NAADAC, MEDICATION ASSISTED RECOVERY IN COMPLEX SITUATIONS

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>> Hello everyone and welcome to today's webinar on Medication Assisted Recovery in Complex Situations, presented by Doctor Michael Weaver and Don Hall.

It's great that you can join us today. My name is Samson Teklemariam and I am the Director of Training and Professional Development for NAADAC – the Association for Addiction Professionals. I'll be the organizer of today's event.

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We are using GoToWebinar for today’s live event. Here are some important instructions: You have entered into what’s called listen only mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have trouble hearing the presenter for any reason, I recommend switching to a telephone line as some internet connections are not strong enough to handle webinars. If you have any questions for the presenter, just type them into the “questions” box of the GoToWebinar control panel. It looks like the one on my slide here. We’ll gather the questions and, if time permits, I’ll pose questions to the presenter. Otherwise, we will get the answers from the presenter and post the questions and answers on our website (of course this only applies to live presentations; if you are watching the recorded version there are no means of posing questions – instead, you have access to the questions and answers from the live presentation).And now, let me introduce you to today's presenters, Dr. Michael Weaver is a Professor in the department of psychiatry and medical director of the center of neural behavioral research of addiction in the University of Texas, the McGovern medical school in Houston. He received had his degree from northeast Ohio

university completed residency in clinical medicine at Virginia Commonwealth university health system and board certified in both internal and addiction medicine. Michael has extensive experience teaching about addiction to mental health students, residents, and community professionals at all levels.

And our other webinar present certify Don Hall. He is a personal in long-term recovery which to him means that he has not a needle in his arm for recreational purposes for 25 years. Since the initial initiation of his recovery, spent most of his career---- he serves on the advisory committee of the school of human services, of Houston community college. And involved in drug control policy.

With no further delay I will turn this webinar over to Don and Dr. Dr. Michael Weaver.

>> DON HALL: Okay, this is Don. And one of the questions that we had after the last webinar about a year ago which may be, a little over a year ago which maybe some of you attended was about many of the things that we're presenting on this. Our running objective for the -- counselor will be prepared to talk to the doctor with common issue of MAT clients. Counselor will be nor knowledgeable about medications used in the treatment of substance use disorder. And the counselor westbound prepared to educate the patient about medical medication-assisted treatment for various substances. And this includes clients that are experiencing more complex situations.

First of all we need to do a review of where we were at last year, the basic medications you are used to-- that are used to treat substance use. And of course, medication-assisted treatment has been used for some time with nicotine. With kind of an exception that there doesn't seem to be any stigma about that.

And with that, Mike, could you describe some of these medications?

>> Dr. Michael Weaver: So I've used a variety of medications for treating tobacco use disorder. First is nicotine replacement therapy. This has been around for quite sometime. Most of them are available over the counter without prescription, patches, gums and loss synergies.

There are also Cress prescription medication, Bupropion, sold under the name Zyban and Wellbutrin for treatment of depression. There's Varcicline, Chantix. This is for the nicotine receptor and both Bupropion and Varcicline are success. At helping people quit smoking. They are used the same way, you start seven to ten days before people quit smoking. And then you will ramp up the dose for a few days. They stay on it three to six months or longer especially in the case of Bupropion if treating depression with it. Do you have any other comments for medications, for nicotine, done in

>> DON HALL: No, not really. I had people have great success with it. Many of our programs are state funded programs in Texas they're required to recommend some form of smoking cessation during their process. Also the the review of alcohol.

>> We have several med indication of treatment of alcohol disorder. Acamprosate is a medication that's FDA approved in the United States for a number of years and reduces cravings very successfully. Disulfiram, it's been around even longer. And this works a little bit differently instead of reducing cravings, it makes it an unpleasant experience when you drink alcohol when you're taking the Disulfiram. It only works if you take it every day. And that could be a challenge for some folks. It's better if it's in a monitored setting where a spouse, employer, sponsor, counselor or even a judge is monitoring whether someone is continuing to take this. And it does have potential side effects and drawbacks. It's not really first line. And now, Naltrexone has also been available for a while. Vivitrol is the brand name for the extended release, intramuscular injection of this. All the forms work the same way. They reduce cravings and pleasurable servings of alcohol. Is a slip is less likely to become a full blown relapse in someone who is trying to stop drinking.

>> DON HALL: One of the things that I learned with Naltrexone is many of the clients that are experiencing fairly severe alcoholism are willing to try the Naltrexone and sometimes progress to Vivitrol after they had positive results from the oral version.

>> Dr. Michael Weaver: Both of them work well. Vivitrol is expensive because it's still brand name and once a month as oppose to once a day. There's a cost differential. Something to keep in mind when talking to clients about this.

>> And of course, medications in use for opioids.

>> So Methadone and Buprenorphine have been around now. It's used in a variety of situations, but more limited in the setting of medical assisted treatment or federally narcotics programs with dispensing initially. It is less restricted you don't have to go to a Methadone clinic. But it can be pricier. There are varieties and names available although they are often covered by insurance as well as Medicaid and Medicare. You can have it set up quickly because you're paying separately for the medication, the office visit with a doctor or nurse practitioner to get the prescription and then for the counseling which is separate as oppose to Methadone maintenance programs where you have one stop shopping.

Naltrexone is available for opioid use disorder as well as alcohol use disorder. It's effective for opioid because it is an opioid blocker. It's the same forms and exact dosing for opioid use disorder as for alcohol use disorder and all of these have significant data showing that they are effective although Methadone and Buprenorphine is-- they're agonist. You have to detox someone out of the opioid with Methadone and Buprenorphine before to transitioning.

>> DON HALL: I worked with Methadone, and some Buprenorphine clients. Methadone seems to be more for the hardcore users where Buprenorphine works with those using less long. Occasionally I get someone who wants to get off the stuff and move to Naltrexone even from Methadone.

to go straight to Naltrexone is somebody that comes from a pill addiction and wants to get loose of it meetly and willing to go through detox and continue with Naltrexone.

And here is our polling question.

>> Thanks, Don, Michael. Everyone you will see this poll launch on your screen in a moment to interact with your presenters. This is the first of several opportunities to interact. The question asks MAT should always be recommended for opioid users. You'll see four answer options there for you to select. In just as a reminder if you have any questions for our presenters, you can send them into the questions box at any time.

We will collect those questions and give those to our presenters in the order in which they are received in either a live Q&A or a Q&A document we post on our website later. So for we have 60% plus voted. I'll give you all about ten more seconds to respond to the poll.

Excellent. A little more than three quarters voted. I'll close the poll and share the results.

>> Dr. Michael Weaver: Excellent, client form choice was I was hoping to come up. One of the important things is people know what they're stepping into when they go into a treatment center or a program. One of the questions that we filled after the last session that I continue to educate people about in Houston is pregnancy. And I'm going to turn this over to Mike for a bit because I have stories about this. But he has much more of the knowledge on this one. So Mike?

>> Dr. Michael Weaver: This is not an uncommon situation. We have gotten a lot of questions about using MAT in pregnancy. We're going to spend time talking about these issues. So let's tart with nicotine. So we can use nicotine replacement successfully in pregnancy. Although the American college of obstetrics and gynecology recommend starting with behavioral therapy. Most of the folks listening on in webinar, if the climb is coming to us during her pregnancy, then more likely than not she's beyond the period where she would benefit just from behavioral therapy and may be smoking enough that she would need to have nicotine replacement therapy of some sort.

Usually it's recommended for women who are smoking more than five cigarettes a day so a quarter pack and beyond. Nicotine is considered safe in terms of replacement therapy because the woman has already been exposing herself and baby to this throughout that time up until once she decides to quit. So you're not exposing her to anything new. But in fact are preventing exposure to the other chemicals and carcinogens that are in tobacco smoke as oppose to nicotine itself.

It isn't to be used without a behavioral component. That is more likely to be successful when you combine it with counseling. Although a woman who are pregnant are highly motivated in general.

We can also use Bupropion in pregnancy. This is more rare. After behavioral therapy, nicotine replacement is first line. We don't have as much data about effects of Bupropion. We know it's not going to cause birth defects. But it, we just don't have a lot of database country as to long-term effects. So it can be used. It needs to be used with caution and in conjunction with the physician who is prescribing it.

As far as the alcohol use disorder medications in pregnancy, it's a similar story. We don't have a lot of data for some of these. So it becomes a judgment call. With Disulfiram, it can be prescribed but generally not, it can be potentially dangerous to an unborn child so is not recommended, not first line.

Naltrexone, may be used and has been used successfully in pregnancy, although we don't have lots of data. It's something we are collecting now. And it may have the potential for some adverse effects, but you always have to balance that with the potential for adverse effects from the mother continuing to drink during pregnancy which we know clearly has effects in the form of fetal alcohol syndrome. On balance, you would have to recognize that there are some risks compared with the benefits from stopping drinking.

Acamprosate same story. Not a lot of data. You have to weigh the benefits versus the risks are with anything that you're going to be using in pregnancy.

Now, for opioids, same medications as we have previously reviewed. The good news is that we know that Methadone and Buprenorphine are safe in pregnancy. Methadone has been used for decades and is still the recommended treatment of choice for women with opioid use disorder who are pregnant. And Buprenorphine is continuing to have data available that is showing that it's worthwhile to use in pregnancy. It doesn't have specification from that from the FDA but neither does Methadone. But clinical judgment would dictate that these are safe and worthwhile to use. So if a woman is in either one of these for maintenance, that can be continued through pregnancy. If they want to get on either one of these while pregnant it's an acceptable choice. As far as Naltrexone, you have to start with they think dope and Buprenorphine and taper off during pregnancy. This is generally not recommended but

there is emerging data that if a woman is highly motivated to come off of opioid like Methadone and Buprenorphine, Naltrexone is a possible option.

But in generally you're going to want to start with an agonist and most of the data shows that it's better to continue that throughout pregnancy. Naltrexone can then be considered after pregnancy. But it is going to end up being a case by case decision. But the majority of women are going to remain on Methadone or Buprenorphine.

You have comments on meth donor Buprenorphine, at this point, Don, or should I go on?

>> DON HALL: One of the things I want to say there, is a client will say I want to go ahead and withdraw from the Methadone. From the counselor's viewpoint, my job is to basically recommend, you need to talk to the doctor about that. I'm not going to make that call. I'm going to do my best to help educate the client that it's better for them to stay on the Methadone or Buprenorphine throughout the pregnancy. But I'm going to schedule an appointment for the doctor so they can hear it from the doctor or hear whatever, go over their situation with the doctor.

I also, my job is to support whatever the doctor decides on that matter with the client. If the doctor says we're going to start tapering you down and bringing you onto first Buprenorphine and now Naltrexone, my job is to help guide the client through that and refer back to the doctor if issues arise.

>> Dr. Michael Weaver: That's a very good discussion. And the things that I as a physician will talk to the woman about especially in case of Methadone and Buprenorphine maintenance would be the fact that it is very useful for stabilization of both the mother and the fetus, not just medically in terms of the pregnancy but also socially so that the mother to be can concentrate on preparing for the arrival of the newborn and work on the behavioral issues related to her recovery.

And that can be much more successful when she doesn't have to worry about the physical aspects of withdrawal and detoxification. It helps reduce stress on the fetus because you don't have the fluctuations in maternal opioid level that you get in using of frequent dosing of heroin or slow acting opioids, avoiding all the adulterants and

contaminants and stuff that's used to cut the heroin actively using as well as other drug use such as cocaine, methamphetamine and an and other drugs. Doing all this helps to improve the growth. Fetus and after the delivery of the newborn because it has the best start possible because of avoidance of all these compounds and exposure during pregnancy.

So which is the best alternative during pregnancy, Methadone or Buprenorphine? Methadone has some advantages as Don mentioned earlier, it tends to be better for hardcore user. High opioid tolerance, dealer's habit. Those using high doses of prescription drugs. It's also less expensive and you have colocation of services. We'll touch on that. I mentioned about one stop shopping in Methadone clinics. You get advantage of daily monitoring which is useful in the latter stages of pregnancy to make sure that labor isn't starting or that conditions can be confused with label or aren't arising. And having that kind of look-see by a professional could be valuable.

The advantages of Buprenorphine as oppose to Methadone are the fact that it has a bet every safety profile in terms of potential for overdose. There are fewer medication interactions come compared to Methadone especially medications taken for mental health conditions or long-term treatment of HIV. Buprenorphine is less restricted, so you're going to have more options to where a woman can open it or more flexibility in terms of appointment scheduling because you don't have to worry about daily clinic visits. A woman can take it in the safety of her own home on a daily basis.

In terms how well they do in reducing or eliminating elicit opioid use, they are both equally effective and have similar identified effects like you would see from any opioid in terms of constipation and mild sedation in the tolerance.

Just in case you aren't convinced of the equivalence of these two medications or their usefulness in pregnancy, there's a large scale study that was done a number of years ago. The results have been published and widely distributed. This was called the maternal opioid treatment human experimental research trial. Compared Methadone and Buprenorphine in 175 women and there was no difference in how the two performed in terms of relapse rates as determined by urine drug testing. The number of prenatal care visits attended by the women, the rates of need for a C-section or the

need for analgesia with opioid medication and epidural at the time of delivery and the instance after delivery.

So all of these important aspects were equivalent between Methadone and Buprenorphine when used in pregnant women.

What they also showed was in terms of differences women on the Methadone arm of the study were likely to complete the entire course of the study as oppose to Buprenorphine. But the women that were in Buprenorphine, those newborns were, had better outcomes in terms of NOWS, they needed less medication and had a shorter treatment course as a result. Basically Methadone kept the women engaged longer but Buprenorphine had a shorter and simpler course in terms of newborn withdrawal syndrome.

At the time of delivery there are some important consideration to keep in mind. What I tend to do is continue the medication assisted treatment throughout the early stages of labor and delivery where Methadone and Buprenorphine, it's okay it give additional doses of other opioids to treat the pain. But the Methadone and Buprenorphine also will to some degree help with pain as well as the substance use disorder. And it's important to prevent withdrawal which can cause complications during labor and delivery.

One way to make this more effective is to split up dosing regardless of whether it's Methadone or Buprenorphine. You can get a quarter of the daily dose four times a day. So about every six hour in order to have a pronounced analgesic effect.

That way you may get away with needing less 30 opioids or other medications to control pain at the time of delivery. And then after time of delivery, you can consider tailoring off. But generally not immediately after. My preference is to wait until six weeks after delivery in order to allow appropriate time for bonding and getting over the stress of having a newborn especially if there are other younger children in the household. That could be a stressful time. Give the mother some time to settle in with the new child before bringing up whether it is time to taper off.

And all of these can be very effective strategies during pregnancy and during a time period after to help prevent relapse and continue engagement in addiction treatment because, if you discontinue early and try to detox off, you may even end up causing premature labor. That can sometimes lead to miscarriage. Those are obstetric outcomes that you want to avoid. And this could be done by simply maintaining a woman throughout the time of pregnancy.

In terms of dealing with pain at the time of delivery you would treat this like you would any other woman who is not on medication assistive treatment. So anesthesia with epidural is the recommended treatment. This is commonly done and there are no contraindications because a woman is on Methadone or Buprenorphine. You can use-- you can use medications from a normal vaginal delivery. But if the pain is more severe it's fine to add other opioids that would be traditionally given such as oxycodone or hydrocodone as well as intravenous medication at the time of delivery if needed for more serious pain.

All right. Any other comments about MAT during pregnancy, Don?

>> DON HALL: Just a couple. One of the things that are very important is that someone gets engaged with the client enough that they can begin to engage the OB/GYN that's handling the pregnancy and helping to ensure that that person is engaged in the concept of medication assistive treatment so that they don't do something like demand that the woman with Methadone a month before the birth. Or in one case that I had not too long ago, the young lady gave birth to the baby. The baby was slightly blue when it was born. And the doctor immediately-- the baby without doing test. And found out after that didn't work and they found out the other tests that the baby was, had slightly low blood sugar, of course, this extremely upset the lady that was having the baby. And she did not have a pleasant experience for the rest of the hospital stay.

So it really takes-- the old saying, it takes a village to help the client through this. It really does. It takes some engagement with the hospital and with the hospital team. And I would really recommend if you're dealing with pregnant ladies, if you don't have the functional in the community to really work on building that.

The next section we were going to go to is mental health issues. Any of you that have worked with mental health clients will know that many mental health clients have current smoking issues. It kind of goes with the territory. And again we have essentially the same medications. And the counselor's job is to try to engagement with the client and help them to see how their life might be better without smoking.

>> Dr. Michael Weaver: You can use nicotine replacement with most other mental health medications, anti-psychotic, antidepressants. There may be some reactions, depending on which one. Current smoking may increase or decrease the level of those medications.

If someone stops smoking, then that may change how they're affected by the medications. It's worthwhile to let the patients know there's a possibility. If the medication doesn't seem effective because they have been successful of stopping smoking. And now they need to talk to their psychiatrist or primary care provider about adjusting the dose since the client is no longer smoking.

Not as many interaction but there is the potential for some with the antipsychotic medications. Not so much data for bipolar disorder. It's worth while to keep in mind that nicotine and the other ingredients in tobacco smoke can affect levels of other medications and stopping smoking can also have an effect. It's not just the presence of the medication but the absence once someone has been on both medications for a while.

>> I think one of the things I'm hoping was coming a cross in this is establishing communication between the client, the doctor, counselor. The client is expressing the symptom. If I'm counseling the client without paying attention to what they're going through, I can't give the correct information to the doctor or to the client. Obviously this would indicate I'm a client centered therapist or counselor. But that is very important. Again when nicotine Bupropion personal history this is the medication that helped me quit smoking many years ago.

I did have some issues that-- there are side effects to Bupropion that are not real pleasant. But I hated smoking more than I hated the side effects. So I survived this. Mike?

>> Dr. Michael Weaver: Bupropion is effective and has been around for a while. If your clients have both depression and are trying to quit smoking, you can kill two birds with one stone. However if that depression is part of bipolar disorder, then if they're already stable on bipolar medications, sometimes this can interact with some of those medications or you can in someone who hasn't been formally diagnosed yet with bipolar disorder, push them into a manic episode by treating the depression. It's good to be in communication with any mental health providers for the patient to make sure that, if that starts to happen, it can be caught and addressed quickly.

For patients who have schizophrenia you can use this for the smoking cessation as again keeping in mind that there may be some interactions with some of the antipsychotic medications that the patient may be taking. You can see if in conjunction with nicotine replacement therapy.

In terms of Varcicline, this has been effective for a wide variety of patients with video variety of mental health diagnosis. And this as well as Bupropion have helped patients who have schizophrenia to be more successful at quitting smoking compared to those who do it on their own without medication. And Varcicline, because it's not an antidepressant and closer to nicotine, may be a better bet for patients who have bipolar disorder for the reasons I mentioned in the previous slide.

And okay-- in terms of alcohol, we have good reasons for people to stop drinking if they have another mental health diagnosis. Disulfiram has been around for a long time. So it's been looked at with a number of other conditions. But we don't have a lost good data. And unfortunately, psychotic disorders including schizophrenia are one area that Disulfiram may not be quite as useful because of the side effects are worsening of psychotic symptoms. It's a population in which it pays to believe cautious. The negative drawback is it can cause a reaction with even small amounts of alcohol. It's worth cautioning your clients about if they do end up on Disulfiram to help them with the drinking. They may be exposed to alcohol in ways they don't expect. The alcohol that's

in mouth wash or in cough and cold preparations can cause a reaction that make them feel unpleasant. If they don't have intentionally had a drink of wine or liquor. A little bit of anticipatory guidance can save I lot of unpleasantness.

I mentioned that it can worsen psychotic symptoms and if you try to stick to lower doses that could be helpful in terms of reducing the chances of that. But there are some patients who may not respond as well to lower doses and find that they can drink through that in which case you may end up using higher doses just to have the beneficial effects of the medication itself. Again being very cautious that any sorts of psychotic symptoms do appear, that you're in communication with the client's prescriber and help make the client aware of what may be happening here so they contact their doctor as well to address these issues.

But it can be beneficial in patients who do have schizophrenia that are heavy drinkers. Again, must be used with caution. And then as far as Naltrexone goes, this is a kinder and agenda letter approach compared to Disulfiram which has fewer interactions with medications. Does not directly increase psychotic or mental health symptoms like depression. And even though it blocks opioid effects, it's blocking the pleasurable effects of alcohol that people get through the opioid system. It's not going to block other effects of the endogenous opioid system. It's not going to make people less happy or joyful with other activities. It simply reduces the pleasure of alcohol but not the pleasure that someone gets from any other enjoyable activity like completing a project or getting a good grade or attending a graduation and things like that.

Very low doses of Naltrexone have actually shown some benefit for patients who have chronic depression. Although that's an area that's still understudy.

And Acamprosate, is pretty benign. It doesn't have any drug interactions. So it can be used with more confidence and patients who are on a variety of other medications. And that's one particular advantage of this medication especially compared to Disulfiram.

If we're talking about risk for bordering of depressive disorders, that's the risk with any of these medications. And has been looked at. Some of them it's worth

keeping in mind that patients who have an alcohol use disorder are likely to have higher rates of depression which means that they are likely to have higher rates of suicide attempts. And so it may not necessarily be the medication itself that is causing some of these associations with suicide attempts. But it's worthwhile to caution our patients and to give them anticipatory guidance that if they find any of their depression symptoms or other mental health symptoms are worsening after starting these medications for alcohol use disorder that they talk to their prescriber right away and let someone know about their symptoms. If you're the first one hearing about that, that might be worthwhile to communicate with the prescriber and let the patient know about the need to do so.

>> DON HALL: What I would like to say about the medication-assisted treatment and alcohol use disorder, I'm seeing this turn around where Acamprosate and Naltrexone are used more with alcohol use disorder especially with people with severe mental health issues. I do not understand why either one of these medications are not used all the time with alcohol users.

Both of them are benign. You cannot even-- you can't poison an animal with either one of those medications. Why not give it to the client if the client's willing to try it and help them reduce their use? I think we're doing a client a disservice when we refuse to recommend these types of medications.

Mental health issue was Methadone, one thing I have noticed with several clients I'm working with, is the bottom point here that it reduces depression. A lot of this is probably situational. But it really does seem to reduce depression in some patients.

>> Dr. Michael Weaver: I would agree with that in Methadone clinics. Being on Methadone help stabilize a variety of mental health conditions including psychosis as well as depression. I have the advantage of the fact that you get daily dosing especially initially. Folks at risk with mental illness symptoms and with difficulty taking their medications on a daily basis, this could be an ideal setting for daily observed therapy of other medications in addition to Methadone.

It's also worthwhile when starting Methadone and starting other medications for depression or psychosis that you see the patient frequently enough to see if there is a drug interaction. Some of the ones listed her, Risperdal can lower Methadone levels and elevate symptoms of withdrawal-- a need for dose increase with Methadone after it's been started with Prozac that can elevate Methadone leveled.

If you have a client who comes off of-- they might find that Methadone is less effective or they're having withdrawal symptoms.

As I mentioned earlier about smoking, when you're stopping that can also have an effect on other medications you're taking if you're on Methadone stopping other medications may have an effect or stopping and starting other medications while on Methadone can affect Methadone levels.

Another one of these is-- antidepressant can increase Methadone levels. Worth watching out for clients who may feel sleepier or constipated after starting these medications. It's also used for pain management-- they can have similar side effects as well.

in terms of Buprenorphine, this also like Methadone can reduce some of the symptoms of depression. Although this may be situational for at least a part of it as they get into recovery and start to stabilize. Their mood is going to stabilize along with it.

There are some interactions with medications that that tends to be far and fewer and far less clinically significant with Buprenorphine as compared to Methadone. So if you have clients that are on lots of other medications for other conditions, that may be another reason to consider Buprenorphine as we mentioned earlier.

And then when you are starting or changing to Buprenorphine, it's tricky in terms of induction. You have to wait until someone has started to develop withdrawal before giving Buprenorphine, otherwise you can precipitate the withdrawal and get the opposite of the effect. This is the reason why it's safer in overdose and has reduced potential for abuse. But this can also make starting it trickier if you're not careful about the timing.

And in terms of Naltrexone which is the antagonist, it's not going to have a significant impact on other medications in terms of interactions and side effects which is

good. And it may be just by virtue of the fact someone is stopping their opioid use help to stabilize the mental conditions they have and improve compliance with other medications. As we mentioned earlier Naltrexone can be helpful for depression that occur in folks that have opioid use disorders.

>> DON HALL: The thing I'm focusing here with the entire look at the mental health issues, pain management as we go into this is developing that rapport with the client so that the client is reporting real symptoms to you and so you can report those things to the doctor to discuss the situation with the doctor. Establish that communication because we're dealing with sick people. To help them get healthy, we have to provide correct information.

One of the issues, this one comes up quite often is pain management. I can't seem to get these slides to stop where I want them to. It's pain management because especially with opioid use. The problem started with some car accident, sports injury, motorcycle accident or whatever. And so you're dealing with a client who became dependent on the drug because of an accident initially. Sometimes not even realizing the level of medication that they were being prescribed. And then something happens and their fly of the legitimate medication is stopped or whatever. They find themselves using heroin or using excessive amounts of pain killers. And they show up in the treatment program because now they have issues.

However, they still have the pain issue in the background especially if they have severe back injuries, leg injuries, hip injuries, whatever. I can't even describe to you how many people that are in the program, Methadone program I work at who's induction to opioid and alcohol was because of a car accident. It happens all the time.

In recovery this has to be addressed with the client and with the doctor because, if the doctor says, well, we can't prescribe Methadone because me had a car accident and they had final vertebrae damage in the back, that makes no sense to me. Mike?

>> Dr. Michael Weaver: So a lot of medications have been shown to help with chronic pain conditions. Things like Bupropion and some of the antidepressants have been shown to be effective for neuropathic times of pain. Naltrexone has been used for

neuropathic pain in low doses. There's a 10% may be help. But not a lot right now to draw any conclusions. And Methadone and Buprenorphine have been used extensively for pain management for years before they were used as medications for MAT.

Okay. All right. So in terms of nicotine replacement, there's some evidence that nicotine may have some analgesic properties. This has been shown in animals, less data in people but some folks report less pain when they quit smoking. Transdermal patch may reduce notes who are already smokers, the evidence is less clear for non-smoker, and nausea tends to be a problem if you try using nicotine replacement in folks who are nonsmokers.

In terms of other forms of MAT and pain management, all right. So Antabuse has actually been linked to chronic pain problem such as neuropathy. Naltrexone as I mentioned earlier including in low doses has been used for chronic pain treatment. So if someone doesn't have chronic pain, then Naltrexone may limit the use of opioids. But itself may have benefits for chronic pain. Methadone as I mentioned has been used extensively for pain management and considered first line as a long acting opioid that has lower abuse potential in many of others that are currently available. One is used for medicated assistive treatment and prevent use of other opioids inappropriately.

It's also able to become combined with a whole host of other medications that are used for treatment of chronic pain such as antiinflammatories as some of the antidepressants we talked about. Topical medications what not. However being on Methadone maintenance can complicate situations where you have acute and unexpected pain such as a broken bone from a car accident or skiing accident or other sorts of injuries that people may experience. However as we mentioned in the case of women who have undergo a C-section or have pain with a vaginal delivery you can't add other opioids on top of Methadone for treatment of acute pain and work in conjunction with the surgeon or emergency physician or the other physician managing the opioids for pain as well as the folks that are managing the Methadone for medication assistive treatment to be able to taper down the other opioids appropriately as the medication assistive treatment continues.

With Buprenorphine, it too, has been used pain management before MAT. And as with Methadone, very effect any for both these situations. With Naltrexone as an opioid antagonist, it can be difficult to treat acute pain while you'll on a medication that will block the effects of opioids. But if you are using higher doses of opioids or higher potency opioids like fence nil.-- the trauma surgeon would need to know that they're on Naltrexone. Waiting for it to wear off may be required for elective procedures to allow opioid recovery, recovery period and the Naltrexone can be resumed after the post operative pain or acute pain has subsided.

>> DON HALL: Polling question here.

>> Thank you, Michael and Don. You will see the second polling question pop-up on the screen in just a moment. It asks the question, MAT patients should be offered pain management alternatives. You will see three options. If you answer the poll now and in just a moment we'll close the pole and share the results. As lot of you have sent in a lot of questions already. Thank you for sending those in. We are putting them in an order for Don and Michael it answer in our live Q&A. If we don't have time for Q&A each question will be answered on a Q&A documented posted in our website. We'll give you ten more seconds to respond to the poll. Thanks everyone, I lot more than half of you have responded. We will close the poll and share the results and turn this over to Don and Michael.

>> All right. It look likes people are catching on. On going MAT is a patient informed choice.

>> Another category that we run into a lot, I work at a Methadone clinic. And I obviously, when people are exposed to IV drug use, HIV disease goes side-by-side with that.

And just a couple of, few quick things about medication assistive treatment with HIV disease. All forms of smoking cessation have been demonstrated to work for HIV positive clients to reduce smoking. There's some of these that do cause medication interactions. Sometimes the is not aware of what medications will interact with their HIV medications because people have been working with HIV medications for a number of

years now and have developed really good information about what interacts with what and what's available on the internet to even help research interactions.

Um, with alcohol use disorder, there's one study that I ran across that was weird that said that you may wake up dormant HIV in certain cells -- I have not found verification with that as with any study. Find duplication or taken with a grain of salt because the next studly will probably find something different.

Again the Naltrexone has been shown to be effective, low dose Naltrexone door -- and one anyone I want to make clear here, what most doctors will prescribe for alcohol use disorder is also considered low dose Naltrexone. It does address more than one thing at a time as far as I've been able to observe.

My main purpose here again is to educate the client and be able to establish communication between the client and the doctor with my help to help make sure that everybody gets on the same page so we reduce the patient's distress as quickly as possible. Mike?

>> Dr. Michael Weaver: Nothing to add here.

>> Okay. Methadone and HIV disease, actually, the program that I work for right now we have state grant funding. And part of the grant funding we're required to assess people for HIV disease. As you'll see in a few minutes, hepatitis C and TB. And we get results back and help to educate the client and provide referrals to whatever their situation is.

The first thing with both Methadone and Buprenorphine is they reduce IV heroin use with reduces expose you're to disease. If you're working with an HIV client, ask the counselor or I would say as a doctor, definitely point out what all medications they're on and research what possible interactions if there are. And talk to the doctor. Talk to the client. And find out what value these medications have and what needs to be done from there. Make it a group decision.

>> Dr. Michael Weaver: I agree, there are a variety of HIV medications that affect levels of Methadone and Buprenorphine. So you need to have good

communication with all the members of the team to make sure that you're not having unexpected problems.

>> My main thing is, the client is a member of the team. Hepatitis C with smoking, some studies indicate that smoking increases liver damage and hepatitis C patients. Quitting and reducing smoking can enhance health improvements even as they're going through the treatment. The treatment for hepatitis C are way more effective than the alternate treatments.

But quitting smoking it removes one more poison that the body is processing out through the liver. Mike?

>> Dr. Michael Weaver: Some of the same points we brought up before, Bupropion can kill more than one bird with a stone. As well as depression and smoking cessation with nicotine replacement being able to reduce smoking, reduce the chances for interactions with medications the patients may be taking for their hepatitis C treatment.

>> DON HALL: Hepatitis C in alcohol use disorder, obviously the idea is to get people to reduce and eliminate alcohol use. Disulfiram may not be the objective. My thing with Disulfiram, when I'm talking to the client, if the client has had past experience with Disulfiram or Antabuse, and success with it, I would relate it to the doctor. If they had bad experience with it, we'll probably going to something else.

Naltrexone again can help to reduce and eliminate the drinking and it may have some liver damage but less than hepatitis C if the person continues to drink alcohol. Acamprosate I did not find one study that found any comparison of using this.

Acamprosate isn't metabolized in the liver. But both Disulfiram and Naltrexone can have negative effects in the liver. If someone has have hepatitis C with liver disease it's important to be cautious and important to have good communication.

>> DON HALL: Hepatitis C and-- Methadone clinics have become one of the primary venues for treatment of hepatitis C. In Houston, there were numerous clinics around that provide medication and funded for medication for hepatitis C. It's fairly easy

referral. And usually I can find a place near where the client lives that's really easy for them to interact with and get started on.

The Buprenorphine, most of the same advantages. Again hepatitis C medications are readily available in most large cities at least at this point.

Naltrexone it can help reduce and eliminate IV heroin use. I really didn't find that many studies on Naltrexone and hepatitis C except it did say that if they reduced their heroin, IV heroin use, they were in less risk however they got there. Any comments on that, Mike?

>> Dr. Michael Weaver: I would agree with that. You have to balance the risk and benefits. If they continue to engage in elicit drug use especially with sharing internets, that's higher risk than any of the potential health risks related by using Naltrexone to eliminate that behavior.

>> DON HALL: Again this is a place to really communicate with the client and communication with the doctor. We're up to a polling question.

>> Thanks, Don. Yes, everyone you'll see this third question pop-up. The question is HIV and HEPC patients that are on MAT should-- it may not be worded. Let's see. Oh, and there's the fill in the plank. You'll see four answer options. Looks like most of you get that. I'll give you ten more seconds.

Perfect. Thank you so much everyone for answering that question. We're going to go close the poll and share the results and turn it back to the presenters.

>> Dr. Michael Weaver: Good. People are paying attention.

>> DON HALL: Obviously people have been studying some of the term out there. So we're across the nation, approaching this opioid epidemic and trying to figure out what to do with it. And people are reaching for the things that work which is most awesome.

Many cases, the treatment of other drug use often you'll-- often, at least in the Methadone clinic where I work, we know people that use many other drugs. Probably #1 being nicotine, cocaine. There's obviously we just talked about the MAT for nicotine.

It does help. Actually currently with some of the clients in the clinic where I work, I have, I think at least eight clients that are using some form of MAT for smoking cessation.

And there were a couple that were using behavioral. There's amazing amount of stuff on smoking cessation that helps. Cocaine, is probably the second popular drug in injection after heroin. Methadone and Buprenorphine almost have no effect. And as much as of the literature now will say, there's really know medication assisted treatment for cocaine yet. Michael?

>> Dr. Michael Weaver: I agree we can use multiple types of MAT for use of multiple substances

Tobacco MAT and opioid MAT can be successfully used together to reduce both those addictions for cocaine we don't have anything. Not for lack of trying and studies are ongoing.

>> Benzodiazepines.-- it can help minimize withdrawal symptoms and keep them from even having seizures or whatever. Stimulant clients, amphetamine clients would use Benz pines. Clients will have panic attacks, they'll use the benzos. They're highly addictive and with drawing from benzos is complex and potentially deadly. I have had clients who came in. Well, my doctor cut me off benzos. And two days later they're in the hospital.

Any comments on that, Mike?

>> Dr. Michael Weaver: That that it's important to be cause if they're using benzos and opioids. It's a cause of overdose death. Pay attention to it and caution clients about those interactions when they're using one or both elicit drug.

>> DON HALL: One thing that's common in Houston right now is a lot of people with pill-- make these pills made out of fentanyl. The clients that are still using have access to fentanyl test drugs so they can see what they're using.

We bypassed sedatives. I see clients coming in with prescription for Ambien or Lunesta. The same thing with similar to benzos is taking them with opioids even

Methadone even is usually contra indicated and probably would want to spend time with that client discussing what they were doing. Jump in, Mike.

>> Dr. Michael Weaver: I think you're covering it well. It's true that things like am by general and Lunesta and-- are similar to benzo. People might not realize that they can cause nearly as much trouble in terms of intoxication and potential for overdose as well as addiction.

>> DON HALL: Amphetamine. There is no assistive treatment for stimulus use disorder. However, even, I was listening in NPR, they are doing experiments with Naltrexone. And with amphetamines is a drug that quite often clients that are being treated with Vivitrol is criminal justice clients would use amphetamines because they can get high through the Naltrexone is shown to have effect on helping reduce amphetamine use. I don't know how accurate that is. I just heard it on the radio this morning.

>> Dr. Michael Weaver: Research shows that there may be potential there. But we'll wait to see. There's big studies that have wrapped up.

>> DON HALL: Alcohol and marijuana-- it increased effect of alcohol and benzo. There's no known medication assistive treatment for marijuana use disorder yet. However marijuana has a fairly mild withdrawal symptom. Marijuana use, withdrawal can trigger psychotic symptoms in some individuals.

Some of the clients that I've worked with as they have tried to get off of benzo have moved to marijuana and actually had some positive results with that. The hope here is that eventually there will be constructive research on what marijuana actually does and some research that makes sense. Because there may be some benefits that we don't know about but there may be some detrimental concerns that we have to look at.

>> Dr. Michael Weaver: Methadone is becoming more and lore legal in more states and jurisdictions. It's not benign. It can worsen panic attacks and psychotic symptoms. So even though clients may use it to try to mellow out, it may have sometimes the office effect. And it's worth while to know about that especially if they

are high dose or high frequency users. And this can also, as a gateway drug, lead them back into use of other substances even while they're on MAT.

>> DON HALL: They'll be going back to see the same people, too so that could be the problem. Okay. Another polling question.

>> Thank you. And yes, everyone this will be our last polling question, launch it on your screen. You'll see four options patients that abuse other drugs during MAT should be-- you'll see four answer options there. As a reminder, thank you so much for those of you who have sent questions. If we have time in QA-- or they will it looks like about half of you have completed the poll. We'll give you five more seconds. Thank you so much everyone. Almost at 75% in attendance have answered the poll. I'm going to close and turn it back to our presenters.

>> DON HALL: Again, we see that people who are moving towards the client center model. We're getting and counseling the client not just discharging them from treatment. A few points on withdrawal from-- when a person is on MAT, when they stop the MAT, they have to, they may have to take any where from weeks to sometimes even years to come off of the medication-assisted treatment. The duration of pharmacotherapy is not indefinite. I am convinced this needs to be the client's decision as to where they are. I will help guide that decision if they want to talk about withdrawal even from Methadone. We can withdraw from Methadone. It may take a while. If we're talking about with drawing from Buprenorphine, it probably takes less. If we're talking about with drawing from nicotine replacement therapy it takes a little bit of time for some people.

The goal is stabilization. Any comments on that, Mike?

>> Dr. Michael Weaver: That's one thing I like about MAT especially with things like Methadone and Buprenorphine, you don't have hard stop necessarily. You can give people that luxury of time because some people are going to need to unlearn a maladaptive behaviors than others. That's really one of the points that I really like working with clients with medication assisted treatment. Is because I have the time to work with them and a longer period of time and I have time to work through some of

their other issues. Should people might need to wean off nicotine-- Bupropion said there were no withdrawal symptom along with other drugs like some of the antidepressants. And it was eventually noted that there was a discontinuance syndrome kind of amusing to me because it's the same sort of thing.

Any of these medications, it's recommended to taper off gently.

>> I think that covers it. If someone's on maintenance medication, you have to have an exit strategy. Medication, because it can trigger a relapse.

>> DON HALL: Naltrexone and Acamprosate is not noted to have withdrawal symptoms, some people up to two weeks after the last dose of opiates. Methadone has a long withdrawal syndrome and tapering should happen over a period of weeks if not years. A lot of other things need to go into the thing. One thing I want to point out on this. This is a tapering readiness that could be used with counselor to help-- to help the counselor and the client and the doctor identify if the client's ready to taper.

Withdrawal from that, Buprenorphine, other opiates, somewhat mild. Tapering could be over weeks and months motivation is highly important. Stable life, (Record read.)

On that last one, what Michael was saying, plan ahead, have a support system in place, communication between counselor and client and doctor for that matter, meeting the treatment goals and figuring the relapse factors and taper down slowly to avoid withdrawal.

>> Dr. Michael Weaver: I like to tell patients, once the medication has been stopped, it's not that the treatment is ending, it's just that particular prescription. The recovery plan will continue with the support components even if they're not on pharmacotherapy.

>> The objective is that the recovery continues whether or not the medication does. Just a couple of quick things before we end here. If I can get the slide to move.

>> And Don and Michael you have one more minute.

>> DON HALL: I want to mention the stigma that relates around MAT. We're going to point through these really quick. Part of this is changing the language. I know you've seen this in the material. Instead of calling the person an addict. Call the person a substance abuse disorder. I get the client to use the language change-- I can return to be an addict in any day you make a wrong decision. I'm not an addict of this moment, and I am a person in long-term recovery.

The difference in that is that, when I say I added, the part of my brain has to add to late 80s when I was actively using. If I say I'm a person in long-term recovery, that's the personal since I got sober. And that's all I have.

>> Dr. Michael Weaver: I agree completely. The more we can do to reduce stigma, the better clients will be comfortable with options we have for them to further their recovery.

>> DON HALL: Thank you all for coming and observing this.

>> And Don and Michael, thank you guys so much for this incredible webinar on this great topic and a very collaborative method. We have a ton of questions that came in. I think that people were very interested in everything presented. We will get all of your questions on the Q&A document. We'll send them to Don and Michael and have an opportunity to answer the questions and post them online. Everyone you need to know about each presentation is on our NAADAC website, the same web page you used to register for the webinar. We will have the recording CE quiz and additional resources on that webinar will be hosted on that web page. The web address for this webinar is www.NAADAC.org/medication-assisted-recover-webinar. And reap are the introductions for revving CE credit. Make sure and watch and listen to the webinar, pass the CE quiz within an our or less. And then of course, after you have completed CE quiz, a certificate will be emailed to you within 21 days of submitting the quiz. If you have questions, refer to email us. Here is the schedule for our upcoming webinar. Just like to the we have gifted presenters, training on pertinent topics in advancing the addiction profession. The new clinical supervision in the addiction specialty online series has begun.

With the author of NAADAC's newest workbook-- the next webinar will actually be this week on Friday at 12#T to 1:00PM eastern, using technology for clinical supervision by Dr. Malcolm Horn. You can register to that webinar by going to the specialty online training series web page,□ w□ww .. NAADAC. Org/clinical--- again the next apartment of the series is on November 8

you pay upon registration.

In addition to West Side we'll have the military vet specialty online training series. You will have access to the specially online series on demand. If you'd like to connect with the presenter, Duane will be live Saturday November 23. Registration for that series is also $25 per webinar. If you would like to join NAADAC, there are a lot of benefits as you see on the slide. Allegation feel free to vid us-- to learn more about the benefits or email us at NAADAC. Thank you again for participating in this webinar and Michael and Don thank you for your expertise. Learn how NAADAC help others. Stay connected with us on LinkedIn LinkedIn, Facebook, and Twitter.