Questions and Answers from Role of Medication in Opioid Use Disorders
August 24, 2015

Question: "Can you give some statistics on success or abstinence rates re: medication-assisted treatment effectiveness versus non-medication assisted treatment?"
Answer: Research was conducted in the early sixties and opioid replacement therapy was recommended based on elimination of illicit opioid use and better outcomes in school, employment, and homemaking. Some of the research can be found in reports included in the *NIDA International Program Methadone Research Web Guide.* Current research is focused more on comparison of outcomes between medications and with characteristics of the patient mix.

Question: She also says re: slide 24 " I heard naltrexone use with an opioid could precipitate withdrawal. Please comment."
Answer: Yes, The individual must be completely detoxed before beginning naltrexone. Identifying the safest interval between use of opioids and starting naltrexone is one of the items ASAM lists for future research.

Question: "Doctor, may I respectfully request as a suggestion that in any process (screening, treatment, recovery, etc.) that counseling be a main part of the focus for these processes that supports and educates individual(s) seeking help for their disorder or for getting off of Opioids... Your Thoughts Please"
Answer: I agree. The national practice guidelines recommend that psychosocial treatment (counseling) should be an integral part of MAT.

Question: "Nursing on Suboxone or Subutex Safety?"
Question: "breastfeeding on suboxone"
Question: "You talk about breastfeeding and Methadone but what about on Suboxone"
Answer: Research on methadone is comprehensive and well documented. That is not the case with buprenorphine. There have been three studies and the results are conflicting. Women are encouraged to breastfeed when on buprenorphine but this is not a recommendation until more research is conducted. See Jansson, *Lauren M. (2009). ABM Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman. *Breastfeeding Medicine*, *4*(4), 225–228. doi:10.1089/bfm.2009.9987 for more information.

Question: "Should teens and early 20s be discouraged from taking the Vivitrol shot due to their higher levels of accidents and inability to treat pain?"
Answer: The guidelines recommend the use of any of the three medications with integrated psychosocial treatment (counseling).

Question: "Is there available research on best practices management of active opioid users while in need of acute care?"
Question: "acute care meaning a medical hospital"
Answer: I think that the approach would take into consideration 1. Is the patient taking a prescribed opioid medication as prescribed; 2. Is the patient misusing or abusing their prescribed medication; 3. Is this illicit use? In many cases the default could be Detox and a replacement opioid following state and federal regulations and the new ASAM national practice guidelines.

Question: "Re: initial assessment of the patient you mentioned that the patient should have a CBC, liver functions and an EKG. In my experience these patients can't even afford the treatment they are requesting. Insurances are not reimbursing for opioid detox (in a hospital setting) and it is very difficult to get reimbursement for residential treatment in general. And most patients don't even have insurance. So I agree the physical assessment is essential but the labs are not always able to be obtained"
Answer: I think we can be thankful for the changing insurance environment. More individuals will have insurance due to ACA, there is a focus on expanding Medicaid coverage, and more funding is being made available. Insurance companies will be under increasing pressure to cover more because of practice guidelines that define the need for these tests under evidence based treatment protocols.

Question: "I treat a lot of pilots and nurses and I find that Vivitrol seems to work very well with people who have a license to lose. I also find that for every one else (meaning non-professionals) extended use of suboxone has a fairly low success rate. Can you comment on this?"
Answer: It has been my experience that most licensing boards will not authorize a return to employment if the individual is on methadone or buprenorphine. They will accept naltrexone. I think the low success rate with extended buprenorphine is associated with a tendency for individuals to be on medication without the attendant psychosocial treatment. Research has shown that approach as less effective.

Question: "Naloxone is not absorbed orally. Naltrexone is absorbed and can precipitate withdrawal if a patient is dependent."
Answer: You are correct. Naloxone is intranasal. Naltrexone can and does precipitate withdrawal if an individual has an opioid in their system.

Question: "I see some off label use of suboxone 4-8 mg b.i.d. for chronic pain. Do you know of studies about efficacy of this practice?"
Answer: The off label use of buprenorphine for pain is addressed in a PCSSMAT document http://pcssmat.org/wp-content/uploads/2014/02/PCSS-MATGuidanceOff-label-bup-for-pain.Gordon.pdf.

Question: "I have a comment regarding the low number of patients that are receiving medication assisted treatment. Nurse Practitioners do not currently have the ability to prescribe buprenorphine. This is a huge problem and contributes to the lack of evidence based treatment, especially in rural areas. Please continue to advocate for this change. "
Question: "IntnSA is working on developing those letters that we will be able to send out to our membership community"
Answer: I believe that the International Nurses Society on Addictions intends to continue their advocacy in this matter and that current President Dana Murphy-Parker is working on a project that will develop 'Talking Briefs' for individuals to use in their own advocacy efforts.

Question: "Al, you could refer the person asking about the nursing care to the TIP authored by Kathy Fornili and others. A great resource for Nursing care of Buprenorphine. I think the question was about Buprenorphine."
Answer: Just to reiterate. This is a reference to a very good resource TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. It is available for order at SAMHSA.org and also for electronic download.

Question: "Can you comment on Naltexone implant?"
Answer: The practice guidelines do not address the naltrexone implant. Current status is that the implant is not even at the point of submission for FDA approval.

Question: "Suboxone is good for pain - see reports for opiate induced hyperalgesia"
Answer: See the PCSSMAT document http://pcssmat.org/wp-content/uploads/2014/02/PCSS-MATGuidanceOff-label-bup-for-pain.Gordon.pdf.

Question: "What is your view on making these opioid treatments affordable through a collaborative shared partnership across communicate and neighborhood boarders by services providers? (away from silo mentality) what does this mean to the impact on those communities and neighborhoods"
Answer: There is a great deal of discussion on how to make treatment more accessible and more affordable. Two good resources on this is **http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf** and http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final. It is interesting that there was discussion at AATOD this year among providers and the problems they were facing in being able to share client data among their own sites within their own organization across state lines. The problem was HIPAA regulations. We might have to start there.