Psychiatric Medications, MAT, and Recovery

Recorded October 1, 2020

Presenter: John Smith, PhD, LCSW

continued Social Work Course #98

- [Katrinna] Hello, and welcome to Social Work at Continued.com. My name is Katrinna Matthews. I'm the Managing Editor for Social Work at Continued, and it is my pleasure to welcome today's session titled, Psychiatric Medications, MAT and Recovery, a Guide for Mental Health and Substance Use Disorder Professionals by Dr. John smith. Social Work at Continued.com is excited to welcome Dr. Smith here today to share his knowledge and expertise with us. Dr. Smith is a licensed clinical social worker, and as the Director of Education and Training at Social Model Recovery Systems. He is a professor of addiction counseling at Mt. San Antonio College, and he has also been in private practice in California since 2000. Dr. Smith has over 40 years of experience working with mental health and addictions, and he is the author of "Co-occurring Substance Abuse and Mental Disorders: "A Practitioners Guide," and he is also the best-selling author of "The Authentic Man: "A Guide to Happiness and Purpose." Without further ado, I'm gonna turn it over to Dr. John Smith.

- Oh, thank you, Katrinna, I appreciate it. Hello, everybody, I'm glad to be here. This particular topic is one of interest, and for social workers, other mental health professionals, addiction counseling professionals, this particular topic I think is very timely and necessary. Some people may say, "Well, why are we talking about medication? "That's outside my scope of practice." Well, some aspects of medication probably are outside our scope of practice yet almost all of our clients are going to be on some sort of psychoactive or psychotropic medication. Many of them will be receiving what we call MAT or medication-assisted treatment, and you are the eyes and ears for doctors and other people that might be monitoring and prescribing medication. So it's really important to understand what medicines do, what their side effects are, how to know whether clients are benefiting or getting better with medication, if their symptoms are being relieved. Also, it's a good way to be able to track how clients are doing with their medication compliance. All these are factors and issues that you will be responsible for. And so it's important that you understand and know a little bit about medication, including MAT or medication-assisted treatment,

and also how it affects recovery. So without further ado, I'm gonna go ahead and start talking about that.

First, let me make sure that I discuss disclosures. I have no relevant non-financial relationships to disclose. I am receiving an honorarium for presenting this course. This learning event does not focus on any specific product or service. And this course is presented by continued Social Work, an organization I am very excited to be a part of and involved with. They're doing a wonderful thing. So I hope that will continue. So after this course today, participants will be able to identify the classification and use of most major psychiatric medications. Participants will be able to describe the use of specific medications used in the treatment of addictions or MAT, medication-assisted treatment. And participants will be able to describe the pros and cons of using these medications with persons in recovery from substance use disorders. So we've got a lot of ground to cover and a lot of information to go over. And I will do my best to cover that information as thoroughly as possible.

So let's first talk about some things that I think are really, really important to remember. And they're important because most of us are not receiving education with or even in the mental health field or the substance use disorder counseling field. We don't receive a lot of training or education relative to psychiatric medication. Also, there are a lot of myths and misconceptions about medication, especially in the recovery community. And so I wanted to spell them and give you as much factual, evidence-based information as possible. So here's the first thing that if you got nothing else out of the training today, I want you to get this. All, and I mean all symptoms, now not all disorders, but all symptoms of mental disorders can be caused or mimicked by problems related to a medical condition. I'll say more about that in a minute. Secondly, all symptoms of mental disorders can be caused or mimicked by either drug or alcohol intoxication or withdrawal. So what does that mean? That means that when we're assessing and evaluating someone, and we see someone who's presenting with

psychiatric symptoms, we also need to understand that while these might be symptoms due to an underlying mental disorder, these symptoms may be caused or mimicked by either medical problems or substance intoxication or withdrawal.

Let me give you a couple of examples that will highlight this. I had, fortunately, my stepfather passed away recently at about age 89, but about a year or two before, I received a telephone call from them, my mother and stepfather, and my mother was frantic because my stepfather had all of a sudden started to act really bizarre. He was running around the house, moving things around, and I spoke to him and he was coherent, but he says, "I can't stop moving things," almost as if he was having some sort of a obsessive compulsive episode. Keep in mind that he had no history of any mental health issues or conditions. And so my first thought, especially at his age, was there's something going on with him medically. He drank alcohol but not excessively, so I wasn't concerned about drugs or alcohol intoxication, although some sort of medication reaction could have been an issue. But my first thought at his age, was he's having a stroke, or he's having some sort of a medical issue in his brain that's causing this rapid onset of these, what appeared to be psychiatric symptoms. Well, of course, my first thought was, well, he needs to be evaluated. So I had my mother get him to the emergency room to be evaluated, got a call back in a couple hours from my mother, I said, "What's going on?" And you'll probably never guess what it was. So the first thing was, they ruled out that he was having a stroke or an aneurysm or any other condition of his brain. After they ran several tests, it turned out, and I didn't even know that this was possible until later on, then I heard that it's a fairly common thing. It turned out that he had a very severe urinary tract infection. He was asymptomatic, meaning that he didn't have the usual symptoms of a urinary tract infection. Therefore, he had no awareness or idea that there was anything going on. But apparently the infection was causing an alteration in his mental status. Once they got him on antibiotics and started to treat the infection, all of those symptoms went away.

The reason I'm telling you this is that all of the symptoms he was expressing were psychiatric symptoms, yet those were due directly to a medical condition. There are other medical conditions as well that cause a lot of psychiatric symptoms. For example, hypo or hyperthyroidism are conditions that can cause mental health-related symptoms. Certain medications are notorious for causing mental health conditions. For example, prednisone is very often going to cause significant anxiety, sometimes even psychosis, sometimes beta blocker and blood pressure medications like propranolol, Inderal, things like that, are gonna cause severe depression. So we just have to always be aware that when someone presents, especially if they have been in relatively good health in their middle age, in their mid 40s or older and they have a sudden onset of psychiatric symptoms like my stepfather did, we always wanna make sure that we first rule out any sort of underlying medical condition. Now, since most of us are not medical professionals, obviously, we would want to have, that's an indicator for us to have someone who is a medical professional, evaluate that person before we move forward, because sometimes a medical condition could be severe enough that if we don't treat them or get them treated, it could be a life-and-death situation. The same is true with drug withdrawal, because certain types of withdrawal come along with certain very severe health conditions and what appear to be psychiatric conditions. I'm gonna tell you more about that in a second.

So number two was all symptoms of mental disorders can be caused by drug or alcohol intoxication or withdrawal. In our business of mental health treatment and substance use treatment, of course, we're going to see people all the time who are under the influence of drugs and alcohol, or who are in the early stages of withdrawal. Why is that important? Well, certain drugs and certain drug withdrawal are, again, notorious for causing or mimicking psychiatric symptoms. For example, stimulants like methamphetamine in particular, it's relatively frequent that those drugs cause psychosis, amphetamine-related psychosis, which means that a person is out of touch with reality, acting bizarrely, hearing voices or having hallucinations, having delusions,

especially paranoia. These could be due to an underlying mental health issue or they could be due to, again, drug intoxication or withdrawal. Alcohol withdrawal and benzodiazepine withdrawal, which are pretty much have the same symptoms, can cause alterations in mental status and more severe form of alcohol withdrawal called DTs or delirium tremens is actually considered a medical emergency. In that state, a person can be experiencing disorientation, they can be delusional, they can be experiencing hallucinations, they can have all kinds of what appear to be psychiatric symptoms, but the symptoms are also due to the severe alcohol withdrawal. So if a person comes in to drug and alcohol treatment in particular, experiencing these symptoms, we always wanna make sure that we determine are they in any type of drug or alcohol withdrawal.

So I could go on and on about how these two things have to be ruled out before we proceed with the underlying mental health issue, or until we know really the best treatment for the person, given how they're presenting to us upon assessment. So mental health providers tend to rely a lot on medications, and more and more mental health providers think more about symptoms and diagnosis in terms of mental disorders. And unfortunately, the majority of mental health providers have not received a great deal of training in substance use. I know when I went through school and social work school, there was probably about one chapter devoted to substance use, and there was one elective course that not many people took in addiction-related issues, but there wasn't a constant amount of material in the curriculum. That's true in medical schools. That's true in nursing schools. It's true in most mental health training programs. And so the problem is that the majority of people that walk through our door with either a substance use disorder or a mental health disorder usually have some sort of co-occurring disorder. So it means they have a substance use disorder and a mental health condition. Obviously, sometimes one is more prevalent than the other but we have to evaluate, assess and treat both. On the other hand, substance use disorder professionals are not necessarily big proponents of medication, even

medication-assisted treatment. Some people that are in their own recovery or working certain programs, and many people who are involved in 12-Step programs promote the belief that one "isn't truly sober" if they're on any medication, psychiatric medication, including medication-assisted treatment. We'll talk about that more in a little bit. But this philosophy and belief, of course, makes many people either not want to stay on or take their psychiatric medication because they want to be sober, or in some cases, it could cause that person to stop taking their medication. And that could cause them either to relapse with their substance use disorder, or their mental health disorder or both. So there is that philosophy that we have to overcome, and a lot of that philosophy is based in myths and false information.

So hopefully, by the end of the training today, that a lot of those myths and misconceptions will be handled. Substance use disorder professionals tend to think in terms of the substance use rather than the mental health condition. So depending upon which door you go through, if you go through the mental health door, professionals tend to think in terms of psychiatric disorders, symptoms, mental health conditions. They don't necessarily focus on substance use. On the other hand, people walking through the door of the substance use treatment program are going to tend to think substance use, and less about underlying mental health conditions. So part of it is in the training, part of it is in the philosophy that the different professions tend to have. And of course, many substance use professionals have little training in mental health disorders. So it's a training issue and a philosophical issue. When we're dealing with clients that have underlying substance use or mental disorders, as I mentioned, problems with medication compliance, that often leads to exacerbation or relapse of both disorders. So there are reasons why people stop taking their medication. One of them is that they don't think they're truly clean and sober. One of them is that when they start feeling better, they think they're okay and they don't need it anymore. And also, many of the medications, as you'll find out, come along with side effects that are unpleasant, so people stop taking the medicine because of the side effects. But

unfortunately, the medication was treating their symptoms, and then their symptoms return because now the medication isn't there to help regulate those symptoms.

So 12-Step programs and treatment programs have to support medication usage. Mental health professionals have to be trained in substance use disorder assessment and understand when those disorders are contributing to other symptoms and problems. A combination of medication and psychosocial therapies have consistently shown the best outcomes. So medication alone isn't as effective therapy, or treatment alone isn't as effective. Combining the two shows better results. And that's evidence base that is been shown consistently in all of the research and outcome studies that I've seen and that have been done to date. So let's move on to the specific classifications of psychiatric medications and also how those medications affect people that might be in recovery from substance use disorders. So we break down, most psychiatric medications are divided into the following categories, and we're gonna look at each one of the categories individually. So antidepressants, which of course are primarily used to treat depression. Antipsychotics, which are the primary treatment for psychosis, of course, which is common in schizophrenia. It's common and also they're approved to treat mania and bipolar disorder, or any other psychosis, even drug-induced psychosis.

So those are the primary drugs of choice to treat those symptoms. Remember, first of all, medications treat symptoms, not disorders. I'm gonna say that again. Medications treat symptoms, not disorders. Mood stabilizers are used to treat the mood swings that accompany bipolar disorder. So bipolar disorder is characterized by severe mood swings from severe depression to mania. So mood stabilizers help to regulate the extremes of those mood swings. Anxiolytics or antianxiety medications are those that are used to treat anxiety. Sedative/hypnotics are medications used to assist in sleep. And then stimulants, which are used primarily in the treatment of attention deficit hyperactivity disorder, narcolepsy, and in some cases, obesity, but primarily, we see

stimulant medications used to treat ADHD. So why is this all important? Well, again, it's often you that will make the decision this client has symptoms that may be treated or may need an evaluation for medication. Now, it's not necessarily your job to decide which medication that they're going to need, that's the doctor's job, but it's important that you understand do they would do they need evaluation, and like they benefit from medication. Clients will come into your treatment on medication or they'll go to the doctor, be prescribed medication and come back with it.

So it's important that, again, what these medications are and what they do and what they're for, so that you can observe the client and can tell whether their symptoms are improving, or in some cases, whether they're getting worse, and or whether or not they are complying with the medication. If they're on medication and they're not getting better, or they're getting worse, they're either not taking it or the medication isn't, or dosage isn't correct and the doctor needs to know that. The reason I say this is that clients who go to the doctor, very often don't tell the doctor what's actually happening. They'll walk into the doctor, they're with the doctor for 15 minutes, the doctor will say, "How are you doing?" And the client will say, "I'm doing fine." "Any problems?" "No, I'm doing okay, how's the medication?" "Fine." "Okay, carry on," when none of that's true. Sometimes the clients won't know exactly what to tell the doctor. And often, unfortunately, the doctors don't ask the right questions to elicit the information from the client. So you're the eyes and ears. And so it's your job to be able to tell the doctor what you're seeing, what you're observing, what's happening, and then they make the decision about whether to change the medication or add additional medication or whatever. So and some of these medications you may be familiar with, you may know them by name. I've put both the brand name and the trade name or the name of the actual medication. The generic name, if you will.

So let's start with the first type of antidepressant that is probably the most commonly prescribed. Those are the class of antidepressants called SSRIs. That stands for

selective serotonin reuptake inhibitor. Did you all write that down? SSRI is selective serotonin reuptake inhibitor. What that means in short, is that these medications are designed to boost the amount of serotonin in the synapse in the brain and the nervous system, because it's based upon the idea that low serotonin levels are causing the symptoms of depression. And while that might be true for some, it isn't true for others. And recent research is showing that actually, nobody really knows for sure what's causing depression, and the whole idea that it's based on low serotonin levels has never actually been proven. In fact, if you open the box of an SSRI and you look at the insert that has all of the medicine information on it, the first sentence is mechanism of action is unknown. It is thought that the drug works, so they don't even really know. So for some people antidepressants might work, they might be effective. For others, there's been several large studies that show that antidepressants, especially SSRI antidepressants, are actually not that effective in treating mild to moderate depression. Now, don't stop taking your medicine or tell your clients to stop taking it. That's certainly out of our scope. What I'm saying is that if the medication isn't working, then maybe other types of medication would be better. But that's something that you just need to know.

So what are the SSRIs? Well, all right, Prozac, most of you are familiar with that, or fluoxetine, Paxil or paroxetine, Zoloft or setraline, Celexa or citalopram, Lexapro or escitalopram, I can never say that, or Trintellix which is vortioxetine. Say all of that really fast, okay? Again, these medications boost the level of serotonin. Sometimes they also are used in the treatment of anxiety. I'll explain more about that when we get to anxiety, but their main purpose is to treat the symptoms of depression. These medications also have side effects. The good news about SSRIs is that they're very difficult to overdose on. Of course, you can overdose on anything, but people that are depressed very often have suicidal thoughts. So many times their method is to take an overdose of the very pills that are being prescribed. And the good news is you can overdose on these or take a lot of them and not necessarily die from them. Of course,

that's possible, but it takes a lot more. The other thing about SSRIs is that they do have pretty often people will have some unwanted sexual side effects. One of the sexual side effects is decreased sexual desire or libido. Of course, that's common in depression anyway. The other one may be a little more troubling, is that these medications often cause the inability to ejaculate or achieve orgasm, and that people don't like that as well. Ironically, sometimes doctors are using as kind of an off-label practice. They're using these medications for men who have premature ejaculation problems because these medications delay or actually even stop ejaculation. So for some people, it's a good thing and for other people, it's not such a good thing.

All right, so SSRIs, the primary treatment for depression these days. There are other medications that are also used as well in the treatment of depression that are not SSRIs. Wellbutrin or bupropion is, I think, one of the best antidepressants out there, just my opinion. It focuses a little bit more on dopamine and less on serotonin. It has mild stimulating properties. So off label uses might be for some treating ADHD, for people who might not be able to tolerate stimulants or who might also have some co-occurring depression. So Wellbutrin or bupropion might be an appropriate one there. Again, not everybody can tolerate Wellbutrin because for some because of the stimulating factor, it makes them agitated or anxious. And so they don't tolerate it. But for those that can tolerate it, it's it's a pretty good medicine with relatively few side effects other than the ones I mentioned. It also is used in a lower amount than it is to treat depression, to treat and help with stopping smoking. It's marketed as Zyban for that use, or it can be given in smaller doses than treating depression for smoking cessation. Remeron or mirtazapine, Serzone, Desyrel or trazodone are also antidepressants. Now, I don't see these used as often as the other ones, but they certainly are. The one that you might be more familiar with is trazodone.

Trazodone is technically an antidepressant, but it's very often given especially to people in recovery. It's given to help them sleep. It's in smaller doses, and it would be

to treat depression. And so it is often used in smaller doses to help people sleep because it tends to cause drowsiness. So trazodone is used more for that than it is as a treatment for depression, but just understand that if you see someone on trazodone and fluoxetine, that's okay because you look at the dosages, the fluoxetine is more than likely being given for the depression, the trazodone more than likely is being given for sleep. To see somebody on more than one of these medications other than the ones I just mentioned, that might be concerning, but again, we're not doctors, but it's certainly questionable if one is on more than one medication in the same category. That's something they maybe notate and let the doctor know that that's happening, just so the doctor is aware 'cause sometimes people come in to treatment with a lot of different medications. And if the doctor isn't aware of all those medications, then sometimes they don't know that the client is on too many medications or too many of the same medications. So that's important.

Oh, one other thing about SSRIs to keep in mind is that there's a lot of research to show that SSRIs may trigger manic episodes in those who are bipolar. So we don't want someone who's bipolar to be taking an SSRI for that very reason. Again, we're not doctors, so we wouldn't go to the doctor and say, "You shouldn't prescribe that medication "because Bob is bipolar." But I've been known to notate to a doctor, I think that Bob has bipolar, I noticed he's on an SSRI. I'm concerned as to the effects of that on his bipolar, and I let the doctor take it from there. So I'm not telling the doctor how to do his job, I'm just bringing up the fact and bringing it to the doctor's awareness, and then the doctor can do whatever the doctor wants to do. But another reason I say this is that when you're observing and working with a client, it might be helpful for you to note if all of a sudden the client starts showing manic episodes, and they are on an SSRI, that might be what's triggering it, and that would be something to alert the medical professionals too as well.

SNRIs are medications that boost serotonin and norepinephrine, so they have the mood enhancement and the norepinephrine increases energy and interestingly, helps decrease chronic pain. So sometimes they're using these medications to actually treat chronic pain as opposed to opiates or other more, maybe more addictive medications. So Effexor or venlafaxine, Cymbalta or duloxetine and Pristiq are medicines that contain serotonin and norepinephrine-boosting materials. So these are the primary medicines used to treat antidepressants. I'm not gonna talk too much about this older class of medications, which actually were pretty effective and they are still used. They had a lot more side effects, one of them including death. So they tended to move away from them when they had the less lethal SSRIs, but you may be familiar with some of these medicines, you may even see them used. They're called tricyclic antidepressants. And most important, they cause dry mouth, they cause constipation. They weren't tolerated as well by most people. And again, the one of the big problems is that they did in some people, cause some heart arrhythmias which caused problems. When people overdosed on these medications, that was often a lethal overdose because of what I just said. It affected the heart rhythm, and so people overdosed and died because it caused arrhythmias and they didn't come back from those. So while they're out there, they're used, they're not used as much anymore because of those reasons that SSRIs are safer, but maybe the tricyclics might have actually been a little more effective. Let's move on to the class called mood stabilizers.

These are drugs that are used to treat the mood swings with bipolar. We could call them anti-manics. Interestingly, other than lithium, which I'll talk about in a second, all of these medications are actually anticonvulsants. They're used to treat seizures amongst other things. But they also found that these drugs help to treat the mood swings with bipolar, and so these are more frequently used. Lithium is not a medication, per se, it's actually a mineral that's used as a medication, and lithium may be the gold standard in treatment of bipolar disorder. Lithium has been around for a while, lithium works extremely well in treating the mood swings with bipolar disorder.

Two problems with lithium. One is that the therapeutic range and the lethal range are very close together. So lithium toxicity is a problem. Sometimes people taking lithium can become lithium-toxic without doing anything. So lithium requires usually a monthly or at least a regular blood test. And again, compliance with blood tests and the risk factors associated with it, cause doctors to not prescribe lithium as often as they used to, but it's still the gold standard of treatment.

Other medications that might be a little safer in terms of taking them for mood swings would be Depakote or divalproex, Tegretol or carbamazepine, Neurontin or gabapentin, Lamictal or lamotrigine, Trileptal, Topamax or topiramate, now you may go, "Well, I've got a aunt that's on Neurontin." Well, Neurontin or gabapentin is also used to treat diabetic neuropathy or nerve pain. It is used to treat other things as well, but it also can be used in treating bipolar disorder. Probably the one that seems to be most favorable to doctors these days is lamotrigine or Lamictal. Tegretol sometimes, Depakote sometimes, topiramate, also those of you that might be interested, topiramate or Topamax is also associated with weight loss. So some people take it to help them lose weight. I don't know but that's not necessarily why I would wanna take a medication like that, because it is a pretty strong medication, but just so you know what it can do.

Antipsychotic medications are of course, drugs that are used to treat the symptoms of psychosis, again, which can be caused by many things that can be drug-induced psychosis, most commonly caused from stimulants like methamphetamine, marijuana, in case you didn't know, because it's the THC content of today's marijuana is so high, it has been associated with causing psychosis and exacerbating the onset of schizophrenia in those that are predisposed or vulnerable. The problem is we don't know necessarily who's predisposed and vulnerable, so when they smoke pot or they are using stimulants, psychosis is something that is not uncommon, it can happen. Schizophrenia in particular, or the different forms of schizophrenia, and sometimes with

bipolar disorder, sometimes with depression. sometimes with other things, psychosis can be a symptom. So these medications are usually indicated to treat those problems.

Atypical is the classification for most of the antipsychotics that you probably will see being used today, Abilify or aripiprazole, interestingly, if you watch television, you'll see the ads that identify Abilify as a treatment for or adjunct treatment for depression. Abilify focuses primarily on the neurotransmitter dopamine, where the antidepressant focuses on serotonin. So they find adding the two together often will help alleviate depression or symptoms of depression, I should say. Pretty powerful medication, if you ask me, but okay for some people, it must work. Clozapine or clozaril is a very effective medicine in treating psychosis related to schizophrenia. It's not used very often because it has a side effect that is called agranulocytosis, which is a blood disorder, and it also can be fatal or at least cause some really serious problems. It requires regular blood tests, regular being weekly. And so because of that, doctors are reluctant to prescribe it even though it shows to be one of the more effective antipsychotics. Zyprexa or olanzapine, Seroquel, Risperdal or resperidone, Geodon, these are all atypical antipsychotics. Again, these drugs you probably are gonna see mostly Abilify, olanzapine and Seroquel as the primary medications used to treat psychosis. In higher doses, they're used also to treat psychosis and mania. So they're anti-manics.

So the difference would be for example, Seroquel is another medication that in small doses is used, often for people in recovery, because it's not addictive, to help them sleep. So small dose Seroquel, usually given at night, is primarily for sleep. Larger dose Seroquel, 300 milligrams up to 600 or 800 milligrams is a higher dosage which is usually to treat symptoms of psychosis or mania. So understanding the dosage helps you also understand a little bit about what it's probably being used for. The older class of medications, you still see them and they still work. They also contain or can have relatively high level of nasty side effects. Thorazine or chlorpromazine, Haldol or haloperidol, you'll see it used usually in an injection to help somebody who's really

agitated to calm them down. Mellaril, Navane, Stelazine, Prolixin, these are the older, what we call traditional antipsychotics. They're still used. Sometimes they're used in conjunction with an atypical.

The side effects that are actually more common in the traditionals but also a potential in the atypicals, the worst one is called TD or tardive dyskinesia. Tardive dyskinesia, if you've seen people kinda shuffling along or kinda moving their tongue or they have strange kind of movements with their hands, that's called tardive dyskinesia. It's a neurological condition that is very often permanent and as a side effect of these medications. So it can happen with the atypicals. Usually, it's dose-dependent, so someone's who's on higher dosages for a long period of time, might develop this. That it's more common with the traditionals. Another one that is kind of similar to TD but is related again to these medications is called EPS. Extrapyramidal symptoms like pyramid, extrapyramidal symptoms. So EPS are Parkinson-like symptoms. So again, tremors, shakes, agitation, restlessness, pacing around. And interestingly, muscle dystonia meaning muscle stiffness, or actually muscle rigidity is a side effect. And so someone who's having these problems, it could be due to their medication. There are medications that are given, of course, to counter these side effects. One of them is Targin or a similar type of medication that helps to counter the EPS symptoms.

So, again, why is that important to you? Because you're gonna be looking at clients, you're gonna be seeing these things or they're gonna be complaining of these things. They probably don't know that it's related to their medication. Again, your job isn't to tell them to stop taking their medication. That's not something that's in your scope of practice, but it is, again, your scope of practice to assess, observe and report that this is going on, and if you understand that it could be linked to medication, then you can provide or forward that information to the client's doctor.

Up until now, the medications that I have discussed are not problematic for someone in recovery, meaning that they're not addictive medications. They're not habit-forming, if you will. They're not medications that are drugs that can be abused. So they're perfectly safe to use with people who are in recovery. In fact, they may help to ease some of the symptoms that might lead people to relapse. But now I'm gonna talk about antianxiety medications that are probably not indicated or at least some of them are not indicated for people in recovery because they are habit-forming. They are drugs that can easily be abused, they are drugs that can cause somebody to get high. And so again, we can't tell somebody to not take them, but we certainly would want to be concerned if somebody is being prescribed or using these medications. The ones that are most concerning are the benzodiazepines or benzos. The one that is probably the most addictive and maybe one of the worst drugs to get off of ever, is Xanax or alprazolam. Notice all the benzodiazepines or most of them end in ams and pams. So whenever you see ams and pams, it usually contains some level of benzos.

So Xanax is the one that's probably most often abused. For some reason, the young folks, young adults have an affinity for Xanax. It's in their music. So I've seen an increase in the use and abuse of Xanax. Xanax used continuously for more than two weeks is physically addicting, and Xanax withdrawal takes weeks, months, sometimes even years, but weeks or months to get off of Xanax, it's horrible, but it's a popular drug. And unfortunately, a lot of people are mixing Xanax with alcohol. Mixing a benzo of any kind, especially Xanax with alcohol can be lethal. Xanax and alcohol to your brain uses the same route and the same system, and therefore your brain can't tell the difference between alcohol and Xanax. Combining the two together enhances or exaggerates the effect of both of them. It's a condition called potentiation. And so potentiation happens, which can cause the two of them together to make even a stronger effect which can be lethal. Both are central nervous system depressants that cause breathing and other vital functions to slow down or stop all together. And so overdosing and dying on the combination of these two is, unfortunately, a common

occurrence. Mixing it with an opiate, mixing benzos with anything that is also a downer can be lethal. Klonopin or clonazepam, Valium or diazepam, Ativan, lorazepam, these are medications that are benzodiazepines. And while their use is primarily to treat anxiety, and they work, long-term use is not indicated because of the actual physical dependency that occurs, and abuse is very common because these drugs make you feel good, they make you high, so they're easily abused and they're also easy to get addicted to without much trouble. So we don't recommend them for people who are in recovery. Frankly, I don't recommend them at all. If someone's taking them for say serious panic disorder, panic attacks, fine, but use them only in case of emergency. Don't take them on a regular basis because that's where they'll get in trouble.

Other antianxiety medicines, Inderal or propranolol which is a blood pressure medication. Remember I said earlier that that's one that can cause depression as a side effect, but it is a beta blocker so it slows down the central nervous system, and also then can help to maybe quiet or slow down anxiety. Buspar or buspirone is one that treats anxiety. A lot of people don't like it 'cause they don't feel anything when they take it, even though it may help with anxiety, they're used to feeling that sedation that you get, that tranquilizing effect you get from the benzos. So they don't like Buspar. Atarax and Vistaril are actually, antihistamines, but because they also kind of quiet things down, they sometimes are used to treat anxiety as well. Am I overloading you with information? I hope so.

Hypnotic medication, these are medications that are used for sleep. And you may notice that the ones on the left have benzodiazepines in it, notice the ams and the pams. So ProSom, Dalmane, Restoril, Halcion, you can see their generic names. These are medications that are used for sleep. Because of their potential to be habit-forming, we, again, don't recommend them for use in people with substance use disorder problems. Again, I probably wouldn't recommend them for anybody, except on a very temporary basis. The ones you might be familiar with are not benzos but also are

problematic. The one most people are familiar with, that is very problematic is Ambien or zolpidem. Ambien is you probably heard stories of people sleepwalking and sleep-driving and sleep-eating and doing all kinds of things while they are under the influence of Ambien. Mixing Ambien and alcohol also is no bueno, not good. So Ambien is one again, that I would not recommend for people to take on any type of a regular basis. I especially wouldn't recommend it for people in recovery. If one is going to take Ambien, it would be on a very short-term basis, and under no conditions should someone mix it with alcohol. And we can't really tell who are the people that might wind up sleepwalking, sleep-eating, sleep-driving. We can't tell who that is. So you gotta use that medication if you're taking it with a great deal of caution. So again, I wouldn't recommend them.

So I wouldn't recommend the antianxiety medications, especially the benzos. The other ones are probably okay, if necessary. I wouldn't recommend the hypnotic medications for people in recovery, especially the ones containing benzodiazepines. And I really wouldn't recommend Ambien either. So again, that's why we use other medications for sleep, like Seroquel or trazadone, because they work just as well and they are not habit-forming.

Our next class of medications are stimulants. Well, why would we notice? Notice many of them are amphetamine. In fact, some are actually methamphetamine, you go like, "Wait a minute, "isn't that what people get addicted to?" And the answer is yes. Obviously, these are prescription-manufactured medications rather than the ones made in a garage or in a trailer out in the desert or whatever. So they don't contain all the horrific chemicals that are used to make the street level methamphetamine, but they're the same chemical combination anyway. So yes, they are addictive, they are habit-forming. They're easy, but then why would we give them to Billy, who's eight years old, who has ADHD? Because they work. So under controlled conditions at controlled dosages, these medications for people who truly have ADHD, work

wonders. Interestingly, for Billy if he truly has it, and I say if he truly has it, because if he has ADHD, he'll probably do well with a stimulant. If he doesn't have ADHD, he probably won't do well. In fact, it could make him worse. So if he has ADHD, a stimulant might help. It actually causes what's called a paradoxical reaction. So for Billy who has ADHD, instead of getting more hyper and more stimulated, he'll actually get sedated, and he'll get quieter, and he'll be able to focus, and he'll be able to do things that he can't do because of the ADHD. So for people that truly have it, these medications are effective. And interestingly, so far, the research shows that a kid taking a stimulant medication is less likely to go on and become addicted to other drugs than someone who was untreated. Go figure, I don't know. But that's what the research is showing so far. So those parents that are totally against putting their kids on medication, I understand. But if sometimes, the benefit of medication is greater than the risk associated with it, for kids who truly have ADHD, we generally don't recommend these medications for use in people in recovery with addiction, especially if they've had a stimulant addiction, because, again, they can be easily abused.

Adderall, for example, can be crushed and snorted as can some of the other medicines that you see here. So we try not to recommend them very often. An interesting little side note is that when I'm talking to someone who has used stimulants like methamphetamine, I'll say, "So what effect did it have? "Did it rev you up or did it quiet you down?" And I tell them, "If it quieted you down, "the paradoxical effect, then it may have actually, "you may actually have ADHD and you were self-medicating "and didn't even realize it." Because for most people, if they're taking a stimulant, it's gonna give them energy and stimulate them, rather than quiet them down. So just an interesting little side note if you work with people who have abused stimulants, ask them what their reaction to the stimulant was, and if it sedated or quiet them down, now obviously in mass quantities, it would have stimulated them, they would have gone without sleep and all of the other symptoms with stimulant abuse. But if it did quiet them down and help them focus and such, then it may have been treating an underlying ADHD

problem. The only medication on this list that is not officially a stimulant, therefore it's not addictive in that sense, is a medication called Strattera. I've heard mixed reports about it, some people use it and say it worked really well. Some people use it and say they didn't like it, it didn't work well. I don't know why that was. So we tend to stay away from stimulants for people in recovery. And so the classes of medication that I recommend be avoided would be the benzodiazepines, the sleep hypnotics that contain benzodiazepines, and most stimulants. That doesn't mean that it's horrible if they're on them, but if they're on them, that should be under controlled conditions.

Let's talk now about MAT or medication-assisted treatment. These are medications that are used to treat addiction, in particular, opioid addiction, also alcohol addiction. These are the medications that are currently being used. Disulfiram or Antabuse that causes one to basically get sick, get ill if they drink alcohol. So it's used as a deterrent. Somebody's taking Antabuse, if they drink alcohol, it makes them violently ill. So obviously if they know that they're gonna get ill, they're not gonna drink. I've known people that have done it anyway, sometimes they get sick, but they're willing to suffer to drink alcohol, or they just stopped taking it and then drink. Let me skip down to the last two, and then I'll skip up to the middle two. Well, so this is where the controversy comes in addiction treatment because there's a belief that if you're taking some of these medications, that you're not really clean and sober. In particular, buprenorphine or Suboxone, or methadone contain opiates. Because they contain opiates, there's often a belief in the treatment community, in the 12-Step community that because they're still taking opiates, that they're not really clean and sober. The idea with buprenorphine or methadone is that they are opiate replacements. Buprenorphine or Suboxone is not indicated to be on forever, although some people wind up on long-term maintenance. The idea is to get on it and to titrate the dosage down over a period of time so that they don't have to be taking it anymore. Methadone is taken over usually a longer period of time, and there are people who are on long-term, even lifelong methadone maintenance.

Methadone and buprenorphine both contain opiates. It's enough opiate, not so much to get high, it's enough opiate to offset withdrawal symptoms. Methadone has to be given in a dose that I get at a clinic. Usually it's a liquid, and they have to go to a specific methadone clinic to get their dose each day. Buprenorphine or Suboxone can be given in a prescription. Usually it's given in a dissolvable strip. Usually you are given a week's worth, maybe even a month's worth, and they take it as prescribed hopefully. It could be diverted to other people, but ideally, if they're using it themselves, it contains enough opiate to not go into withdrawal. Both buprenorphine and methadone also contain blockers, which means that they fill up all of the opiate receptors, except for the ones that it's allowing in to offset the withdrawal. And so because it blocks the other opiate receptors, it means people, if they used other opiate, say heroin, it's gonna block the effects. So the person's using heroin, and they're not gonna get high because the opiate receptors are all blocked, it can't get in. So the fact that they're on some sort of an opiate is controversial, as we call it, harm reduction therapy and or medication-assisted treatment, as opposed to folks who talk about abstinence only, which is off of everything. The research shows us that people who are on Suboxone or methadone are less likely to overdose and die, and they're less likely to relapse, especially when you combine those medications with other psychosocial treatment. So I don't know how we're gonna get past that controversy. It's a little more accepted than it used to be, but it's still very strong, especially for people that are in their own recovery, they have really strong beliefs, either pro or con.

As sort of a middle ground, there are two other medications that do not contain any mood-altering substance, but work as to decrease craving, and they also work as blockers. So they do pretty much the same thing, but they don't contain an opiate or they don't contain any narcotic or mood-altering chemical. The first one is Naltrexone known mostly as Vivitrol. Vivitrol can come in pills, but most often it's given in an injection that lasts for about 30 days. So if a person gets on Naltrexone, they get a shot

every 30 days, and during that time, it's supposed to reduce their cravings for opiates. It also works to reduce cravings from alcohol. It also blocks receptors for opiates and alcohol. So if one drinks or one uses during that time, they're not gonna feel the effect because all of their receptors are blocked. Now, again, that requires them to have to stay on the shots on a monthly basis even after they leave treatment. So that's an issue for some but at least we have a medication that is proved pretty effective for those that are on it. There are not as many studies yet for people who have used it long-term. But short-term use, we see that relapse, it decreases the relapse rate, which means people stay alive. People that go into treatment that stopped using opiates, that were addicted to opiates, during that time, their tolerance decreases. When they get out, if they relapse on opiates, then because their tolerance has decreased, quite often, they're taking too much and they overdose and die. So these medications keep people alive. Hopefully it keeps them alive long enough that they don't overdose, and some meaningful treatment can occur so that ultimately, they move towards abstinence. The other one is Acamprosate or ReVia. I don't see that used as much. It's primarily similar to Naltrexone, and it's used more with alcohol-use disorder than with opiates.

So these are the medications now that are used primarily in medication-assisted treatment. Opioid overdoses cause one death every 20 minutes. So anything we can do to keep people from overdosing and dying, I think is important. So I'm a proponent of harm reduction. Am I against abstinence only? No, I'm a big proponent of abstinence, but only in as a goal. I'm also okay with harm reduction until we get there. So there's a lot of evidence to show that MAT is an effective treatment, especially when done in conjunction with other behavioral or psychosocial interventions.

Great list of references for anybody who is interested. Please take a look at those. I've got several of them that are really good. I wanna mention to you about cultural competence. For additional information regarding standards and indicators for cultural confidence, here's the link to the NASW Standards and Indicators for Cultural

Competence in Social Work Practice. So I refer you to that link if you're interested in that. It's been my complete and total pleasure. I know I talked fast and gave you a whole lot of information in a relatively short period of time. But hopefully, I gave you a good overview of medications and recovery, especially medication-assisted treatment. I'm sure there might be questions. Katrinna, any questions you might have before we finish up today?

- [Katrinna] Dr. Smith, actually no questions. This was a wonderful overview. I especially appreciated your example, your example that you used in the very beginning. As a medical social worker, I knew automatically that you were gonna say your new track infection, but I have learned from being in a hospital setting that I only know that from being in a dialysis clinic in a hospital setting, 'cause that's not something that as social workers, we readily identify delirium and those type of things as being associated with being septic, basically. That does not come to our mind. So I think that is a great example. So I thank you for sharing that example.

- Thank you.

- [Katrinna] And I thank you for sharing your expertise with us today, because as social workers, oftentimes we think we don't necessarily need to know about medications, because that's out of our our scope of practice, but it's so very important that when we're working with our patients, whether we're working with them in a mental health setting or recovery setting, or as for me, working in a general healthcare setting, it's so important to understand the medications, to understand their interactions, and to also understand how they impact our patients, because it definitely helps us as social workers in taking a very primary role in their care.

- Yes, thank you. And I agree 100% that it is so important, and yet it's it's often overlooked. And you're right, a lot of social workers and other professionals don't think that it's important 'cause it's not something that they're taught in school. So-

- Exactly. So I hope that social workers are able to use this as a guide as they work with their patients, as a guide to help them better understand psychiatric medications, medical-assisted treatment and recovery. So again, thank you all for joining us on Social Work at Continued.com.