphine at low dose is 24-36 hours) and then directly to oral or injection. That last step off the low dose of suboxone is more psychological discomfort than withdrawal.

Can you speak to the use of Benzos and opiates? Specifically talking about their risks and other things to consider.

A: Again, as a non-physician, the literature STRONGLY contraindicates buprenorphine and benzos and alcohol. The naltrexone only blocks respiratory suppression from the opioid receptors, not the benzo receptors. The research shows many OD deaths from that combination.

Will clients go through a withdrawal if tapered off or decreased dose?

A: Most of my patients report some mild discomfort at each dose reduction, but it usually resolves in a day or two. That's one reason physicians tend to taper slowly.

Wouldn't you agree that many persons will need lifelong MAT to combat a permanent imbalance in their endogenous endorphin system?

A: I agree. The problem I have is that many patients want to START from that premise, and treat suboxone like methadone maintenance. I'm unaware of any studies reporting ill effects from long-term suboxone, so from a harm-reduction standpoint it makes sense. So, as with any clinical decision, it's a negotiation between patient and clinician – particularly the prescribing physician.