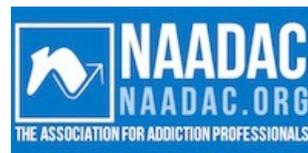


Questions Asked During Live Webinar Broadcast on 11/6/19



Medication Assisted Recovery in Complex Situations

Presenters: Don Hall, LCDC & Michael Weaver,
MD

What are your thoughts of using CBD as anti anxiety med?

A: (Don) While CBD has some testimonials that say it can be beneficial in various ways, including treating anxiety, there has been little scientific review of CBD. Personally I don't like recommending anything that does not have evidence backing it's use.

A: (Michael): There is some evidence of benefit for social anxiety disorder, but this is limited.

Where can I find the Tapering Readiness Inventory?

A: (Don) <https://www.yumpu.com/en/document/read/37849983/tapering-readiness-inventory-camh-knowledge-exchange>

What about varenicline in pregnancy?

A: (Don) Do not know. Mike will have to answer this question. I was able to find very little research in this area.

A: (Michael): Varenicline is not recommended during pregnancy. However, the benefits may outweigh the risks of continued smoking on a case-by-case basis, but this will require a discussion with the patient and close monitoring for potential problems. Varenicline has not been studied for use in pregnancy.

Do you have any research on the Sinclair" method of naltrexone and continue to drink?

A: (Don) Some information can be found here. <https://www.sinclairmethod.org/sinclair-method-studies/>

A: (Michael): The Sinclair method is taking naltrexone only before situations in which someone might drink, not taking it daily. I don't recommend this method in early recovery, since it is simpler to just take the medication every day and not have to worry about whether or not you will be in a situation where you may drink. If someone unexpectedly ends up in a situation where they may drink and don't have naltrexone with them, then that is a risky situation that could be prevented by just taking naltrexone daily.

Would it be advisable to recommend naltrexone, for pain management use, for a person using suboxone in a taper treatment to assist with pain management following the MAT treatment?

A: (Don) Naltrexone could possibly be utilized a couple of weeks after the person had completed the taper from Suboxone.

A: (Michael): I agree.

What are your thoughts about the use of naltrexone/other medications with cannabis users in early abstinence?

A: (Don) I know of no research of medication that has showed benefits of any medication for helping with abstinence in cannabis users.

A: (Michael): One study showed some modest benefit from N-acetylcysteine (NAC, which is a dietary supplement and also used for some other medical conditions, including treatment of an overdose of acetaminophen [Tylenol]) to help quit cannabis use in adolescents, but another study showed no benefit in adults. Naltrexone has not been used for cannabis use disorder.

Is there still a ceiling effect with buprenorphine at 24 mgs for pregnant women?

A: (Don) I believe there is a ceiling effect with buprenorphine at 24 grams for any human subject. I believe this is a characteristic of the drug.

A: (Michael): The ceiling effect for buprenorphine can start at 24 mg regardless of pregnancy, although the maximum dose where the ceiling effect is definitely noticeable is at 32 mg.

Have you found any type of interventions that have successfully helped those in MMT that speed-ball? That seems to be the most difficult usage to help in the 12 years I've been working in MAT.

A: (Don) Motivational Interviewing and continuing engagement combine with MAT to reduce/remove the opioid use.

A: (Michael): I agree that behavioral interventions have shown benefit, and the MMT program where I formerly worked would have clients who continued to use cocaine or methamphetamine while on methadone go to additional specific group sessions for this. SAMHSA CSAT has a Treatment Improvement Protocol (TIP) book on *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients* available at <https://www.ncbi.nlm.nih.gov/pubmed/22514817>

Will a mother who is receiving MAT treatments be subject to any issues with social services/removal of baby following end of pregnancy? Does this help them to keep custody of their child following birth?

A: (Don) Unfortunately, this often still depends on the jurisdiction. This is always an opportunity for the counselor and the doctor to advocate and educate the community. In the communities where Evidenced Based Practices have been established as the norm, the mom will usually keep custody unless there is evidence of other severe issues.

A: (Michael): Yes, there is a lot of variability between jurisdictions and even between Child Protective Services workers.

What about Sublocade? How soon after stopping Sublocade can a person transition to Vivitrol?

A: (Don) Do not know. Mike will have to answer this question.

A: (Michael): Sublocade (injectable long-acting buprenorphine) lasts 26-45 days after the last injection, so a patient needs to wait this long before starting injectable long-acting naltrexone (Vivitrol).

Due to dangers of combining opiates and benzos, what is the best practice to detox off benzos while on methadone ?

A: (Don) Once the client is motivated to reduce or remove the benzo use, I help them develop a long term tapering plan over a period of months. Some clients have considerably more difficulty withdrawing from benzos than others.

A: (Michael): I agree. Tapering off of benzodiazepines faster is better, but often leads to relapse, so it is important to find the right balance of speed, safety, and patient motivation.

Due to stigma, isn't client informed choice problematic if they have been given possibly negatively biased information regarding MAT as a treatment option?

A: (Don) Education and advocacy is the key here, not just for the client but in the community.

A: (Michael): I agree.

How do you feel about chantex or wellbutrin for a patient that has been diagnosed as bipolar and has a substance use disorder?

A: (Don) Do not know, however, from the material, it was mentioned that normally a person diagnosed with bipolar disorder might have negative reactions to Wellbutrin. That would mean to me that Chantix might be the preferred option.

A: (Michael): For either medication in patients with bipolar disorder, the benefits may outweigh the risks of continued smoking on a case-by-case basis, but this will require a discussion with the patient and close monitoring for potential problems.

To clarify, if a client is taking methadone daily, but also drinks alcohol, which can be dangerous, it would not be appropriate to prescribe Naltrexone? We can't mix the two, methadone & Naltrexone, is that accurate thinking? Perhaps, Campral would be more appropriate in this situation?

A: (Don) Since Naltrexone would trigger immediate withdrawal in someone taking methadone, that option would not be used. I would leave that one up to the doctor.

A: (Michael): Naltrexone should not be used along with methadone. Acamprosate (Campral) would be an appropriate option for treatment of alcohol use disorder while on methadone maintenance.

If a client ingests cocaine daily and is on methadone - will cocaine diminish the effectiveness of the methadone? The thinking behind it is, cocaine is a stimulant which speeds up the metabolism and it may impact the methadone dose and establishing a therapeutic dose?

A: (Don) This is kind of like the clients that speedball. If the client is taking a medication that reduces or removes the heroin use, then utilize the counseling and motivational resources to reduce the cocaine use. While cocaine may have some effect

on methadone, I have witnessed many clients that have initially removed the opioid use and then reduced or removed the cocaine use later.

In Baltimore, one of the trends that is noticed is clients taking Clonidine and methadone simultaneously have been observed to severely impaired by the two. It appears to be synergistic. Is this common in other communities, states and cities?

A: (Don) I have not seen that in Houston, but thanks to you I will be watching. Here, the worst problems are the amphetamines and fentanyl.

A: (Michael): Clonidine can also be sedating, which is another reason it can be helpful for treatment of opioid withdrawal. I have not seen patients using both clonidine and methadone that have been significantly impaired.

Is there any difference/benefits to being on naltrexone in tablet form versus the vivitrol extended release shot?

A: (Don) The main benefit of tablet form naltrexone is the cost and the fact that with vivitrol we know that the client will have it in their system for at least four weeks.

A: (Michael): The extended-release injectable form of naltrexone (Vivitrol) has much better compliance than taking a tablet daily, and studies have shown additional modest benefit from the shot compared to the pill for patients with alcohol use disorder in terms of number of heavy drinking days.

What do you recommend when housing is limited to those receiving MAT and the participants are leaving treatment and learning of the lack of housing due to current stigma or lack of funding? How do we best support participants if we know they won't have a place to go after treatment?

A: (Don) One of the reasons for continued MAT is that the counselor and the doctor can interact with the client for months or years while the client finds safer housing and employment. This is also an area where considerable advocacy is necessary to develop housing in the community that is friendly to MAT clients.

Do the newborns withdraw from both MAT medications?

A: (Michael): The MOTHER study showed that Neonatal Abstinence Syndrome (NAS), also known as Neonatal Opioid Withdrawal Syndrome (NOWS), can be caused by either methadone or buprenorphine, although it appears to be generally less severe from MAT than illegal opioids. Newborns born to mothers on buprenorphine had a slightly lower incidence of NAS with reduced severity and required less medication to treat NAS symptoms.

Can opioids be prescribed on top of Suboxine in cases of acute pain?

A: (Don) This is actually a question for Mike, but I believe that it was mentioned in the material that in extreme emergencies that opioids could be used on top of Suboxone for acute pain. In reality, I am not sure how many ER doctors would be willing to utilize the amount of opioid that might be required.

A: (Michael): Yes, for clients on buprenorphine maintenance who have acute pain, it is recommended to continue buprenorphine and to split the dose from once daily to 4 times daily (1/4 of the dose every 6 hours) if possible. Additional prescription opioids can be used in usual doses to treat the acute pain, then tapered off as the source of the acute pain heals.