

Recovery U: Medication Assisted Treatment (MAT)



MS. TIKKANEN: Welcome to the Recovery U Online Learning Community for Understanding Medication-Assisted Treatment.

This is Skye Tikkanen. I am a clinical substance abuse counselor, licensed professional counselor. I do policy work, and I also have a small private practice.

DR. FELGUS: Hi there. I'm Dr. Matt Felgus. I am an M.D. I am board certified in addiction medicine as well as psychiatry. And welcome to this presentation.

A slide with a dark red header containing the text "Module Goals" in white, bold, sans-serif capital letters. Below the header, on the left, is a numbered list of five goals. On the right, there is a light red rectangular box with three white checkmarks. Below that box is a dark red rectangular box with white text.

Module Goals

1. Understand bias against and for MAT and what the research says.
2. Be able to list the components of a successful Medication Assisted Treatment Program.
3. Gain a basic understanding of methadone and which people are best suited to this medication.
4. Gain a basic understanding of buprenorphine and which people are best suited to this medication.
5. Gain a basic understanding of naltrexone and which people are best suited to this medication.

All resources and references are located in the Resources tab of this presentation.

DR. FELGUS: Module Goals.

Number one, understand bias against and for medication-assisted treatment and to have a sense of what the research is telling us, even though the research, there are some things that are not being researched, and hopefully will be soon.

Number two, be able to list the components of a successful medication-assisted treatment program.

Number three, give a basic understanding of methadone and which people are best suited to this medication.

Number four, gain a basic understanding of buprenorphine otherwise known as Suboxone, and which people are best suited for this type of medication treatment.

And number five, gain a basic understanding of naltrexone, which one of its forms is Vivitrol. And which people are best suited to this type of medication treatment.

Theme 1:
MAT &
Recovery

Bias Against MAT

"You're not really in recovery when you're on replacement therapy."



JUNKIES BE LIKE...
NOW BRO, I'M
CLEAN... I TAKE SUBOXONE

OUR ON SUBOXONE/METHADON
BUT YOU'RE GRATEFUL
TO BE CLEAN AND SOBER
TODAY?

WE'LL CONVINCED THEM THAT THEY NEED SUBOXONE
THEN WE'LL HAVE THEM
TAKE IT FOR YEARS!

THIS ISN'T RECOVERY
It's Government drug dealing

MS. TIKKANEN: There is a lot of bias against medication-assisted treatment in the recovery community. I'm sure that all of us in a meeting or in the recovery community have heard that you're not really in recovery when you're on replacement therapy. The idea that someone who is on a maintenance therapy, like buprenorphine or methadone, that is still getting some opioid, who is also in recovery seems like a very foreign concept to us.

DR. FELGUS: What I tell my patients, there is a difference between being in recovery and being opioid-free. And while it is true that individuals that are on Suboxone and on methadone are still taking an opioid medication, recovery is a state of mind. And if somebody is looking at their inner stuff, working their steps, really day-to-day, practicing mindfulness, doing all the things that you need to do to be in good recovery, the issue is not whether or not you are on methadone or buprenorphine, it's how you are living your life.

And I think this is an important distinction to keep in mind. Because the flip side of that is that there are people who may be on these medications who are not working a recovery program. So it is an important differentiation to keep in mind.

**Theme 1:
MAT &
Recovery**

SAMHSA Definition of Recovery

There are many pathways to recovery.	Recovery emerges from hope and gratitude.
Recovery is self-directed and empowering.	Recovery involves a period of healing and self-redefinition.
Recovery involves a personal recognition of the need for change and transformation.	Recovery involves addressing discrimination and transcending shame and stigma.
Recovery is holistic.	Recovery is supported by peers and allies.
Recovery has cultural dimensions.	Recovery involves rejoining and rebuilding a life in the community.
Recovery exists on a continuum of improved health and wellness.	Recovery is a reality.

MS. TIKKANEN: That leads us really nicely to the substance abuse and Mental Health Services Administration definition of recovery.

There are many pathways to recovery. Recovery is self-directed and empowering. Recovery involves a personal recognition of the need for change and transformation. Recovery is holistic. Recovery has cultural dimensions. Recovery exists on a continuum of improved health and wellness. Recovery emerges from hope and gratitude. Recovery involves a period of healing and self-redefinition. Recovery involves addressing discrimination and transcending shame and stigma. Recovery is supported by peers and allies. Recovery involves rejoining and rebuilding a life in the community. And recovery is a reality.

Those of you who are listening to this who are recovery coaches have now become professionals in this field. And in order to be a professional, the way that we got into recovery has to stop mattering quite as much, and we have to support those we work with in whatever way they want to recover.

12 Step Meetings and MAT

Narcotics Anonymous Bulletin #29 published 1996

1. Clarifies that those on replacement therapy are members.
2. States that those on replacement therapy participation should be limited the same as those who are actively using.
 - A. Suggesting that those who have used any drug within the last twenty-four hours refrain from sharing during the meeting.
 - B. Abiding by our fellowship's suggested clean time requirements for service positions.
 - C. Seeking meeting leaders, chairpersons, or speakers who help further our primary purpose of carrying the message to the addict who still suffers.

Don't take other people's inventory!

"The inventory was ours, not the other man's." says the Big Book on page 67.

MS. TIKKANEN: Twelve step meetings and medication-assisted treatment have a long history. In 1996, Narcotics Anonymous published Bulletin Number 29. It clarifies that those on replacement therapy are members in NA, but it does place restrictions on those on replacement therapy.

It suggests that those who have used any drug within the last 24 hours refrain from sharing, but it does encourage them to get together with members during the break or after the meeting. It abides by the fellowship suggesting clean time requirements for service positions. And seeking meeting leaders, chairpersons, or speakers who help further our primary purposes of carrying the message to the addict who still suffers.

That means that in some NA meetings that follow this bulletin, people that are on some type of maintenance therapy are not allowed to share, are not allowed to hold service positions, and do feel some type of bias or stigma towards them in those meetings.

On the flip side of that, there's also the idea that we're all so familiar with of don't take another person's inventory. Judging someone's recovery based on whether or not they're using a medication-assisted treatment is taking their inventory. The inventory was ours, not the other man's, says the Big Book on page 6 and 7.

I really challenge you to look at what your inventory is versus the people that you are working with.

Coaching vs. Sponsoring

How is a coach different from a sponsor?

- Sponsors come from 12-step programs.
- Sponsors are not paid.
- A sponsor's job is to help their sponsee stay clean, abstinent, or sober by working through the 12 steps.
- A coach isn't limited to using the steps and traditions and coaches don't focus on the past.
- Recovery Coaching is not affiliated with any 12-step program. However, many recovery coaches are members of 12-step programs.



MS. TIKKANEN: I also wanted to highlight, that coaching is very different from sponsoring. Sponsors come from a 12 step program such as AA, SA, DA, NA, CA, HA. Sponsors are not paid professionals. They benefit personally from the service they give by staying clean and sober themselves. A sponsor's job is to help the sponsee stay clean and work through the 12 steps. They stick with the steps and traditions, and often the focus is on cleaning up the past.

A coach isn't limited to using the steps and traditions, and coaches don't focus on the past. Recovery coaching is not affiliated with 12 step programs. However, many recovery coaches are in 12 step programs.

Understanding that a coach's job is to challenge and support their clients as they make lifestyle changes and begin to have a better quality of life will serve you well in this profession.

Abuse Potential

Narcan (naloxone)	Vivitrol (naltrexone)	Subutex (buprenorphine)	Suboxone (buprenorphine & naloxone)	Methadone	Heroin
Antagonist	Antagonist	Partial agonist	Partial agonist	Full agonist	Full agonist
Short half-life	Long half-life	Long half-life	Long half-life	Long half-life	Short half-life
Intramuscular Intranasal	Intramuscular Pill	Dissolving pill or strip	Dissolving pill or strip	Pill or liquid	Powder that can be smoked, IM, IV
Very low abuse potential	Very low abuse potential	Moderate abuse potential	Mid-Low abuse potential	High abuse potential	High abuse potential
Low regulation	Low regulation	Moderately regulated	Moderately regulated	Highly regulated	Illegal

MS. TIKKANEN: I want us to talk a little bit about the abuse potential for the different medication-assisted treatments. This slide has a lot of information on it, so we'll try to go through it as quickly as possible.

NARCAN or naloxone is an opioid reversal medication. It's an antagonist. It has a short half-life. It can be given intramuscularly or intranasally. They say that it has a very low abuse potential. I would say that it has no abuse potential. If you're not on an opioid, it won't do anything to you. And there's very low regulation because of the low to no abuse potential.

Vivitrol or naltrexone is an antagonist. It has a long half-life. It can be given with Vivitrol as an intramuscular injection that lasts for around 30 days or oral naltrexone is given in pill form. Again, they say very low abuse potential. I would say no abuse potential and low regulation because of the low abuse potential.

Subutex or buprenorphine is a partial agonist. It has a long half-life, so it stays in a person's system for a long time. It's a dissolving pill or a strip. It has a moderate abuse potential. And because it has a moderate abuse potential, it is moderately regulated.

Suboxone, which is buprenorphine and naloxone, is a partial agonist. It has a long half-life of 35 hours in the average patient. It's a dissolving pill or strip. It has a mid to low abuse potential. I think that's probably more on the moderate side, but with the combination of naloxone, it does bring it slightly lower than Subutex. And it is moderately regulated.

All of the medications, NARCAN, Vivitrol, Subutex, and Suboxone that we've gone over so far can be prescribed in a doctor's office. And so there isn't a need for daily contact in order to receive those in prescription.

Methadone is full agonist. So it works in the same way as opioids.

It has a long half-life, which is different than street opioids. So it doesn't -- your brain doesn't go through as many ups and downs because there is that long half-life. It's given in a pill or liquid form. It has a high abuse potential, not as high as street opioids, but it does have a much higher abuse potential than Suboxone.

Because of the high abuse potential, it is highly regulated. The only place that you can get methadone is at an opioid treatment program which you receive your methadone every day. You have to go into the clinic to get it, except for on Sundays where they give you a take-home dose, until you have proven that you can step up in their system. And even then, they won't give you a take-home dose for longer than three days.

Heroin is a full agonist. It has a short half-life, and it's a powder that can be smoked, given intramuscularly or intravenously. It has a very high abuse potential. And it is illegal. So because it is so dangerous, that's why the regulation is so high.

Suboxone/Methadone: Miracle Drugs

Doctors approved to use it call Suboxone a “wonder drug” when it comes to helping opioid addicts kick the habit. **Suboxone** is known as the **miracle drug** for the treatment of opioid addictions like heroin.

This has led to a belief that medication alone can treat addiction.

SAMHSA and federal guidelines are clear that medication alone is not an approved treatment. Medication should be part of a treatment program when appropriate and should be paired with individual counseling, group counseling, and peer support.

MS. TIKKANEN: You may have heard the bias for medication-assisted treatment, too.

There's a lot of stuff coming out that said that Suboxone or methadone is the miracle drug. When Suboxone first hit the market, there was a lot of press saying that this was the cure for addiction to opioids. And we all know that there's no silver bullet. There's no one thing that leads a person into recovery.

It can be a very useful part of a treatment program, but it is medication-assisted treatment. The medication is assisting the treatment. It is not treatment-assisted medication. This is something that's really important to an effective program for medication-assisted treatment.

Medication Assisted Treatment Program

Medication Assisted Treatment is Defined by SAMHSA

Medication-Assisted Treatment (MAT) is the use of medications, in combination with [counseling and behavioral therapies](#), to provide a “whole-patient” approach to the treatment of substance use disorders.

Counseling and Behavioral Therapies

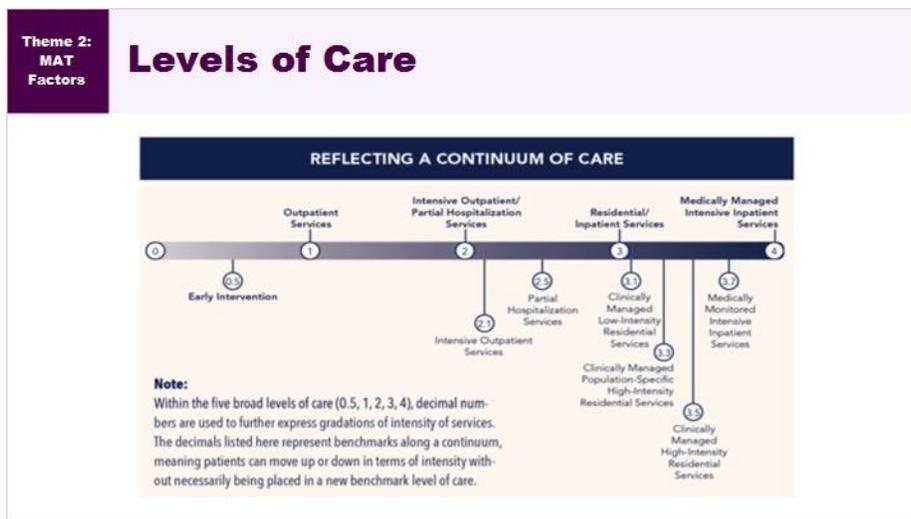
Under federal law, MAT patients must receive counseling, which could include different forms of behavioral therapy. These services are required along with medical, vocational, educational, and other assessment and treatment services.

MS. TIKKANEN: All right. I want to talk a little bit about what the components of a medication-assisted treatment program that is effective are. Medication-assisted treatment is defined by the Substance Abuse Mental Health Services Administration as the use of medication in

combination with counseling and behavioral therapies to provide a whole patient approach to the treatment of substance abuse disorders.

Counseling and behavioral therapies are very much stressed under SAMHSA's guidelines. Medication-assisted treatment patients must receive counseling, which include different forms of behavioral therapy.

There's lots of different ways to support somebody's recovery through counseling and behavioral therapies. There's lots of different ways to support the whole patient approach. But medication alone is not the key to recovery.



MS. TIKKANEN: The American Society of Addiction in Medicine recommends different levels of care for an effective medication-assisted treatment program. The levels of care are early intervention, outpatient, intensive outpatient or partial hospitalization services, residential or in-patient services, and then medically managed intensive in-patient services.

My bias with levels of care is that I do think that medically managed intensive in-patient services usually consist of a detox program and treating the body's signs of opioid withdrawal are different than treating addiction. So I would actually put that kind of as a separate piece, and really look at what treatment is going to be best for that person.

ASAM Criteria



MS. TIKKANEN: The levels of care are determined based on ASAM criteria. So the way that we figure out how intensive services need to be for a person is by looking at these different six dimensions. So we look at whether or not they are currently intoxicated and their withdrawal potential, their biomedical conditions and complications. Emotional, behavioral, or cognitive conditions or complications. Readiness to change. Relapse, continued use, or continued problem potential. And then their recovery and their living environment. It really gives us a way to look at the whole person and the problems that present in different areas of their lives.

Importance of Co-occurring Disorders

1. In 2014, the National Survey on Drug Use and Health found 7.9 million people in the US had both a substance abuse and mental health disorder.
2. The lack of co-occurring services has been cited as a barrier to the success of medication assisted treatment.
3. The integration of substance abuse and mental health is one of the keys to a successful program.

MS. TIKKANEN: I wanted to make a quick note about the importance of co-occurring disorders. The National Survey on Drug Use and Health found 7.9 million people in the U.S. have both a substance abuse disorder and a mental health disorder in 2014. Around 80% of the people that we see present to a substance abuse treatment program will have some type of mental health disorder.

The lack of co-occurring services has been cited as a barrier to the success of medication-assisted treatment many, many times. And in your role as a recovery coach, making sure that the person that you're working with is referred to a program that can best fit their substance abuse and mental health needs is a really important part of your role. The integration of substance abuse and mental health is one of the keys to a successful medication-assisted treatment program.

Just another side note is that the more complex the mental health of that person, the more challenging it might be to find resources for them. Just because this is a challenge, does not mean that that person should not advocate for themselves to find the medication-assisted treatment that is best for them. And it does not mean that you should not stop searching for those programs or stop advocating for that person.

Theme 3:
Opioid
Replacement
Therapy

WHY NOT?: Concerns

- Over reliance on medication vs. recovery tools.
- Doses can be too high (clients appear 'stoned').
- Establishing a pattern of dependence on opioid medications – sometimes at a young age.
- Opioid Replacement for a less severe habit.
- It is possible to abuse opioid replacement meds (methadone and suboxone).



DR. FELGUS: Okay, so switching gears a little bit, I would like to talk about actually some concerns around opioid replacement, specifically methadone and buprenorphine, otherwise known as Suboxone.

We've talked about some of the benefits. And I think it is important to understand some of the concerns. I think you're going to hear them with your clients, but I also think understanding both sides of this will make you a better recovery coach. I think both for your own knowledge, but also to be able to give your clients and their families the best education possible.

So as far as some of the drawbacks, which does not mean that people should not be on opiate replacement. But some of the drawbacks would be more mentally an overreliance on medication versus recovery tools. And the bottom line on that is that both are equally important. It is very easy for individuals that get on either Suboxone or on methadone to think, okay, I'm good. I feel good now. I'm not in withdrawal, I'm not using. What do I have to do all this other work for? And don't fall into that trap, because medication is just one piece of the puzzle.

So that is one concern. Another one, and this is actually true for either methadone or buprenorphine is that doses can be too high for the client and that they actually appear as though they are under the influence.

I've had individuals that are in treatment groups that come in after either getting their dose at the methadone clinic or taking their dose, if it's at home and its buprenorphine. And they really look like they're nodding out and they're triggering other individuals around them in their treatment group because they look like they are stoned. And this is something that really happens. And it's something that you do need to be aware of. Because unfortunately, just because somebody looks like this, what's going on, they may be on more medication than they need, but not all doctors will be open to listening.

So the best thing you can do in that situation is point this out to the patient. The client actually does have the ability to go to their treater and say, hey, this is a little bit too much. Again, that can be an uphill battle because a lot of individuals, it's hard to say no, I'm on too much, and I would like to get less. That is a little bit challenging, but again, it's something as a recovery coach, I think it is important to keep this in mind that this can happen.

Now another concern is establishing a pattern of dependence on opioid medication sometimes at a young age. There are people that may get on opioid replacement after a fairly short period of time of use. So if somebody's been using heroin or pain pills for three or four months, and I've seen this happen, they can still get on opioid replacement, which that treatment lasts years.

So again, we talk about matching the individual up to the best treatment for them. And this is something to keep in mind. And this is something that some doctors, substance abuse counselors, there are people in the field that do not like medication-assisted treatment, and this is one of their concerns. So this is important to be aware of.

That leads into the next one, somebody getting opioid replacement for a less severe habit. If somebody is taking 20-40 milligrams of, say, oxycodone a day or a quarter of a gram of heroin a day, even though it's, you know, hard to get purity of dose across heroin since it's not pharmaceutical and, you know, quarter gram of one batch maybe different from a quarter gram of a another batch.

Either way, if somebody with a lower habit winds up on a high dose of either methadone or buprenorphine, again, we do have to look at what we're doing. And I think that's more about client education and clients advocating for themselves. And as a recovery coach saying hey, wait, this seems like this really is too much for what you're needing. But again, it's tough because not all of the counselors or the doctors or nurse practitioners that are prescribing these medications are always open to listening.

And finally, it is possible to abuse opioid replacement medications. And this includes both methadone and Suboxone as well as the other formulations of buprenorphine that are pretty

much the same as Suboxone, but they may be called something differently. It is possible to abuse those medications.

And what happens if somebody does not have an opiate dependence, so they are not dependent on opiates. If they are to take either of those opiate replacement medications, they will get high from them. And this is a concern. This is the reason why corrections officers right now in Wisconsin are asking that the film form of Suboxone be taken off the formulary for Badger Care. What that means is these corrections individuals are saying there's too much of a problem with abuse of this medication in the jail and prison system. These are being smuggled in, and the reason these are being smuggled in is because people are getting high from them. And that is important to keep in mind.

Again, that does not mean that these medications should not be utilized, because they do save lives. But there are a lot of people that don't believe that you can get high off of buprenorphine. But the reality is it can and does happen when folks do not have an actual habit on opioids.

Theme 3:
Opioid
Replacement
Therapy

Methadone

- In use since 1960s
- Blocks other opioids and reduces cravings
- Can be overdosed
- At high doses, individuals can appear to 'nod out'
- Individuals can get high on methadone

DR. FELGUS: All right, so let's shift gears again a little bit and I'm going to talk specifically about the main medications for opioid replacement, specifically methadone, and then I'll talk about buprenorphine or Suboxone.

So methadone has been around for a long time. It's been used for opioid-dependent individuals since the 1960s. How it works, it blocks the effect of other opioids and reduces cravings. It is important, methadone, because we talked before that it is a pure agonist. So methadone is as much of an opioid as pain pills, heroin, and any other opioid.

It can be overdosed, and that is an important thing to keep in mind. People that do not have a habit or people that have a lower habit than the amount of methadone that they ingest can overdose and die on this medication.

And at high doses, and I addressed this before, individuals can absolutely appear to be under the influence. And they will tell you that they are quite honestly, if they are getting more methadone than they need.

Theme 3:
Opioid
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Suboxone®: Dosage

- Dosage Range: not agreed upon
- Research shows receptors saturated at 16mg although some prescribers go MUCH higher.
- Manufacturer does NOT recommend >24 mg



DR. FELGUS: Now shifting over to buprenorphine, the most common formulation of buprenorphine is Suboxone. And as we mentioned before, Suboxone is a combination of buprenorphine and naloxone, which is, if the thinking behind that was that if you took too much Suboxone, it would have a ceiling. So it's harder to overdose on, which it is, but that may not be because of the naloxone, quite honestly. The idea with that was that they were trying to make the buprenorphine less likely to be abused.

Now the dosage range is not agreed upon. Addiction experts in the field do not agree on the dosage range of buprenorphine. Research does show that the receptors are saturated at 16 milligrams. So I think it is. And I would say from how I practice, 16 milligrams is the maximum amount of buprenorphine that I would prescribe.

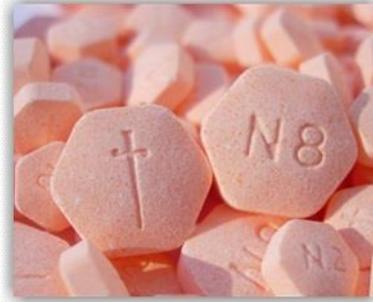
However, there are prescribers that go much higher than that. But I think it is good to ask the question of your clients if somebody is on much more than 16 milligrams, okay, what's, you know, what's going on here? What are you needing?

The manufacturer does not recommend -- the manufacturer of Suboxone does not recommend doses above 24 milligrams. So again, that is worth asking that question if somebody is on a higher dose of Suboxone than 24 milligrams.

Suboxone®: Tapering

Is it possible to taper off?

- It is, but some treaters disagree.
- Quick detox (less than 3 months) is not usually effective.
- Over 1-year slow taper (can be 3-4 years) is more effective if addressing underlying issues.
- Lifelong maintenance: some argue this is needed.



DR. FELGUS: Now the question of is it possible to taper off Suboxone? Some people see opiate replacement as something that somebody needs to be on for the rest of their life. I do not subscribe to that philosophy. And again, you're going to get disagreement among addiction treaters. Is it possible to taper off? Yes, it is. There's different ways to do it. One way to do it is a quick detox, which means somebody gets started on buprenorphine, and then they wind up coming off, usually within three months or less.

That is usually not an effective treatment, unless they're shifting and getting on a different medication, such as Naltrexone or Vivitrol, which is the injectable form. Unless they're doing something like that, just having somebody on buprenorphine for such a short time, you're not having time to address the underlying drivers of the addiction. And there is a high relapse rate with the short detoxes unless, like I said, you are getting on another medication, such as Naltrexone or Vivitrol. There's -- so that's the quick detox.

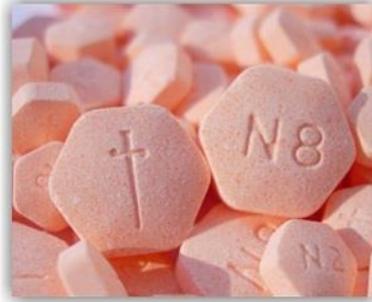
Then there's over one year of a slow taper. In my practice specifically, the average length of buprenorphine treatment is about three to four years, sometimes even five years. And this type of slow tapering down is more effective if the underlying issues, so if somebody's got anxiety or trauma or depression, if those underlying issues are being addressed this, in my experience, is an effective way to utilize buprenorphine, specifically Suboxone.

The other method of treatment is lifelong maintenance. So people get on buprenorphine and there's no plan for ever getting them off. Now some addiction specialists do state that this is what's necessary because when individuals taper down, yes, there is a chance of relapse.

So again, there's not agreement in the field, and I think it's important to understand the different philosophies behind the different treatments.

Suboxone®: Safe Use

- Half-life is 22-40 hours (average 35 hrs) so only needed once daily.
- Safer in OD since less respiratory depression than other opiates.
- Best if used as part of a treatment program.



DR. FELGUS: Buprenorphine, the half-life is 22-40 hours. The average in the body is 35 hours. So buprenorphine is actually only needed to be taken once a day. However, there are some doctors and patients who are recommending or taking their buprenorphine two times a day or three times a day. And again, that's something that it's worth asking that question, especially given that the half-life, you really only need to take it once a day.

Buprenorphine is safer in overdose since there's less respiratory depression, and that's what kills people with opioid overdoses. It is basically the opioid shuts down your respiratory center and you stop breathing. So that's how people die. There is less respiratory depression with buprenorphine, so it is safer if somebody overdoses.

And as we have stressed, it is best if used as part of a treatment program, not the only piece of treatment.

Suboxone®: Concerns

- Yes, you can get high... if not opiate dependent.
- Diversion of prescription.
- Party drug for those without an opiate habit.
- Prevention of opiate withdrawal in those using.
- Self detox for those trying to quit.



DR. FELGUS: With buprenorphine, yes, as I stressed before, you can get high on buprenorphine, if you're not opioid dependent. And it is important to be aware this is a prescription. Not everybody that gets prescribed buprenorphine uses their buprenorphine. Some people are selling it. Some people are still using other opioids such as heroin or pain pills, and they may just use their Suboxone or days that they can't get their drug or choice or they try to do a self-detox.

They, for whatever reason, are choosing not to engage in treatment, either out of choice or they may not have insurance. And they try to detox themselves. The reality is that almost never works. Unless you know how to properly do this, people try to take steps down that are too large, the withdrawal is more than they can manage, and they wind up relapsing.

Theme 3:
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Suboxone®: Prescribing

- Physicians take an 8 hour class to get licensed.
- Not enough prescribers for demand.
- No addiction training is needed.
- Nurse practitioners and physician assistants can take 24 hours of training to get licensed.

DR. FELGUS: Prescribers of buprenorphine take, now these are the MDs, because there's been a new recent development with this. What the slide says is that prescribers take an 8-hour class to get licensed to prescribe buprenorphine. There's not enough prescribers for the demand. So in that sense, it's a benefit that doctors only need to take an 8-hour class.

However, there's no additional addiction training needed. So the majority of doctors that are prescribing buprenorphine are not experts in addiction. So sometimes the doctors may know less about addiction than the counselors or the recovery coaches. And again, this is important to keep in mind, because this surprises a lot of people.

Now the recent development is that nurse practitioners and physician assistants are now able to get licensed to prescribe buprenorphine. However, they need to take 24 hours of training. I find this interesting because most doctors do not have addiction training. So they don't have any more addiction training than the nurses or the physician assistants, but the nurses and physician assistants are being asked to take a lot more hours of training. I just find that interesting.

And it's important, I think again, I think too much -- it's never -- no such thing as too much information. I think the more information you have, the better you're going to be at what you're doing.

Theme 4: Opioid Receptor Blockades

Opioid Receptor Blockades

Naltrexone <ul style="list-style-type: none">• Oral• Daily	
Vivitrol <ul style="list-style-type: none">• Injection of Naltrexone• Lasts 4 weeks	

DR. FELGUS: Moving on to the next category of medication-assisted treatment. These are the opiate receptor blockade medications that are not agonists. So these medications, Naltrexone, and its long-acting injectable form Vivitrol, these medications are not opiates. Buprenorphine, Suboxone, methadone, these are opioids. Naltrexone, Vivitrol are not opioids.

Theme 4: Opioid Receptor Blockades

WHY?

- It's not an opioid.
- It can not be abused (no high).
- No street value.
- It saves lives. Injection as leaving incarceration or rehab does help prevent overdose.



DR. FELGUS: So when you talk about the advantages, because you're going to be asked this question by your clients. Should I go on Vivitrol or Naltrexone or should I do Suboxone or methadone?

An advantage of the opioid blocking medication, such as Naltrexone or Vivitrol, it's not an opioid. It is not abusable. It can't be sold on the street. There's no diversion because it doesn't get people high. It absolutely does save lives. The Vivitrol injection, when somebody is coming out of either a residential treatment facility or incarceration, so they have not used for a long period of time, over a month. And they do not have the same tolerance to opioids that he had before. Giving somebody an injection before they leave either treatment or incarceration has been shown to save lives. Because one of the most dangerous times for individuals who are depending on opioids is right after they come out of either treatment or incarceration.

They are used to using a certain amount if they are going to relapse, whether it's pills or heroin, and they often are not thinking about their tolerance being much lower than it was before. So they may use what they used in the past, and that -- there is a very high likelihood a lot of individuals will overdose when they get out of treatment or incarceration. And this is a major public health problem, giving somebody a shot of Vivitrol. They're not going to -- it's going to block the opioid, and it does save lives.

Theme 4:
Opioid
Receptor
Blockades

WHY NOT?

- Injection is expensive (\$800-1200/vial).
- Not an opiate and does not numb pain (physical and emotional) so still can have cravings.
- May be done under duress (legal, family pressure).
- Patients may try to overcome block as injection wears off and overdose.



DR. FELGUS: Some of the disadvantages of Vivitrol specifically is that the injection is expensive. Some insurances do cover it. Not all insurances cover it. So this is something that the individual or the treatment facility or the treater is going to need to find out, because the injection can be quite expensive, as you see on the slide.

It is -- another disadvantage is that because Naltrexone and Vivitrol, because this is not an opioid, it does not numb pain. Now there are many people that say that they do not have cravings on Vivitrol and naltrexone. However, a lot of cravings are more driven by anxiety and low mood and bad memories. And Vivitrol does not numb that out. So the individuals can still

have cravings. And this is an important distinction. Cravings are not just about brain biology. Cravings are also driven by underlying mental health conditions.

Another disadvantage is that Vivitrol injections may not be done voluntarily. The client may not be on board. And anything, when it is being done under duress due to either a legal requirement, family pressure, if it's not voluntary, if the patient is not buying in, that is a disadvantage. Because it is possible for patients to still use and still overdose, even if they do get a shot of Vivitrol because they're trying to overcome the blockade. They have to use a lot to do so, and there is a point where you can still stop breathing even if you are on a Vivitrol injection.

Theme 4:
Opioid
Receptor
Blockades

Naltrexone (Oral)

Side Effects:

- Nausea
- Sleepiness
- Abnormal rise in liver enzymes
- Possible mood blunting in individuals prone to depression



DR. FELGUS: Some of the side effects of naltrexone, and this is more common with the oral, it can cause nauseousness, sleepiness, a rise in liver enzymes. So it is important to get blood tests to check liver enzymes. And possible mood blunting in individuals prone to depression. So that is just something to keep an eye on. Not everybody will get any of these side effects. But it is important to know. And again, these side effects are all more common on the naltrexone pills versus the naltrexone injection.

Vivitrol Concerns

- Opioid users may attempt to overcome the block (OD as shot is waning at end of month).
- Pain medication will not be as effective (accident or emergency surgery).
- Mood blunting or depression/lack of 'runner's high' type of feeling possible (this is less likely with injection).



DR. FELGUS: As far as additional concerns with the injection, so with the Vivitrol, I mentioned this before, it is possible some opioid users may attempt to overcome the block and overdose as the shot is waning at the end of the month. Because Vivitrol is a shot that's given once every 28 days. So during that last week some individuals, and I think these are the folks that may not be fully buying in, that may be doing treatment under duress are probably more vulnerable to doing this. But they may try to use as they know the shot is wearing off. This is something to be aware of.

Pain medication may not be as effective. So if somebody is getting a Vivitrol shot and they're in some kind of an accident and they're rushed to the hospital and they need surgery or they need some type of medical procedure, it is extremely important that treaters know that this individual is on Vivitrol. Doctors can overcome the Vivitrol block, but if they don't know that this is going on, it can be life-threatening or it could actually be very painful because the anesthesia that somebody uses going in to surgery may be blocked by the Vivitrol. So extremely important that the client's treater knows they are on Vivitrol.

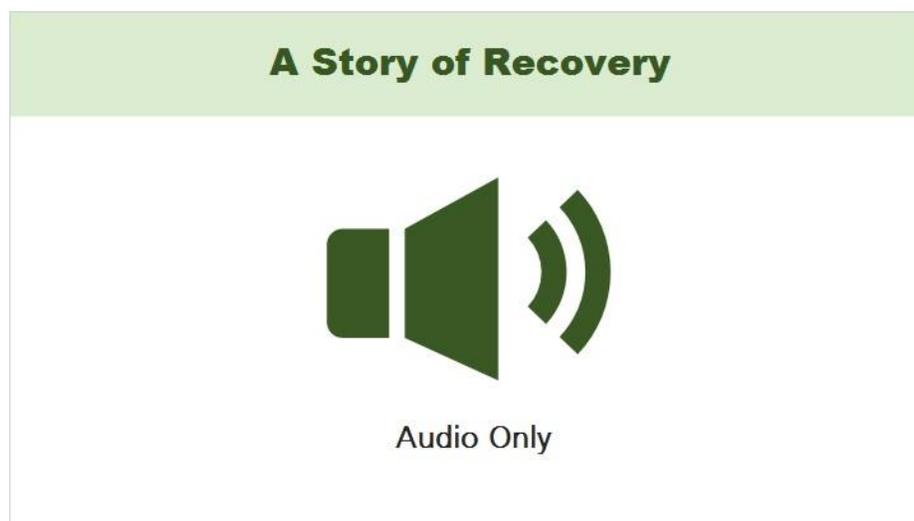
I had mentioned the mood blunting or a lack of, you know, being able to have those runner's high types of feelings. This is possible with Vivitrol, but it is much less likely. In my clinical experience, individuals on Vivitrol do not tend to have that mood lowering that some of the people on the pills can have.

Another concern is there is a washout period. So if somebody is wanting to transition from an opioid, either something that they're taking on the street, such as a pain pill or heroin, or something that they're getting from a prescriber, either Suboxone or methadone, there is a period where they have to be off of that opioid before they can start Vivitrol.

Now the standard and what the makers of Vivitrol are tell you, is that that needs to be a 7-10 period, and that is difficult for many folks that are opioid dependent. That's extremely difficult to go without using for that long of a period of time short of being in a hospital or a rehab somewhere. And again, many insurances are not going to cover that.

There is some difference of on how long this wash out period needs to be. The manufacturers of Vivitrol will tell you 7-10 days. There are some addiction specialists that work in medical facilities that are willing to use a low dose oral naltrexone where the client only has to be off of opioids for 3-5 days.

It's important to know what the treatment options are, because it is important to ask and be able to, you know, both you and your client be able to advocate for treatment, but that's going to be very much based on the comfort level of the prescriber. Some facilities require the 7-10 day washout period, but there are more and more treaters that are using a low dose naltrexone with a not as long washout period. So again, important to keep in mind.



MS. TIKKANEN: To bring these ideas to life, I'd like to talk about a client that I worked with for quite a long period of time. She really demonstrates that every road to recovery is meaningful and can work.

I started seeing her when she was 16 years old. At that time, she was diagnosed with opioid dependence. She was using IV heroin daily. And she was abusing a number of other substances, as well.

She had post-traumatic stress disorder, generalized anxiety disorder that led to panic attacks. Her life was kind of all over the place. So when we first started working together, she had been transferred to me from another therapist. And working with that therapist, she had started Suboxone, but wasn't able to take it every day and wasn't able to stay clean on it.

At the beginning of our working relationship, I had referred her to a residential treatment program that specialized in treating women with complex disorders. She went to that residential treatment program, did well for a while, had a relapse, and came home from that residential treatment program.

We started working together again. At that time, her use had become life-threatening. So I had, knowing that Suboxone did not work for her in the past and that residential had not worked for her in the past, I referred her to the methadone clinic. She was able to get on methadone after a number of overdoses that nearly took her life.

Her dose went up to 120 milligrams. After she had stabilized on that dose, I assisted her with her methadone program to bring her dose down to 30 milligrams. At 30 milligrams, we were able to transition her over to buprenorphine and naloxone Suboxone. She started at 8 milligrams of Suboxone. Was able, over the course of two years, to titrate down to half of a milligram every other day.

At that point she did have a relapse. And we were able to get her into a residential treatment program where she started Vivitrol before leaving the facility.

After starting Vivitrol, she engaged more with the recovery community, went to more meetings, worked more closely with her sponsor and has recently celebrated two years of recovery. She was on Vivitrol for nine months before going off of it and has been medication-free since that time period. She also now does work as a recovery coach and is a pretty amazing and wonderful person.

But sometimes it really needs to be all hands on deck. So it's not just, you know, one medication. Its multiple medications. It's not just treating mental health and substance abuse. It's not just a level of care. It is all of it rolled into one and every single person that we work with is worth that level of advocacy and work from us.

So I hope that that case example helps to kind of bring home, you know, how complex people can be and the need for lots of different approaches in order to get people into and maintain their recovery.

Module Review

1. Understand bias against and for MAT and what the research says.
2. Be able to list the components of a successful Medication Assisted Treatment Program.
3. Gain a basic understanding of methadone and which people are best suited to this medication.
4. Gain a basic understanding of buprenorphine and which people are best suited to this medication.
5. Gain a basic understanding of naltrexone and which people are best suited to this medication.



All resources and references are located in the Resources tab of this presentation.

MS. TIKKANEN: So in conclusion, there is a bias for and against medication-assisted treatment. Your job is to support your client. They have the right to self-determination. And so allow them to choose what's right for them and support them in doing that.

Effective medication-assisted treatment programs are more than just medication. I can't say this enough. Refer your client to programs that meet all of their needs.

Methadone can be effective for some clients, but there's other clients that it's not a great fit for. Buprenorphine can be effective for some clients. And there's other clients that it's not a great fit for. And naltrexone can be effective for some clients, but there are other clients that it will not be a great fit for. As long as you're putting what your client wants and what is best for them as your guiding principle, you're going to do just fine.

