

Questions Asked During Live Webinar Broadcast on 4/25/2018



Comprehensive Medication Assisted Treatment

Presenter: Michael Weaver and Don Hall

Do you have any statics around Native Americans using MAT?

A:

Don: Some of the best studies that I have read about the use of medication assisted treatment with Native Americans was documented by Dr. Gabor Mate, of "In the Realm of Hungry Ghosts" fame. There are several studies, even of one of the first Heroin clinics in North America in his documentations.

So medication assisted treatment can help a person with Alcohol and nicotine issues? Please provide more information about that.

A:

Don: As far as alcohol, read some of the information on this website and then let's talk.

<https://www.sinclairmethod.org/what-is-the-sinclair-method/>. As far as nicotine, I personally used bupropion to stop smoking the last time about fifteen years ago. I have seen numerous individuals quit using one or more of the methods recommended.

Michael: Yes, pharmacotherapy is available for either alcohol or nicotine addiction, in addition to maintenance treatment for opioid use disorder. The 3 medications available for alcohol must be prescribed by a physician, and most of the medications for nicotine are available over-the-counter.

I have heard that the cost of Revia is about \$40/month but Vivitrol is about \$1,200/month. Are those numbers correct and, if so, why the wide disparity in price?

A:

Don: Your prices are within the ranges that I have been quoted. I do not know why the disparity, but in America it is usually what the market will bear.

Michael: The oral naltrexone tablets are generic and have been available for over 20 years. Vivitrol is the only current extended-release injectable naltrexone product, so it is expensive because it is still brand-name-only and the manufacturer is pricing it to pay for the research and development costs and make a profit. Both are covered by health insurance with the out-of-pocket cost to the patient (anywhere from \$0 to \$500 per monthly injection) depending on that patient's specific insurance policy.

What are the implications for Methadone and Buprenorphine for women who are pregnant and on the developing fetus? Any long term studies for children exposed in utero?

A:

Don: Methadone is the recommended method of dealing with women who are abusing opiates and pregnant. Here is one such study.

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure, by Hendree Jones, Karol Kaltenbach, et. al., New England Journal of Medicine, December 9, 2010, 363;24: pages 2320-2331

Michael: Clinical trials over the past 10 years with both methadone and buprenorphine have demonstrated that both are safe and effective during pregnancy. Long-term data for methadone shows no concern about long-term effects to the development of the child. Long-term data for buprenorphine is still being collected, but so far looks encouraging.

I missed what you explained about Methadone has no ceiling effect. Can you please talk about it again?

A:

Don: Methadone is a full agonist, and as such does not have a ceiling effect, i.e. methadone will continue to

increase effect until an eventual overdose if someone continues to take more. Buprenorphine will achieve a certain effect at about 32 mg, and the person will neither get high or overdose even if they take much more.

Michael: The dose of methadone can continue to be increased as long as the person has tolerance to opioids and it will have full effect, even at very high doses. Buprenorphine is a partial agonist, so it has opioid agonist effects like methadone at low to moderate doses, but at higher doses it acts more like an antagonist, so people start to feel some withdrawal and jitteriness when the dose gets high (above 32 mg/day like Don said). Therefore, if someone has very high tolerance for opioids because of using large doses of illegal prescription opioids or high-purity heroin, methadone is going to be more effective than buprenorphine to completely control opioid withdrawal symptoms.

Can you please also explain again the difference between full antagonist and partial agonist in terms of patient's experience of taking methadone vs. Buprenorphine?

A:

Don: The full agonist more closely replicates the effect of the drug of abuse, as far as removing the withdrawal symptoms, which is possibly why it may work better in individuals with more advanced cases of addiction to the opiates. The partial agonist will relieve the withdrawals to a point, but from what I hear from the clients, does not fully allow them to feel healthy, especially in the more severe cases.

Michael: See answers above.

How do you handle patients who are aversive to tobacco treatment medications and want to try to quit "cold turkey"?

A:

Don: This is where I drop back to my counseling skills, using Motivation Interviewing and Cognitive Behavioral Methods, along with social support. Just because there is medication available, does not mean to forget the skills I have worked very hard to gain.

Michael: Many people successfully quit smoking "cold turkey." I help my patients who want to do this by providing lots of information about how to handle cravings and nicotine withdrawal symptoms. There is also lots of good information available at the www.smokefree.gov website.

How fast does ReVia take effect after you take it?

A:

Don: When I have seen a doctor prescribe it, they have recommended that the client be observed for about an hour to make sure that they do not experience any withdrawal from the opiate. If used with alcohol the recommendation in the United States is to be alcohol free before taking it, but in the studies done by Dr. Sinclair there were only minimal side effects noted of taking even with alcohol, only a reduction of the desire to drink.

Michael: For opioids, oral naltrexone can cause opioid withdrawal symptoms within 30 minutes or so. There is no direct adverse reaction with alcohol, although reduction in pleasurable effects of alcohol would theoretically occur within 30-60 minutes if someone had a drinks after taking the oral naltrexone. The peak anti-craving effects for opioids and alcohol occur when naltrexone reaches steady state, which is usually after a few days of taking it every day.

Does Varenicline require tapering off period?

A:

Don: Do not know. Doc?

Michael: No, it can be stopped with no ill effects from the usual twice daily dose.

Is there any data on the long-term use of NRT?

A:

Don: Do not know. Doc?

Michael: NRT is generally recommended for 3-6 months until tapered off. NRT is safer than nicotine plus the carcinogens and other chemicals in tobacco smoke, but nicotine itself is still a drug of abuse that causes addiction and leads to atherosclerosis (cholesterol buildup in blood vessels) that can cause heart attacks and strokes over time. Therefore, using NRT for years is not as bad as smoking tobacco, but still not completely safe. The risk is justified over several months or so because it improves the chances of quitting smoking. These risks of long-term nicotine use are often overlooked when talking about electronic cigarettes as being safer than tobacco cigarettes, but e-cigarettes are still not as safe as air.

I've heard that people try to abuse Suboxone. How do they do that?

A:

Don: Suboxone does have some painkilling and euphoric effects, so there is some abuse potential. In the clients that I have met that claimed to be diverting Suboxone, they were often trying to help a friend, or sometimes themselves to control heroin use on their own, often because of bad experiences in programs.

Michael: Buprenorphine can cause some euphoria, as Don said, but not to the same degree as most other opioids, and only in people who use opioids occasionally, not daily. It is less likely to be abused because if someone who has an opioid addiction with daily use tries to abuse buprenorphine for euphoria, they will go into opioid withdrawal. However, it does have value on the Black Market because people will divert it to use to detox themselves instead of going into a treatment program, and buprenorphine is better than no opioid at all if you are in opioid withdrawal.

Do you advocate treating tobacco use disorder concurrently with other substance use disorders?

A:

Don: Yes, if the client is willing to address this at the same time. I understand there have been positive results even in programs that went to a non-smoking policy, but I really dislike forced situations.

Michael: Recent evidence from addiction treatment programs and hospitals (and even prisons) that have banned tobacco shows that people often have less withdrawal from other substances when they do not use tobacco at the same time as starting recovery from other substances. However, we treat individuals, so I try to give my patients a choice about when they want to tackle quitting smoking. I reassure them that it is not impossible to quit smoking at the same time as quitting use of alcohol, heroin, cocaine, etc. and pharmacotherapy for tobacco can be used along with pharmacotherapy for other substances.

Can you combine acamprosate and naltrexone?

A:

Don: I do not know. Michael?

Michael: Yes, but there is no significant benefit from doing so. A research study several years ago looked at this, and the combination was not significantly better than either one alone, just more expensive. However, I have used both for a few select patients who were struggling with their drinking, especially due to continuing cravings for alcohol.

How does MAT help clients who may have comorbid disorders and may be taking medications for their mental illnesses?

A:

Don: I have read studies that have showed that methadone can actually reduce depression, and other studies that say that naltrexone is not necessarily a good treatment for someone that is experiencing depression currently. It would probably be better to individualize, not generalize per each client in this area.

Michael: From a medical standpoint, it is important to be aware of any potential medication interactions between the patient's MAT medications and their medications for mental illness. Sometimes one medication treats both (such as bupropion for smoking cessation and depression). Treating the addiction will definitely improve the mental illness, and vice versa.

You referenced buprenorphine having longer duration in treatment vs shorter, Please explain what is a

longer duration treatment?

A:

Don: Longer duration treatment is normally described as maintenance, that is the person being stabilized on the medication for months or years before tapering, or possibly never tapering. This should only be the client's decision, provided that funding will allow.

Michael: Initial studies with buprenorphine looked at reduction of use of illicit opioids when people took it for several days or weeks. Later studies looked at several months. The longer a study population was on buprenorphine, the better the outcomes while on buprenorphine or while monitored after coming off. There is no specific minimum amount of time to be on buprenorphine in terms of less versus more benefit. Maintenance for methadone and buprenorphine is defined by the federal government as >180 days, so if you are on buprenorphine/methadone for <6 months, it is "detox" and if you are on either for at least 6 months it is "maintenance."

Is the Tapering Methadone questionnaire referenced in Case #2 a standardized instrument? What is the name of the instrument?

A:

Don: Actually, there is a standardized tapering instrument. It was developed at the University of California, San Francisco and can be found here: <https://www.choosehelp.com/topics/suboxone-and-methadone/methadone-ready-start-tapering-self-test>

Is there a benefit or disadvantage to using both naltrexone and acamprosate concurrently?

A:

Don: That would be the doctor's call. I am not sure of this happening and I have not dealt with any clients in this situation.

Michael: Please see the answer to the question, "Can you combine acamprosate and naltrexone?" above.

If one has repeated relapses do you recommend inpt treatment? What about clinics who cut people off the methadone quickly due to multiple relapses or due to owing money to the clinic? Any opinions?

A:

Don: Since many inpatient treatment facilities do not allow Medication Assisted Treatment in their facilities, I would not normally refer to an inpatient program. I would go deeper into the counseling. Often a client that continues to relapse has other issues going on, ranging from their environment, to trying to stay at a low dose so they can "shoot through" the medicine to get high on weekends. There has to be motivation for the behavior.

As far as the "three day detox" or "administrative detox", this should actually be in the same class as any other form of torture and be made illegal, with the person recommending this treatment being forced to experience it at least once as part of their sentence. (Remember, you did ask for an opinion)

Michael: In my experience, if someone is not doing well in the outpatient setting, it is necessary to increase the intensity of the treatment, which can take different forms, depending on the situation. This applies to treatment for all substances, not just opioids, although it is more challenging with MAT for opioids, as Don mentions here. I try to enhance the behavioral treatment component, including things like "90 meetings in 90 days" or additional outpatient supports and services, which may include more formal Intensive Outpatient Treatment (IOP). If this is not adequate, a residential addiction treatment program may be beneficial, especially if the home environment is less conducive to sustained recovery. The challenging part with MAT for opioids is that many residential programs do not provide or allow methadone/buprenorphine maintenance during the residential stay. Part of the reason for this is that health insurance companies don't want to pay for both types of treatment at the same time (having a patient continue methadone/buprenorphine from their maintenance program while in the residential program facility), and many residential programs are not set up to provide maintenance MAT (as opposed to MAT just for the detox phase).