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BUPRENORPHINE PRESCRIBING FOR BEGINNERS: TAILORED TRAINING FOR MENTAL HEALTH CARE PROVIDERS

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[video transcript]

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speaker, Dr. Nicholas Batson is a physician specializing in behavioral health at Crystal run healthcare, a position he's held for nearly 10 years. He's board certified and adult and child adolescent psychiatry. He leads crystal runs psych psychiatry division that serves children, adolescents and adults experiencing a variety of conditions including depression, anxiety, bipolar disorder, developmental disorders, and substance use disorders over to you Dr. Batson.

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Thank you and really excited to spend some time to talk about buprenorphine and buprenorphine prescribing. And you know what that looks like for us. You know, as psychiatrists and mental health professionals across the board, just a couple of quick housekeeping things, don't have any financial disclosures to make I do this because it's fun, and it's exciting work. And it's really rewarding. And so I just, you know, kind of want to spread the good word about it, just a few things that we'll cover, we're going to talk about kind of just the core principles of buprenorphine and treatment and the idea behind it a little bit of the pharmacology, I think the pharmacology piece is important when we're describing to our patients, as far as you know, what are the medication options and, and how they actually work, we'll do some prescribing recommendations, how to start how to think about maintenance, and then some just best practice ideas about dosing, dose stabilization. You know, this, this is, if you're already prescribing, you would kind of be familiar with some of these principles. If you haven't prescribed in a while, we've had some changes in kind of how we think about medication assisted treatment options for our patients. And if you're brand new to this, and you have questions, you've got plenty of resources myself, you know, multiple kinds of state agencies, local experts, I mean, there's a lot of options there. So this doesn't have to be something that you have to go out and do on your own for the first time. So why are we here today? And, you know, why am I doing this, as a psychiatrist, we get to see a lot of different people. And we get to hear a lot of stories. And I actually started prescribing buprenorphine shortly after it was initially approved by the FDA in the Appalachian mountains of North Carolina and residency, and it was much different back then, and much more restricted. And, you know, prior authorizations and dosing strategies were very different than than what we're doing now. And you know, it's a fast forward 15 years, it's really cool, and particularly to be in the state of New York. And it's such a great place to be able to prescribe, and have different kind of treatment options for everybody. You know, as a psychiatrist, sometimes, you know, our patients have chronic medical conditions. And if we start to think about depression as almost a chronic disease model, sometimes it takes a while for patients to get better. And sometimes the rewarding part about working with somebody with an opioid use disorder is that you can take them out of withdrawal very quickly, and it can be very rewarding to see that, and patients will tell you the same to so again, every everyone has different reasons. But you know, it's just exciting to me to see patients respond to medication assisted treatment options, and I'm sure most everybody is aware that the number, the number of cases of deaths, particularly deaths

related to you know, some of the synthetic opioids, I mean, we've all seen the news about fentanyl. And some of these other substances, the synthetics that are out there, you know, there are still patients that are, you know, having struggles with opioid medications and prescribing from different various doctors or you're know buying them off the street or something like that. But, you know, this is this is pretty clear, these numbers continue to go up. And so we do have a role here, to be able to help our patients find treatment and help them have access to treatment that they may have not had to had in the past. You know, just just some kind of staggering things. I mean, to look at the you know, the number of deaths that are that are out there, particularly in the state of New York, and some of us, I'm sure that are out here today. We're in counties that have some of the highest levels, not only in New York, but also in the US as far as opioid overdoses. You know, one of the things that, you know, why should we even do this in the first place, I mean, it saves lives, it may be very simple kind of straightforward way to think about it, you're safer being on treatment than you are not on treatment. So this slide kind of shows mortality rates for for patients that are engaged in either methadone or buprenorphine. As you can see, you know what, buprenorphine, those those numbers are there and the different colors who's in treatment and who's not in treatment? So kind of what's the, you know, what does buprenorphine do? And, you know, how does it help? How does it help the people we work with? Well, one of the ways we think about this is it helps the cravings and the thoughts and the urges that are the people we work with have. It eliminates that and that's really kind of the ideal treat meant sometimes, as we're working with patients over time as we get them stabilized, and they come back to you, and they say, I just don't have cravings to use anymore. And you're like, perfect. That's exactly what we're trying to accomplish here. It prevents withdrawal symptoms, that it can actually help with the withdrawal symptoms. You know, it helps block some of the other opioids that are out there if taken appropriately. That euphoric, you know, high experience that that our patients get. It doesn't have that it's not like you're going to take it and feel like you've actually taken the medication. Most patients say they actually feel kind of normal again, like I don't have that creepy crawly feeling, you know, I don't have that restless feeling in my body, I can sleep better. And it also helps just kind of overall quality of life. But it you know, one thing it doesn't do, it doesn't treat other other substance use disorders. It really is focused on opioid use disorders. There's some interesting studies that are out there. But, but nothing is FDA approved. This is for opioid use disorder. So what do we think about like, what are the principles here for buprenorphine treatment? Well, it's patient centered, right? Every patient is going to be different. Patients are going to need different dosing strategies, some of our patients come in, and they just like, I want the medicine just for a week or two, and then I'm fine. Leave me alone. And I want to be off though, that just data withdrawn, some of our patients come in and say I'm tired of having this life cycle where I go into withdrawal. And then I use and I've overdosed three times, I always call, it's like, the country music song, right, they've lost their family, they've lost their truck, they have no money and their dogs not there anymore. And, and so you know, they don't want that life anymore, they want something different. And so we think about long term use. So it's really kind of a patient centered, I really liked this idea of harm reduction. And getting away from this idea of, if you have a positive drug screen, you can't be on these medications anymore. Or if you're using some other substance that you can't take these medications, and we're really trying to get, I mean, we don't have that expectation for the other things that we do in mental health. And even in medical care, for example, diabetes, you

know, we don't stop someone's insulin, just because they missed a few doses and their hemoglobin a one C score was really high.

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And then, you know, medication as a treatment, and thinking about what that means for patients. It's not going to a program and sitting in groups and individual therapy and things like that, that might be part of it, but it's not required. And it's not something we think of but medication as a treatment. And sometimes we have to get our patients started on medication so that they can do those other things in their life. And, you know, one of the roles I think we can all have here is, you know, this low threshold idea someone comes in, I understand how this medication works, I understand how I can help somebody. And so we're just ready to send that first prescription, the first time that we see them, we don't want to wait and do a re eval. And, you know, it's not like treating a personality disorder where you gotta get to know somebody to figure out if that's really the traits that they're having. It's like, this is an opioid use disorder, they are in withdrawal, or they have relapsed, or they have they're, they're fine, and they're not using, but they're having cravings and urges again, and they want to be back on the medicine, let's just start at the same day. And then it's also just the true biopsychosocial. You know, people want to go back to work we're doing at home inductions. Now, we're not doing in office inductions, and some of those things like that. So what about in the mental health setting? So you know, I've I personally have done it in multiple different settings and inpatient psych setting, a partial hospitalization and IOP setting currently, right now I'm in an outpatient setting. And And if anybody is, you know, familiar with, you know, outpatient mental health, it can be challenging, and it can be a struggle, sometimes, buprenorphine, and the mental health is just like everything else, right. It's just like prescribing Prozac. It's just, it's part of our toolbox that we have to be able to help our patients. I mean, most of us know that there's comorbidity with mental health and substance use disorders. And, you know, some of those numbers ranged, you know, 40 to 60% of the patients that we're seeing, also have a comorbid substance use disorders, it might not be an opioid use disorder, but if it is, now you have that ability without having to have the X waiver, to really simply help these patients or if you don't have access to where you're at to a methadone clinic, or patient choice, then they come out and so on. So you know, I was using buprenorphine a couple years ago, and I wanted to get back on and you say, awesome out, and, you know, now I can help you. You know, what, how do these are some of the concerns and the things that a lot of other mental health people talk about when they say, Well, I'm not, I'm not board certified in addiction? Well, you don't have to be, you know, do you have to be the expert of opioid use disorders, you don't have to be that either. But you do you know, your mental health person, you can evaluate a diagnosis and put a treatment plan together. And so, you know, as our patient populations change, you know, this is some people went, Well, I'm just gonna get all the substance use patients, you're probably not. That's not going to be something that's going to be there. You're not going to now be the substance use person. And you know what, you might end up liking those patients. So you might say, Yeah, I'll kind of take those. There's no Really an increase in medical legal liability. I mean, our patients and psych world are complex, they're suicidal, they're high risk. This is not any different. Personally, I think this is a lot safer. I mean, we're giving somebody a medication that decreases the risk of overdose and death. And this is much better than giving a benzo to somebody or a controlled sleep medication where you kind of worry a little bit of something's going to happen. The other is the

diversion of medication. It's not really a concern. I mean, this is not, you know, we talked about previously, you're not getting high or euphoric off of off of buprenorphine, most of our patients are taking it because they want to get better because they don't want to be in withdrawal anymore, because they don't want to have the cravings. And so you know, it's funny, sometimes like, someone says, Well, I gave a couple of extra, you know, to, to my significant other, my brother or my sister because they were in withdrawal. And I say, alright, that's fine. Awesome, why don't you tell them to come in for an appointment to so so now you can kind of see somebody else. And you know, that whole bio psychosocial model, like sometimes you have to treat the house and the family and the environment that they're in to be able to get them to a better recovery plan. The initiation is not really complicated now that we're doing at home inductions, the dosing strategies are straightforward. New York is great, because there are almost no prior authorization requirements. Most of the pharmacies in the area have things that you can use to be able to start somebody on a medication. The other is the concern for you know, what about drug screens, and I have to get a drug screen every time. It's nice, yes, it's important to have, but it's not something that you need to be able to start somebody on a medication, you know, like buprenorphine at all. And then some people say, like, you know, I just, we don't want to have substance use patients in our waiting room. And, and that was a concern here, the organization that I work at, and I said, I'd be very clear with you, we're not going to have out, you know, sorry, I'll use the terminology but strung out, and junkies in our waiting room, like, that's just not going to happen, because these patients are motivated for treatment, they know that they're getting better, they're not going to be in withdrawal when they come in the office. And, you know, we can help them with those kinds of things. And it's a structured environment, you know, this is not things that we're doing kind of, you know, these are patients that are already coming in for their appointments, and they're already coming in for care. But again, you know, these are kind of simple things that we can kind of think about. So what are kind of the goals again, you know, I mean, reduce mortality, very clear, this is a life saving treatment. So, you know, it's kind of cool to, you know, to be a psychiatrist and say, Yeah, we save lives, too, we just do it differently. We're not, you know, emergency room doctors, and we're not trauma surgeons, but we get to save lives a little differently. It prevents, you know, with the fentanyl and the other synthetic opioids that are out there, you know, some patients just don't know what they're taking and using. And so this is a way to, you know, prevent an accidental overdose. And then, you know, the other is just access to medications. And, you know, some of the racial disparities when we talk about treatment and treatment outcomes and being able to offer treatment to everyone, it's effective for everyone and different settings, that that gives us that ability to do that with buprenorphine. So I'm going to give you an example of, you know, what it's like, kind of in our office, because, you know, we're primarily a mental health treatment provider, but if someone comes in for a substance use disorder, we will treat them and if it's too complex, same way with you, if you are treating, you can send them to a higher level of care. And then the cool part is now you can kind of take them back after they complete it. Same kind of model. We have someone's suicidal someone's homicidal, someone has, you know, an overdose, you know, on on for a mental health reason for depression type experience, you know, they go to a higher level of care, then come back, now you kind of have that option with with buprenorphine. So this is a this is a real patient and a patient that I have probably seen almost eight years now and I'll give you what he what he looks like, because it Ralph is an interesting guy. And, you know, Ralph actually used to work in a community mental

health facility. He was the maintenance guy there was for 15 plus years. He's kind of semi retired now, but came to me with depression and anxiety. And as we started to talk, he self disclosed that he had started using oxycodone for back injury and I had just kind of struggled to use it. So you know, Ralph, if you can imagine Ralph, Ralph is a guy who's about five, three, missing a couple teeth in the front, has an American flag tattoo on his forearm, and just just a wholesome, you know, guy like you see him and you just kind of feel bad for Ralph like you engage with him really well. I use the story of Ralph and I'll jump ahead to why Ralph kind of sticks with me. I've been seeing Ralph for a while after the first year that I saw him checking in with the patients right. Hey, how you doing? You've been on buprenorphine for over a year now. Tell me what's going on. Like tell me how your life is and he says Dr. Batson, you know But one of the best things that's happened for me in the last year is that I was able to buy a bed. So what do you mean by a bed? He goes, yep. Instead of using all of my money to buy pills, and Heroin and Pills and other things, I was able to buy that in a mattress, and I had got the best sleep I've probably had in over 15 years. And I was like, oh, rough, man. That's pretty cool. Like, not the thing that I thought you would say. But sure, that's awesome. So two years go by and say, Ralph, man, it's been two years, like, how are you doing? And he says, documents, I want to tell you this year, like my biggest accomplishment, he says, this year, I was able to buy Christmas decorations for my house. First time I've ever been able to do that in 15 years, because now I'm not using my I continue to not use my medicine or my money to buy pills. And so you know, I still see Ralph, I feel like I'm Ross primary care doc, I helped him get his he's got diabetes and helped him lift his foot amputation last about a month ago and helped him with the surgery and, and pain management, which again, not a pain management provider, but worked with his anesthesiologist and surgeon about what to do with pain control for him. And the short version is you don't really have to do much. He took some extra time and all he was fine because he stayed on his buprenorphine. But so you know, just about Ralph shows up with his back injury. You know, he's, he's in withdrawal. And we're talking about what's going on and, and,

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you know, he's got a supportive work environment, and he's having these withdrawal symptoms, so it gets some pills, he won't get some pills. And you know, hasn't really had any kind of treatment in the past or anything except his primary care doc, put him on some Paxil because he was a little depressed and anxious. And you know, it comes down like his PHQ, nine scores like 12 or 13. And his gad score was like 14 or 15. I mean, noticeable. But so he said, you know, let's like, let's take care of this, like opioid use thing. I think this might be affecting you as well, like this is affecting some of your mood and anxiety. So I'll tell a little bit more about Ralph in a minute, but just get a picture of Ralph in your head if you can from it. So this is these next two slides are some of my favorite sides when we're kind of talking to patients about what does buprenorphine do and how does it work? This is the whole informed consent, right when we're talking about any of our medicines, just like the SSRIs and how they work on serotonin, same kind of idea. So buprenorphine is a partial opioid agonist. So the kind of the way I describe it with patients, and one of the good things to know about this is the way that it binds to the receptors. And so you start to with patients, you got three kinds of options, right? You have you been morphine, which is a partial agonist, and you have something like methadone, which is a full agonist. So you know, if you're watching your screen, now, I say it sits on the receptors, and

it just stays there. And it sits there for a while. And it activates the receptor. And then on the other end, you have a blocker, which is like the naltrexone Vivitrol kind of stuff. And that's a blocker, it's a good medication, that might not help out a lot with the cravings for you. And then we have something else that's kind of in between, and it's a partial opioid agonist. And so what it does, it goes on and off and on and off and on or off the receptor. And it does that a bunch of times. And that's what helps with the cravings. And that's what helps with some of the other symptoms of withdrawal that you might be having. And it has a ceiling effect. So after a certain amount, when you're dosing it more is not better. And that always, you know, I think that's another thing that makes us feel good as prescribers as someone's not going to come back and keep asking for more medicine because more medicine is not going to make them feel any different. It doesn't actually make them feel any better. And so, you know, it's a sublingual type medication, and that there's the, you know, the other thing we tell them about, it's got two medications that are actually so most of us know, you know, Suboxone, which is the, you know, the brand name of it. But you know, buprenorphine and Naloxone, those things are together. In years past, this probably doesn't happen much anymore. But patients would, you know, try to alter the medication, and they would try to inject it to get high or you know, abuse, it just doesn't really happen that much anymore. But that's why it's together. Because if you break it apart a little bit, it can cause you to go into withdrawal if you try to take it other than orally. But But that's kind of there. So I tell patients that say and, you know, this is this is the big thing, it's the partial opioid effect, there's nothing else like it, it's the only medicine that's out there. And that's kind of where I like to use this little side and say, here's the receptors, here's this, and here's this on the bottom, because sometimes in a patient's in your office, and we all know that, you know, we talk a lot and our patients probably hear about 20% of what we hear. And then after that they just heard like, the Charlie Brown won't want lawn teacher kind of thing. And so, you know, sometimes you have to do the visual things to just kind of engage them. So they kind of like I remember you told me something I was in your office, I felt really bad. I was in withdraw. Remember you saying something about the opioid kind of stuff. But this the affinity is what's the important part. So it has this strong binding affinity. And it can help you know, again, kind of prevent overdose because let's say you did go and use something and patients do that. And they say, Well, I went and took a couple of pills, but it didn't fill anything. It didn't do anything like well, it's not going to do anything because the buprenorphine is there on the receptor and it binds really tight. It's a really strong binding and so those other pills or whatever you took is not going to have And effect because it didn't kick off that buprenorphine. And they're like, Oh, okay. And so they they don't go really try to use again, that's That's it once that's there, there is a little bit of risk because of the strong binding of precipitated withdrawal. It's really strong. I mean, it's a really low kind of effect that happens. But when it does happen, you know, it's something you see there's a little side I'll talk about kind of in a minute, some management strategies for that. But sometimes that's a concern, and particularly fentanyl and some other things we can we can do some strategies to kind of help prevent that, and help patients with other kinds of medications that are there. But we'll talk about that in a minute. You know, it is a this is one of those nice little like board questions or test questions that you hear about that is metabolized through the three a four Cytochrome P 450. system, there are some drug interactions that are there. They're rare, you know, oftentimes when we're thinking about like our patients with like H on HIV medications and some of those other things, that that's, that is a little bit of a concern, this segment, as far as the ones that we're using that are, you know, metabolized the three a

fortnight really not really a big concern. I mean, it's not one of these things where you feel like you have to increase the dose of buprenorphine, or maybe adjust that SSRI or SNRI, it's not really a kind of concern, it's there. The other thing is just how it blocks and the blocking kind of effect. And it's got that, you know, it can display some of the other opioids that are there. So when we talk about the inductions phases in a minute, I'll just kind of give you some ideas of why this is important. The other piece of this as there used to be some black box warnings, and they change some of these related to, you know, patients being on benzos and some of those other, you know, risk factors and the risk factors as any of these kinds of sedating, you know, sedative type kind of medications, or substances that people are using. We do have to have some caution with it. That, you know, there have been some reported overdoses with patients who are using alcohol and buprenorphine or benzos. But the real danger is the mixture of, you know, heroin and fentanyl and a benzo is definitely way more dangerous than patient that's on buprenorphine, and a benzodiazepine, this goes back to the whole harm reduction idea. And, you know, sometimes when you're talking to patients or you know, other people that might be some skeptics of why we're prescribing these medications, I say, would you rather somebody be using injecting heroin or would you rather have them and be kind of, you know, not to, or have them kind of be coming to the office and we can prescribe to them and we can be doing telehealth visits, and we know that they're taking their buprenorphine because we can track it in the eye stop. And which one is like which one is riskier than taking a benzo using fentanyl and heroin or us in a more controlled kind of setting with buprenorphine, and most of us are logical people and say, buprenorphine is definitely a little less less risky there. So precipitated withdrawal. You can see it, it is something you know, the percentages are, you know, single digit percentages that are there. What happens is that the way the induction piece works is if a patient is not in mild to moderate withdrawal before they did decide to take their first dose of buprenorphine, it causes that displacement of the opioid off and the buprenorphine doesn't have enough time really to kind of bind to those opioid receptors. And so in that transition time, while it's kicking off, some of those other opioids it can cause precipitated withdrawal. It's not that common, and a lot of patients are aware of what withdrawal is or even precipitated withdrawal, because maybe they've tried buprenorphine off the street, and they didn't do the dosing the right way. The other thing is that fit now, which is out there, it does have a little bit of a longer half life to it. And so oftentimes, we may have to wait three or four days before someone used their last dose of fentanyl, before they actually decide to use their first use of buprenorphine. But, you know, the old ways we used to do this, we would want a patient to come into the office, and we would want to see that they are actually mild to moderate with withdrawal symptoms. And then we would give them their first dose of medication, we don't need to do any of that anymore. Like it's not it's not that complicated. To be able to kind of do that. The other is, you know, with the buprenorphine piece of it is it's an opioid, so it can cause some constipation and nausea for some people. So this is the cool part about there's a lot of different options that are out there. So there's the tablet form and the film form. So these films that are out there about the size, if anyone's ever seen one of those Listerine strips, they come in as little foil type packet, you open it up, you can cut them in half sometimes when we're talking about half dosing with patients, you know, we'll say hey, just cut one in half. Take that and then say that and then in a couple hours when you need that second dose, you can take the second dose, the tablets do are available. They are in generic now. which is really good. Just some of the prescribing things I like to have my patients take the tablet and put it under their tongue. And the films I like to have them put it

in the cheek kind of the what they call the Buechel area. I think it dissolves a little bit better for most patients. When you do it that way, you just have a little bit more surface area, particularly with the film's hit the tablets and even some of the films have a citrusy, orange buttery taste to it. Some patients do not like that, you know, real quick solution. Sometimes we can just those outweighed meant some people will take a few of those two or three of those 20 or 30 minutes before they use their

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first dose of the buprenorphine for the day or second dose during the day. It does foam up a little bit in there, and some patients don't like that. And so you just tell them, hey, don't swallow, don't swallow the little pieces that are dissolving, you can swallow the foam. That's okay. Sometimes they don't know how to do that. The other cool part is there's extended release versions of it. So supplicated has been a couple of years now. You and you can do that in an outpatient setting. There's a what they call the rim system. It's fairly easy to do from a logistics standpoint with specialty pharmacy delivery systems that are out there now way better than they were a couple of years ago supplicate comes in monthly injections. And so patients that maybe don't want to take oral forms are a little concerned about the consistency of their use sublocade as a as a really cool idea. supplicate comes in an injectable, it's a subcutaneous injection. So that's what that little slide in, in the bottom right hand corner shows, it's almost like it's not a PPD type thing, because it's going subcutaneous layer, and not the sub dermis, but it causes a little bump to be there for a first couple of months. And, you know, some patients like I have these bumps, and I always say, Well, you're not going to have your beach body for the summer, but those bumps go away. And after a couple of months, you'll be fine. And in the brand new formulation that just recently got approved is Breck Sati, which is really cool. And it doesn't actually come out and probably till September is what the FDA is telling us in the manufacturer. But this actually comes in weekly and monthly formulation. So again, it gives you some different strategies to think about how to treat patients in different treatment settings, maybe a correctional setting, or someone who's transitioning from a higher level of care to a lower level of care, or someone who you want to give an injection to, but they can't get admitted to a facility or, or move over to your site. But to be honest, like in the mental health kind of setting, you can do all this, they don't need to go to any facilities. And I think that's the cool part now is that you can do all of this stuff in your office. So you don't have to. It's just like any other injections. You know, for us in the mental health world, we're used to long acting injectables, right. We're used to Haldol and prolix, and Vegas and all that. And so for me, and for us here, this is the same kind of idea. This is just another long acting injectable form to help a patient with their, with their treatment formulations that are there. Again, it's not approved for pain, you can't use it for pain management. But I'm sure most of us are not going to do that. And then, you know, some of our patients have Medicaid. And that's great. It's a real easy process. There's no prior authorizations, you send it in, you send in the milligram doses, it's pretty easy. I mean, I think one of the things to kind of think about is, you know what pharmacy that you're going to be sending it to. So again, kind of what to tell the patient when they're taking it. And there's the sublingual kind of strategy in the in the bucal kind of strategy that's there. So when you're talking with the patient about how to use it, particularly for the first time you tell him don't eat or drink anything 10 or 15 minutes before or after you take the medication. So you put it in your mouth, either under your tongue or inside your cheek, it dissolves in about 10 minutes, that's probably

about the most even with some of the generics, there's some variability and the dissolving. But you say leave it in there, don't swallow it, don't drink anything, don't eat anything, it will dissolve. It's kind of got that, you know, orangey buttery kind of taste. And then you can kind of, you know, just tell them that and that's what will happen and it's fine, it dissolves. If you swallow the whole tablet or the film, you just don't get the same absorption. So you get a much lower percentage, a much lower concentration of the buprenorphine if you saw it, so you don't swallow a pill. It doesn't work that way. It's absorbed differently. And that's why we want you to kind of do it this way. You can switch between tablets and film, some patients do have some preferences. For example, Ralph, we had to switch him because he has dentures, and the tablet was getting stuck on his dentures. And so we had to change him to film, some pain. Some patients, you know, when you're working with patients with substance use disorders, they always tell you, we are substance use disorders because we like our drugs a certain way. And I like my drug as a tablet or I like my drug as a film or I want it as an eight milligram and not a you know, I want it as a 12 milligram tablet and you know, like, Okay, I'm not gonna argue with you fine. If it gets you to take your medicine and it's not it's not a barrier to treatment, like Sure, go ahead, do it that way. So, this is the cool part about all of us. You no longer have to have the ex waiver. They get rid of that at the beginning of the year. All you have to do is have a DEA registration. So if you're writing prescriptions already for controlled medications like Ambien and benzos, and stimulant medications and things like that you're totally okay to, to write your first prescription or your ongoing prescription for buprenorphine, you don't have to put like a special X waiver code on there, the pharmacist don't ask for it anymore. The DEA is not going to come and knock on your door and tell and say, how many patients are you prescribing this medication to? I only know one person that the DEA has ever checked on. And he worked on an Indian reservation out in Arizona. And so different regulations that no, no one is, you know, the government is not checking on your prescribing if anything they're checking on who's not prescribing. And and, you know, we like to sometimes one of the thoughts is we don't have enough people prescribing. And so one of the ways that we can capture some of the patients that have substance use disorders, is with every mental health treatment, the same idea someone saw a primary care doctor, they could treat some mental health issues without having to see us in the mental health work. This just gives us a different avenue. So don't worry about any of that. You know, that's all gone, you can write prescriptions for anything you want for buprenorphine. And, you know, the other the other kind of ideas, just kind of the D stigmatization of addiction and substance use disorders. And, you know, again, they're just like any other, you know, chronic conditions. I didn't, you know, as I mentioned, I really did my residency in North Carolina. And, you know, interestingly, like, we didn't separate substance use disorders and mental health disorders, everything was just under one umbrella as as a kind of a psychiatric kind of treatment model. And, you know, so, you know, we've gotten a place, I think, in this area of the country where we've, you know, divided things out a little bit, and there's reasons for that, and they're fine. But, you know, this is, this is something that it's biology, right? It's, it's opioid receptors, it's genetics, it's dopamine, for cravings, and reward systems. I mean, this is not like, you have a moral defect or, you know, you're just a bad person kind of thing. And people ask, you know, the nature versus nurture question. It's both, right. I mean, it's, you know, it's the environment that you're in. But it's also genetics. And when you're doing your assessment with somebody, and you say, Hey, tell me about your family history, who's got a substance use issue, who's got a mental health issue, you're gonna hear about all those kinds of things like that, that this will, he'll hear

that, and that's where the genetics piece kind of plays in. The other part that, you know, it's just the language that we use, particularly like, dirty urines, and all these kind of, like, I got clean. Now, we're using recovery model we're using, you know, things like sobriety and some of those kinds of other things. Now, it's one, it's, it still have to help that we have to help our patients, right, talk about yourself differently, you know, don't say I'm not, I'm clean. Now. It's like, you never were a dirty person, like, you know, that's not want you to you know, you're somebody who's in recovery. Now. You know, you're you're not a

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you know, you're you're not somebody who's, you know, an addict or, you know, whatever it is, and, and I think the language that we use, not, I mean, just internally like, amongst ourselves, as, you know, as mental health professionals, how we describe patients, and, you know, when the DSM changed recently, and they changed some of that, you know, substance use disorders and, you know, getting rid of substance related disorders, or having substance related disorders and some of these other kind of language things that, you know, there was some intention about that, you know, and you have to sometimes talk about with patients like, Hey, I'm a person with a substance use disorder, or I'm somebody that's in recovery. You know, not that, like, you know, it was a bad person it was, I did these things, because, you know, it was for XYZ reason I know you, you've got a medical condition, and we're going to treat it and help you kind of treat it the way that should be treated. So so how do you, you know, what do we do about initiation, initiating buprenorphine, this is the important part, right? This is the, these are the big takeaways, like we can talk about all this stuff. I mean, you're here, you're engaged, you know, in the, in our presentation today, but you know, how do you do this? Like, how do I go out of here today? You know, hopefully, some of y'all still have a couple hours of patients to see. And I would be really impressed if someone gave us some feedback and said, I went this afternoon and wrote my first prescription for buprenorphine or I decided to prescribe for the first time for a patient that I knew that had a substance use disorder today, that would be really cool. So if if you do that, please let us know. But you don't really have to do a super extensive assessment. I mean, this isn't like in the child adolescent world, where we do a 90 minute initial eval and look at family dynamics, that none of that kind of stuff, right? It's kind of clear. Patients have substance use disorders. They tell you they're using fentanyl. There's your diagnosis, right substance use opioid use disorder, like you know that it's there. You know, you didn't want to ask the questions. How much are you using? How frequently tell me about your withdrawal symptoms? You know, the same type of assessment that you would typically do for anybody with substance use disorders like, you know, in the mental health world, we do Um, nicotine cessation, right. And so we talked about tobacco and how many cigarettes are used, and let's prescribe Chantix or whatever, you know, it's the same kind of idea with with opioid use disorders, the same kind of idea. So you know, one of the SAMSA, which I know, Sam says, one of their new guidance documents, and it's not really new. But it supports this idea of what we call observed and unobserved initiation, the observed initiation, like, maybe there's some treatment settings that we would want to do, but really the, you know, the patient center, the respectful model, the way that we think about how patients want to start these kinds of treatments, like they want to kind of go do this in the comfort of their home. So if they don't feel well, they can be at home and not sitting in an uncomfortable office somewhere and uncomfortable waiting room chairs, kind of struggling with going through withdrawal, while we're

waiting for them to kind of take their next dose. So again, same same day initiation, someone comes in see them, you know, write the prescription, you don't have to get labs to start the same way, you don't have to get a urine drug screen. Yes, it's part of the practice guideline, it's a good standard of care to do. And if you can't do it, that first visit, do it the second or third visit, you know, things like LFTs, that may be something that you want to think about doing. I mean, some of the other stuff that's really in those guidelines, or, you know, the other medical things, you know, the HIV Hepatitis, I mean, again, you don't have to do that. I personally defer to our primary care doc. So whoever your primary care doc is, let them do those kinds of things, because I'm not going to be treating that anyway. But that is something that you should be doing. And think about doing or at least documenting in there that, yes, the patient needs a cmp to check for their liver function because they've been using opioids. This is an opioid medication, small risk of having some increase and elevated abnormal lft levels. There's really no absolute contraindication to starting unless you have had a known allergy to buprenorphine, I've never seen it, I've never heard of it. I've seen people have problems with certain generics. And that was just because they dissolved differently, but not really an allergy. And sometimes it was just a patient education issue. And, you know, the other thing is, you know, the, the ideal standard is that the patient has to be in, you know, long term kind of treatment, right? Six months, 12 months of treatment, to really recommend doing it that long, because it prevents relapse, it's not a thing, like get just get somebody on treatment. So you know what, I know that you're saying, you only want to be this, you know, on in a week, or you only want to be on in a month or six months, that's fine. We'll talk about it that when we get there in a week, or two or three, and most of the time when they come back, they're like, oh, my gosh, I feel so much better. I'm not having withdrawal. And I have your cravings like I think I want to continue it for a little bit longer. And then you have the conversation of well, our best practice guidelines, and the research tells us we need to continue this for a couple of months before, you know we think about tapering off other kinds of ideas. So again, where are the patients coming from? They're coming from emergency departments, they're coming out of detox and rehab programs, maybe they're coming out of an inpatient psych facility, some of our patients are actually coming out of inpatient medical treatment, and there's hospitals in the area that are initiating buprenorphine for patients while they're on the medical floor. But also, you know, they have a secondary prescriber, which, you know, it's like they see you as a mental health person. And then they might even in some facilities, like they go across the hall, and they see somebody for their substance use disorder. And it's like, that's just that's not setting the patient up for success, right. Because more appointments, they go to more opportunities for them to miss care. So these are all things that you can kind of do in your office, one of the easiest way one where, you know, a lot of people say, Well, I'm not comfortable doing like the initiation of somebody, that's totally fine. Just take over someone else's prescription. There's not a lot of us that are regularly prescribing buprenorphine, hopefully there will be from today and talking with everybody, but just take over somebody else's prescriptions, a patient that is stable, that they've been stable on, have you been morphine dose for, you know, weeks to months, just say, Hey, let me just take over your refills, you know, one less person to call one less appointment to go to one less refill to have to go to the pharmacy to pick up. That's off sequence and everything. And so that's really like the easiest, most simplest way to kind of get started this just so you get used to the mechanisms of okay, it's a buprenorphine, eight milligram tablet and I you know, a quantity of 60, and all those kinds of things. And so just kind of kind of do that. So again, mental health

people here, we're talking about a diagnosis. So a diagnosis of an opioid use disorder. You know, you have a certain number of criteria. You know, four to five starts at the moderate. Buprenorphine is approved for, you know, moderate, or higher. opioid use disorders again, personally, not really, someone comes in with opioid use disorder and they're coming into your office and they're saying that they're been in withdrawal or that they've overdosed before or that they can't stop using. That's enough for me to say like, Hey, this is severe, right? I mean, someone could die. I from this. So this is a severe issue. They're obviously having some issues if they're there in the office, you know, social functioning patients using more amount. So the diagnosis is not hard, just making sure that you document it the right way, you know, opioid use disorder, moderate to severe severity. And the cool part about the documentation or the diagnosis part of it is there's a specifier on there that you can say, opioid use disorder, severe on maintenance therapy. And so that means that they're taking something like buprenorphine or methadone, or naltrexone or something like that. So just a couple of things to, to kind of think about on the short checklist of how to manage patients with for buprenorphine. So again, how do you write the initial prescriptions, make sure you're kind of sending it to the right pharmacy. If you're doing it in office, there are some places that actually will keep some buprenorphine there, to be able to do an induction, make sure you're writing it down the right way. For the patients, you know, you can do an induction whenever you can on somebody or maintenance therapy, but if it's somebody new sitting if you can, and there's some scheduling requirements that you might have in place that you weren't trying to maybe do it earlier in the week, because you want to check in with them in two or three days after they started, you don't want to like start it on a Friday. And then the weekend comes and then they didn't get their medicine and they relapsed. And so they see you back a week later, and they still haven't really got the treatment. So think about how you do it in the office and what kind of days but against started kind of whenever, make sure you're checking I stops that we have, they're a great kind of tool to have, make sure you're scheduling the appointments with the refills. So most people will do kind of in the first, the first week, they'll give them seven days worth of medication, don't show them don't give six and be like I hope they come back I'm gonna give them it's just not kind of worth it. Just just kind of keep them there. So how do you do this, you decide if you're going to do it on observed versus observed unobserved kind of means the at home induction type model, that's probably going to be most of our patients that we're going to be working with, make sure you do a Cal's that's on there. The reason why you do the cows is because you do want to see that they're in mild to moderate opioid withdrawal

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to to be able to tell them to start when to start to medication, if they're not now back up a little bit from that the patient doesn't have to be in withdrawal when they come in and see you. But if they are, this is how they will do. A lot of patients will come in and they'll know you say you know, when you start to feel really bad, and you're in withdrawal, and you feel like you want to start to use again, that's probably moderate withdrawal for you. And so that's when you should start your next, your first dose of buprenorphine. So that idea of they're gonna go home, and do this at home, and they don't want to be in withdrawal all day long. Because they have to work they have to maybe pick up their kids from somewhere or whatever their life situation is, they'll go home and do this when they start to go into, you know, kind of mild to moderate opioid withdrawal. You know, when would they go into this or when should they use their first dose

versus their when they took their last dose of an opioid, you know, the long acting opioids like methadone and some of these extended release, opioid pain medications, you know, they can be 2436 hours, sometimes even longer with things like fentanyl, before you actually will start to show some signs of withdrawal. So you can talk to the patient about when they're going into withdrawal. The reason why we're doing that is we don't want to create a precipitated withdrawal kind of situation, make sure you're following up with them in a week doesn't have to be in person. A lot of people will ask this you have telehealth as an option. This will kind of have to be patient centered. Some people are comfortable doing that. Some people are comfortable. You know, making sure at least I want to see you one time, you know, they may do the first one on telehealth and then a week later, they see them in person for whatever reason. Maybe it's the treatment team that they're all working with. So something to think about, but definitely, you know those first couple of weeks that someone's being started on or restarted on buprenorphine, you want to make sure that you're following them. So kind of had this is the kind of the classic type model idea to have them stop all of their opioids, you wait till they're in withdrawal, and then you have them take the first dose. So is their kind of buprenorphine naive or haven't taken it before haven't been on a maintenance dose, you'll prescribe, you know, an eight milligram film or an eight milligram tablet, you say take a half, just cut it in half, break it in half, wait about an hour to two, if you're not feeling any better. If your withdrawal symptoms aren't getting any better, go ahead and take the other half. And then you know, say even you know, at the end of the first day or two, you're still not feeling well go ahead and take another half. Most of the time, we don't go above you know, 12 to 16 in the first two or three days, but you can't escalate it up that quickly. Let's say a person has been on before they're like Hey, I was I was always taking eight milligrams twice a day. You say fine, I still want you to do a little bit of a you know, kind of initiation dosing kind of strategy just just on the off chance that they would have some kind of precipitated withdrawal symptoms. So you know, kind of quick review for milligrams tone await an hour. If they're not feeling any better. Go ahead and go ahead and take the other half the other or four milligrams, they should start to feel better at that point, tell them to wait about six to eight hours before they think that they're going to take a second dose, if they start to feel some withdrawal symptoms, again, take another half a dose that may be the first day. So then then see say, say the next morning, when you wake up, whatever you took the day before, as a total dose, eight milligrams 12, I would take that same total dose in the morning, and then see how you're feeling later on in the afternoon. And if you got a really good relationship, and you have this, you know, support staff in the office, say, give us a call tomorrow afternoon, or better yet, we'll call you. And we'll see how you're feeling tomorrow afternoon or the day after that, to make sure that you're still not in withdrawal, or that your cravings are getting better, whatever it may be, that's kind of a classic, real simple, half, half, and then kind of their withdrawal symptoms should be getting better after that, and then you can titrate it up. So let's say you're at 12. And then they're still feeling some withdrawal symptoms or even cravings, you can kind of go up to that 16 milligram dose, you know, within that first week or so, this is kind of the the at home induction, it really kind of the same idea observed versus unobserved, you're still doing the same things. So you know, take your dose, wait, if you're not feeling well take the other half and for still not feeling well kind of take the other half and then wait. And then that next day, whatever you were taking before, take that. And one of the things to ask patients is what is the worst part of withdrawal for you? And those are the symptoms that you're going to kind of be focusing on? To say what is getting better for them? So is it the

stomach aches? Is it the nausea, diarrhea is it the body aches, the sleep issues, whatever that is just a little kind of, you know, fitting hills, there is what seems like a lot of our patients are using with fentanyl, it does take a little bit longer to maybe do that initiation dose. And that you do maybe want to think about having a patient, not use anything for a couple of days, they won't necessarily go into withdrawal because the fentanyl has got that binding effect to it to where it could be a couple of days that it actually comes off of there. And if you give the buprenorphine too early, that you could run into that precipitated withdrawal risk. So how big is it, you've heard me say it a few times it's small, it's like a one to 2% chance. But most of the time, this goes pretty well, I'll give you some ideas about what to do for kind of precipitated withdrawal. So what happens is if you do if, even if the precipitate withdrawal does occur, you're gonna see it very quickly, after someone takes that first buprenorphine dose, I mean, really, within 1015 2030 minutes, and they're gonna be like, Oh, my gosh, I feel, you know, 10 times worse, 100 times worse than what I felt when I was going through withdrawal before. And again, it's called that that whole receptor thing, the affinity as one's going off, and one or the other, if you are measuring with the cows score, so the clinical opioid withdrawal scale that we should all be familiar with, that score increases by six or more within that, you know, 10 to kind of 20 minute period, and it comes on very rapidly. And so what happens, it's just that displacement, you know, as you're getting the opioid off, and the buprenorphine onto those mu opioid receptors. So a couple of things again, you know, you may want to wait a little bit longer, you may tell patients that, you know, that withdrawal feeling, wait till it really becomes uncomfortable. But the other thing to do is like, let's prescribe all the other medications that we're all familiar with in the mental health world. So we call it the care package, a lot of us do. So I'm gonna write you your first prescription for buprenorphine, and I'm going to write all these other PRN for about 10 or 15 days worth quantity. And if you need them, great if you don't need them, you don't have to take them. And so this is the idea. Well, what's your worst part about withdrawal? And someone says, Well, I get so nauseous. Awesome. I'm going to prescribe some Zofran eight milligrams, take it twice a day, you know, PRN? Oh, so write that as a prescription. But what I do sometimes, and what a lot of us will do is we just write prescriptions for all of these. So we're all familiar with hydroxyzine. Right? So that's helpful for agitation, anxiety, you know, insomnia. So 25 milligrams, three times a day, PRN. Zofran for the nausea, things like a modal and Bentyl that we can do for abdominal cramps and things like that. Trazodone to help somebody sleep, you know, give them 50 Give them 100 milligrams, they're not going to use it, probably more than a couple of days, even if they don't, you know, are starting to feel better. The other is clonidine. Some of us you know, have not always been big fans. One of the concerns I'm gonna give somebody a blood pressure medication, and they're already abusing medications and it's going to drop their blood pressure and you know, they're going to have hypotension and then you know, they're gonna die from it. And it's like now that actually doesn't help a lot of patients with substance use to opioid substance use disorders, like clonidine because it helps them feel like they, they feel calmer, they feel more relaxed, they feel less jittery, they feel less anxious. One of the one of the signs of opioid withdrawal is an increase in blood pressure and heart rate. And so this helps bring that blood pressure heart rate down you know, point 1.1 milligrams point two milligrams I mean, you know, not blood pressure does Same but not really using it for blood pressure. So again, you know, again, the quick things, make sure they have a week's worth of medication, make sure they know how to call back the office, if they're having any problems. This is where you get to be like, you know, super supportive and say, Hey, we're gonna, if you

have any problems, don't do anything else, don't go take extra, just give us a call, we'll tell you what to do. And also making sure that they know which pharmacy they're going to use, you'd hate to write your first prescription, you send it to a pharmacy, they don't have a dose or they're not, you know, their supply chain issue was disrupted that week, and so you got to send it to someplace else on the other side of town, the patient just says, I just don't have time to go get that kind of stuff. Again, most of the pharmacies are really good, you'll find that, you know, there may be a couple of pharmacies that maybe don't feel so comfortable working with, or the patients will come back, they were really nasty to me. And that's okay, like, you know, that's kind of part of the process. But we've worked a lot with the New York State pharmacy societies, and the vast majority of pharmacists are like, I'll do everything I can to help these patients, like I'll do whatever I need to do, and some are actually doing, like needle exchange, syringe exchange for some of these patients. And they're because we know that they might relapse. But we don't want them to relapse. And if they do, you know, harm reduction kind of approach, but you know, some some, particularly if you're sending the first couple of prescription, or maybe a new pharmacy, maybe you call have somebody in your office call and say hey, like, just want to make sure you got that prescription kind of stuff. Again, you don't need labs to start, you don't need a urine drug screen. Again, best practice, if you can get a urine pregnancy, get the drug screens, get all those kinds of things. But you know, this is what you should kind of be thinking about getting, if not you and you know, another medical professional, make sure that that's on the list of things for people to get to, it doesn't doesn't increase your liability, these patients are not more risky than anybody else.

51:56
You know, if anything, it's definitely more controlled, you get to see the immediate effects of your medication. And, you know, I think the other thing is, we all go into health care, because we want to help people and this is just another way to help people and help them really kind of, you know, be and do what they want to do. You know, what if what if you have a patient, you're seeing them for a little bit and then they decide to, you know, give some medication to somebody else? Don't make a big deal about it. I mean, it kind of is what it is. Let's say you get a urine drug screen and it's positive for marijuana or it's positive for a benzo. It's a discussion with the patient, right? You know, urine drug screens are a lot like vital signs, right? If if there's a problem, we talk about it, but it is not a reason. Again, this is a big change. For a lot of us. It's not a reason to stop prescribing for someone just because that that just because they had a drug screen that was positive, not dirty, just positive for substance, you can order a urine drug screen that picks up buprenorphine. It's a special order. So you might want to ask your, your facility that you work with and lab places that you use, how to obtain that. So just kind of quick back to Ralph did this whole induction idea with him, gave him some of the suboxone to take gave him the kind of care package idea that clonidine. Zofran Trazodone, had him go home, comes back in a week, you know, says he's feeling much better. But then he had some questions about like, Well, how do I take it and sometimes the evenings a little kind of feels bad for me. And so the same idea of like, you're listening for cravings, you're listening for patients that are talking about feeling like they're in withdrawal, even if it's mild, we want to treat those those are things that the buprenorphine country and be helpful. You can stabilize so once you get somebody kind of initiated on a dose, you know, you continue that dose and seeing them kind of regularly throughout so you may get to 16 milligrams in the first week, they may still have

some cravings and maybe you go to 20 or even 24 milligrams 24 milligrams is the top dose. That's the maximum dose that the insurance companies will cover. And most of the research shows that above 24 milligrams is not helpful. About half of patients will do a divided dose. So kind of when you get to that 1620 milligram doses, patients will divide that up, you know, eight milligrams twice a day or 12 milligrams twice a day. But some patients are just fine on you know, one eight milligram dose in the morning or 112 milligram dose in the morning, and that's fine. You'll see that but it's probably about half and a half is a good idea. Anyway, Ralph comes back you know he's on 16 He's totally totally gone. There's no opioid symptoms at all. I ended up for Ralph ended up he was I took over his Paxil prescription so that he didn't have to go to his primary care doc every six months to just kind of check in to be able to get his Paxil. So you know, took that over was fine. And again, like I mentioned before, he had the tablets, they weren't working for him they were getting stuck on his denture So we switched it over to the film's not a big deal wrote that on the prescription switching from tablets to films because of oral denture, whatever. And that was that was kind of fine. So how you know how long? How long do you keep somebody on treatment as long as they need to be on treatment, there's no time. It's not anytime. Again, good research shows minimum six months really probably a minimum of 12 months or 18 months. Before we think about trying to slowly taper somebody down off at whatever dose they're on. Usually seeing them weekly for the first month, and then monthly for the next two or three months after that. And then going out to every two or three months after that you can put refills on buprenorphine, and as a different scheduled drug and some of our other controls for you can do that. Let's say somebody's really complex and you know, they're using cocaine and you know, they've relapsed two or three times and it just doesn't seem like it's working, then that's okay. Like you're you can send them to the you know, the the substance use addiction board certified blah, blah, blah, specialist someplace else, they may not be the I would say it's sometimes you're just not the right person at the right time for them, and they just need somebody different for you as well. And then kind of you know what the other things I started asking, What about life? Awesome, you're going back to work now do we need to adjust our appointments scheduled so that you can go to work and not have to miss work to be able to come here? And what other supports do you need, you know, refer as appropriate, a lot of us might have some counties that have some really good county resources. So you know, the social services department, housing, jobs, support programs, all those other things and make sure that they're you always make sure they're connected with a primary care doctor. We talked about drug screens, it's a vital sign. Don't worry about it. It's it's you know, it's a, it's an information piece, but it doesn't tell you everything, it doesn't always pick up on all opioids and benzos. drug screens don't because of some of the synthetic qualities of some of those. And again, the urine drug screen, you can ask for buprenorphine, quantitative and qualitative, that the amount the quantitative level, the buprenorphine in the urine doesn't tell you anything. It doesn't tell you if it's effective. It doesn't tell you if they're, you know, using or not using regularly their medication, don't worry about it, it's not really that big of a deal. And then how do you stop somebody, you start something you got to know how to stop it, you don't have to, there's no reason to do this. It's a long term care kind of model, but a slow taper. So usually going down by two or four milligrams, you wait a couple of weeks, you might wait even a couple of months for some patients to go down. The very quickest that you can take somebody off the buprenorphine is about five to seven days, they're not going to feel good, they are going to have some withdrawal symptoms. But you can even do a kind of a rapid taper. There's all kinds of

resources out there if you have somebody like that, that you need to talk to. So anyways, I've talked enough about Ralph, Ralph is doing good, actually saw Ralph last week, and he's doing great, and he got a brand new car. Six years later, so Ralph's life is doing doing pretty well. So again, easy stuff to do, you know, real simple low threshold, you're already prescribing medications. All this is is understanding, milligram doses and frequency, which is what we're doing for all kinds of other prescriptions as well. So I will stop that was a lot of information for now.

58:14
Thank you so much, Dr. Batson. That was a wonderful presentation.

[End Transcript]