Transcript: Medications for Opioid Use Disorder in Primary Care
June 26, 2025

Kayla Baker: Welcome to the Behavioral Health Substance Use Disorder Integration Technical Assistance webinar, Medications for Opioid Use Disorder in Primary Care. This webinar is supported by the Bureau of Primary Health Care of the Health Resources and Services Administration. Participants have entered in a listen-only mode. Submit questions by using the questions and answer feature. To open the Q&A, click the Q&A icon at the bottom of your Zoom window. If you experience any technical issues during the event, please message us through the chat feature or email bphc-ta@bizellus.com.

This event is being recorded, and slides will be available on the TA portal following this event. We offer behavioral health continuing education units for participation in BH/SUD Integration Technical Assistance events. You must attend the event and complete the Online Health Center TA Satisfaction Assessment form after the event. A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA Team via Smartsheet.

We are so excited to share that we have more learning, collaboration, and continuing education opportunities coming to you. Please register now for Communities of Practice, or CoPs, that begin on July 22nd. Staff members from any HRSA-supported health care can participate. These small group sessions that meet for an hour every other week for eight weeks on a focused care integration topic. The CoP facilitators will host office hours after each session if you want to keep the discussion going. These topics include Behavioral Health Strategies in Primary Care, which will be held every other Tuesday, July 22nd through October 28th, from 2:00 to 3:00 PM Eastern.

A Behavioral Health Integration Primer for Health Centers, which will be held every other Wednesday, July 30th through October 22nd, from 2:00 to 3:00 PM Eastern. Strategies to Support School-Based Health Youth Behavioral Health, held every other Thursday, August 14th through November 6th, from 3:00 to 4:00 PM Eastern. Participation is limited to 30 people for each CoP. To keep the learning group small, so if you are looking to or for opportunities to learn with and from your Health Center peers, these sessions are for you. I will be dropping the topics and registration links in the chat momentarily.

I am pleased to introduce you to today's presenter. Dr. Akiva Mandell is a Senior Associate of Addiction Medicine at Bizzell US and a Board Certified Psychiatrist of more than 30 years with added qualifications in Addiction Psychiatry. His work experiences has included direct clinical treatment at the inpatient, partial hospitalization, outpatient, and residential levels of care, as well as in administration. Dr. Mandell served for eight years as the Medical Director for the Vermont State Office of Drug and Alcohol Programs. There, he was a key participant in the creation of the Vermont Hub-and-Spoke Model for delivery of medication for opioid use disorder.

Prior to joining Bizzell US, he served for five years as the Chief Medical Officer for Community Substance Abuse Centers in New England. He currently supports training and technical assistance activities for Bizzell US as a subject matter expert. It is now my pleasure to turn the webinar over to Akiva. Akiva, please go ahead.

Todd "Akiva" Mandell: Thank you, Kayla, for that wonderful introduction. For anyone who's out there, welcome. I understand we have a large group, so it's very exciting to know that everyone out there is interested. I answer to everything except Dr. Mandell, so any Q&A is, please, to Akiva or to Dr. Akiva if you must, but Dr. Mandell was my late father and is my older brother. Next slide, please.

A lot of this is going to be about language and looking at tools for management of opioid use disorder screening and integration into primary care settings. We're going to be doing some definition of treatment options for medications for opioid use disorder for their patients. MOUD, we don't say MAT anymore. We want to demonstrate and understand the importance of using non-stigmatized language in your practices. **[inaudible 00:04:59]** that's part of what **[inaudible 00:05:01]** for if they're feeling judged or stigmatized.

We want to also identify strategies and plans to create networks to coordinate with mental health concerns and needs of patients with MOUD. After residency, I was in my first job, and it was called a dual diagnosis program. Then it became co-occurring disorders, substance abuse, mental health. I really think, let's talk about patients. You can't split them into their diagnosis, it doesn't help, and in fact, it can be very detrimental. I say complex patients or just patients. Next slide, please.

We're going to talk a little bit about the background of medications for opioid use disorder as methadone being one of the most studied drugs in the entire pharmacopeia of medicine, going back many, many decades. I'm going to talk about what the barriers are, and I'm going to be asking you to help me with this to identify specific barriers in your practices and what keeps you from providing substance use disorder treatment or MOUD. We often hear-- We're going to be talking about stigma, clinicians' fear of diversion of medications, and we're going to talk about other opportunities and topics to be addressed.

We're going to look at buprenorphine, methadone, and naltrexone as the top three, the only three right now, for treatment of opioid use disorder, and screening assessment tools and integration of screening for substance use disorders or for treating substance use disorders into your regular practice, as if it's, as it is, a chronic disease or chronic illness that needs ongoing treatment, the way hypertension, diabetes, seizure disorders, so that they become treated the same way or in a similar manner anyway. Next slide, please.

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To start out with, opiate use disorder is a chronic and very treatable condition. We have effective medications that are FDA-approved to help people stop or, at the very least, reduce their opiate use. Harm reduction, ways of using, if they're going to use, how to use safely, et cetera. Medication for opiate use disorder reduces the risk of overdose deaths and as well as the contraction of HIV and hepatitis C risk behaviors. The medications are safe and effective during pregnancy and breastfeeding, and that's an issue that comes up a lot. Am I allowed to-- a pregnant woman, am I allowed to be on methadone or am I allowed to be on buprenorphine while I'm pregnant or while I'm breastfeeding? Yes, you are. It's your right to, actually. Next slide, please.

You're going to be answering this in, I believe, in the Q&A, and it's to help guide our **[inaudible 00:08:23]** presenters as well, each of your particular-- in your particular practice and across practices. What are your concerns? What are the current barriers to using MOUD in your practice? One choice, people will say there's not enough time, not enough support to coordinate care, lack of education regarding screening and assessment tools. I have **[unintelligible 00:08:53]** your spoiler alert, but fears of the practice becoming overrun by patients seeking MOUD and others. Please--

[pause 00:09:04]

Todd "Akiva" Mandell: I need to know when this is done so we can move on to the next one, please.

Kayla Baker: The poll is closed. We're now sharing those results.

Todd "Akiva" Mandell: Interesting. Thank you. Very interesting that not enough support to coordinate care and lack of education regarding **[inaudible 00:09:46]**. Very interesting. I somehow expected some of the other ones to be more, but I'm really glad to hear this. We'll close that and go on to the next one, please. What do you think would be most helpful? More training, more staff, the EHR integration of screening and assessment tools about substance use disorder into your regular health care patterns, awareness of community resources, or others?

If this is complete, let's see the results. This is so high-tech. More training. You're at the right place. More staff, EHR, community resources. Very interesting. Great answers. It gives us a major springboard here for continuing on. Next slide, please. We're going to start with stigma, which was on the top of the list of the things that I mentioned before. Stigma is alive and well, even today, even with all of the publicity that substance use disorders and the opioid overdose, basically epidemic, have received.

Couple of resources here. The first one is a video understanding addiction to support recovery. It really is a very elegant little-- I'm not going to play it today, but it's a very elegant little video on the path, a person's path to recovery, and the type of support they needed. For the second, the other side of the screen, words matter. Talking about

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yourself or others with substance use disorder. Communication, for example, we don't say junkie anymore, a person with substance use disorder. We also don't say a schizophrenic anymore. We say a person with schizophrenia, a person with alcohol use disorder.

The hyperlink that you'll get in this 'Words Matter' gives a rather large and extensive chart about wording. Wording is very important for people who may be afraid of your judging them, may be afraid of disclosing to you as providers that they have a substance use disorder. Making sure that the words that you use are welcoming and patient-centered, and that even between staff members, you use this type of language so you get used to doing it. You don't say, "I have an addict in room A." You say, "I have someone who has a substance use disorder." You get used to, even in the chart room, using the proper language. Words Matter is a really elegant and nice resource for you to have. Next slide, please.

Fear of diversion is often brought up **[inaudible 00:12:55]** the choices that we had, and I'm sorry, my chair squeaks. Addressing fears of diversion really goes across all of medicine. We often prescribe or people often prescribe benzodiazepines, stimulants, as well as the medications that we're talking about for the treatment of opioid use disorder. Having patient education about what their expectations are for how they use and don't misuse their medications. Education about, "Here's my expectation, I expect you to bring your pills with you," for example. "This isn't mandatory, but I expect you to bring your pills so I can do a pill count with you. Not that I don't trust you, I don't trust addiction, and I want you and people around you to be safe."

Keeping their medication safe, so children don't have access to it. Too many times we see children have access to even a small amount of buprenorphine, while it's very safe, even in large doses for adults, a small amount can hurt an infant. Pill counts. Impairment assessment is something that I really like for people to focus on very strongly, is that-- and this goes for your entire staff, from security to reception, et cetera. If a person looks impaired, based on their eyes looking heavy, their slurred speech, their stumbling, and that's, is this person safe to be driving a car? Is this person okay to give a prescription for more narcotics to, or more controlled substance?

We are not allowed to take keys anymore, but we can certainly say, "Gee, I don't think you should be driving. Can we call you a taxi?" If someone gets into an accident, as they've left your facility, or under the influence of your prescriptions, and someone gets hurt, that can ultimately come back on your practice. Especially someone leaving directly, if they're leaving, look impaired, and they get in the car, there can be major problems. Nowadays, we talk about marijuana not being illegal in many states. It still can cause impairment.

There's no field sobriety test for that that I'm aware of at this point. Making sure that your patients are aware that if you appear impaired to us, we may stop you and offer

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you a cab, or ultimately, you are allowed to call the police and say that someone has just left this area and may be under the influence. Having the expectations ahead of time for safety of themself and others, pill counts is a completely reasonable thing to do, takes a few minutes, but you're not allowed to touch the pills, but a person can put them down to a pill counter and they can count them with you. Impairment assessment, very, very important.

It turns out that expansion of treatment availability actually brings down the risk of diversion. One of the things that happened early on in the release of buprenorphine is that a police chief would call me and say, "Dr. M, we have so much buprenorphine in contraband we're finding, what are you doing about this?" I said, "What's happening?" It turns out that often people are asking for more of buprenorphine so they can give it to someone else who is trying not to use but can't get to treatment. Making sure that treatment is expanded enough in your area and you're looking to be providers, and I applaud you, I think it's what needs to happen, actually is helping avoid diversion. Next slide, please.

Part of expansion of treatment is telehealth prescribing for opioid use disorder. Partially, at least, triggered by the COVID epidemic. People could not get to offices, or it was too far, or offices were limited, and the rules were rolled back in terms of allowing someone to have an online assessment, a telehealth assessment, and treatment started that way without having to come in for a physical.

The removal of the X-waiver. The X-waiver was intended to watch how prescribers were using buprenorphine. There was only an X-waiver for buprenorphine and its cousins, its conjurers, and to show that a person had gotten their eight hours of training. The X-waiver has been removed, and anyone who prescribes, who has a DEA can prescribe buprenorphine on their regular DEA number. Methadone dose requirements are really from an approved program rather than from practitioner's offices.

However, maintaining a connection with that methadone treatment center or actually from an opioid treatment center with your practice, if you have someone who's getting treatment, making sure that the communication is there. This goes for all areas of medicine, OBGYN, for women who are pregnant, who have a substance use disorder, an opioid use disorder, who are on methadone, making sure that the person is being monitored, it's our patient, it's not yours or mine. Next slide, please.

This is a dandy little how these medications work, methadone and maybe-- I'm sure a lot of you have heard this before, but methadone being a full agonist at the mu receptor in the brain, the more you add, the more result, the higher the dose, the more effect that there is at the mu receptor. Buprenorphine is a partial agonist, and so it has a ceiling effect, so if you continue to add more, you don't get more of a response. Naltrexone is a complete antagonist, it blocks opiates and, in fact, tears opiates off the mu receptor, which can precipitate withdrawal, and we're going to talk about that in a minute. Next

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slide, please. Deciding which of that armamentarium to use for someone with opioid use disorder, it's most important to think about the patient's needs, which will help them be most successful. Being able to stick with treatment and the length of time in treatment is a really good predictive factor. If a person, if you're thinking about someone, might be appropriate for methadone, have they had it before? What's happened with it? Have they had buprenorphine before? What's happened in their success with that?

Being able to stick with treatment, if a person has to take three buses or hitchhike to a methadone or an opiate treatment facility, are they going to stick with it? Versus, can they manage to keep a prescription bottle with buprenorphine? Are they someone who's a candidate for an injectable product? Are they someone who hasn't used opiates in a while and can be started in a doctor's office on naltrexone, versus someone who might need to go inpatient to be inducted and to have the opiates washed out?

That has been a problem. Just as a sidebar, that's been a problem up until now, that it takes quite a while for opiates to come out of someone's system in order to not put them into withdrawal when they're started on naltrexone. The NIDA SWIFT project is a way of speeding that up, the protocols that have been created to speed up the time that it takes in a residential program or inpatient program for a person to be able to be on naltrexone, the injectable long-acting naltrexone. It's been very helpful. Next slide, please.

Looking at methadone for just a moment, it is only available for opiate use disorder through licensed clinics. Anyone with a DEA can prescribe methadone for pain. It's very inexpensive and very helpful, but there's a lot of risks to doing that because of the way it builds up in the person's system. Initially, years ago, we would say you have to start low and go slow. Starting doses of methadone has actually increased to higher and the moving up is quicker, which helps keep people in treatment so they're not on withdrawal day after day.

You do have to come initially to daily-- presented to clinic, at least at first. There are take-homes, which can be earned over time. While methadone, like the other medications we're talking about, is very helpful and very safe, there is potential for overdose if it's mixed with alcohol or other sedatives. It should definitely not be stopped abruptly. It is not substituting one drug for another, which is a common myth, and it works. Next slide, please.

Buprenorphine, prescribed from an office with anyone now with a DEA license, it's available in a variety of preparations, including pills or tablets or long-term injection. Effective dose can often be reached much faster. Initially, in the trainings for obtaining your X-waiver, there were recommended stipulations about the ceiling dose, and that's actually gone up because even though the studies will show that X number-- 90-something percent of the receptors are blocked or occupied at a certain buprenorphine

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dose, some people actually do need more, and it isn't just someone wanting more medication.

Withdrawal can be experienced if other opioids have been used recently, but this can be managed. We used to say you have to be in withdrawal in order to start either of these medications, but the protocols have changed, and it's important that you look at each one, and it also should not be stopped abruptly. Next slide, please.

As I mentioned, long-acting naltrexone, there is an approved protocol, I believe, for-- and if you see SWIFT through NIDA, it is a study which demonstrates a shorter amount of time. It is given in monthly injections. It can be given more frequently if a person is experiencing severe cravings. It can be moved into three weeks. First dose really can only be given after opioids are out of the system. While abrupt cessation does not lead to withdrawal, it can lead to cravings. If a person is going to be on long-acting naltrexone, it's important that they come in at this prescribed time for their dose, and that they not just walk away from treatment. Next slide, please.

Where to start with a patient who-- for any of your patients, and we're talking about this for universal screening for everybody in your practice. The TAPS tool is a very important and very flexible, facile tool to use that a patient or the clinician can administer. It is a double algorithm, first a broad screen, and if there's a positive response, and we're going to show you how this works, if there's a positive response, the algorithm kicks into the next level and gives a report which demonstrates the severity of a person's use as they report it and how you might approach it.

This is something that people have said to me they like using in their practices, and that everyone is getting it. You're not excluding anyone, you're not picking out a person to say, just out of random, that we're doing this because many people smoke cigarettes, many people drink alcohol. If everyone is being screened, for example, through TAPS or DAST, or S2Bi for brief intervention, everyone can expect in a practice to be screened. "Don't you trust me?" "Yes, I do. I don't trust the disease of substance use disorders."

It becomes a matter-of-fact approach. "Yes, everyone gets this. As of this date, everyone is being screened because we want to make sure we're keeping you safe and doing everything that we can to provide you the best treatment that we can." It can be difficult to integrate, but integrate this into your overall practice. I think that TAPS is a really nice integration, and I'll show you why in a minute. We talk about drug testing at the same time with this. Drug testing is really a toxicology screen and should be used to gain information about a patient. It cannot be used, should not be used to, for example, if someone comes up with a positive screen to dismiss them from treatment because they come up positive. Kayla, would you like to start since I've been talking about the first half of the algorithm?

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Kayla Baker: Absolutely, one moment.

Todd "Akiva" Mandell: This is public domain. Everyone can feel comfortable using it, downloading it. As you see here, it can be the patient or the clinician and Kayla's going to start being a clinician, and she's going to run through the first half of the algorithm because it goes through all of it, basically all of the families of drugs that someone might be using, and then there's other ways of embellishing on it. What we're going through right now is the last 12 months. How much substance in all the categories have there been used?

At the end of the completion of the first half of the algorithm right now, you see that we've moved alcohol to the past three months. We're not going to follow Kayla going through each of the buttons, but she's going to do that as we talk. It's a way to drill down into an initial screening that the first half of the algorithm does. It's important that we have those criteria of how much someone may or should or should not be drinking as males or females. I'm just going to pause for one second.

The questions demonstrate urges to use, using despite negative consequences, all of which go into the DSM's criteria for substance use disorders. We chose this particular pattern that she's clicking on because I want you to see the report that the TAPS demonstrates, provides for you, and how to actually use it as a, one, as a discussion for your patients, and two, how to integrate that into your EMR. Based on what-- We're showing a range here. This person, and the way this was answered, shows a high risk alcohol level. It's high risk for alcohol use disorder. Patients with this result are at high risk for adverse outcomes.

If you click on the suggested action there, it gives you an idea of where to continue and how to approach a patient in terms of using the DSM, in terms of delving deeper into their difficulties. Then there's additional resources. In turn, the suggested action advises not to use alcohol and drugs. That goes along with almost any of the substances. The additional resources here are all public domain and for you to use. If you scroll down to the next one, please, Kayla.

Based on the reports here, we have three high-risk areas with the alcohol, sedatives, and cannabis risk. We're not going to go through the suggested actions, but they're all there. Having this printout and putting it in front of the patient, saying, "I'm concerned about these three areas." The opiate risk level that was reported here is called problem use. There is a risk. There are potential problems that are associated with heroin use, including overdose. Again, suggested action. Stimulant risk level was an undetermined risk. There was some use. If we continue down, you can see that it's color coordinated.

Other risks for other substances and tobacco risk was minimum risk. Each of these topics can become a discussion with you and your patient. You can look at it over time. How has that been doing? Do we need to send you to treatment? Is someone

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intoxicated in your waiting room? Is the person experiencing withdrawal? You're raising the question. They may not tell you. "Oh, I just drink a little bit." "You can come out of TAPS now. Thank you very much." I had someone say to me, "I only drink a little bit." How much is a little bit? I go like this. "How big is the glass? I have four that size. That's maybe a bottle and a half of wine. Is that--? Oh, I don't see it as a problem."

"Okay, here's what TAPS says about that in terms of the risks. How are we going to address that?" "I don't want to address it." "Okay, we're going to continue talking about this over time, so that you're using the evidence-based research tool, screening assessment tool. You can return to it each time." Next slide, please. I find that TAPS to be very helpful. Now, other-- We're going to talk about that video in just a minute. Drug testing, as I said earlier, drug testing is a toxicology screen.

When you're thinking about drug testing, and everyone, for example, gets an annual test, or if someone has a change in status, if a patient doesn't look the same, they're slurring their speech. They seem to be perhaps in withdrawal, and you are thinking about getting a urine toxicology, for example, a couple of things to consider. One is, why are you doing it? There's a change in patient status. That's one of my favorite comments for saying that something has changed. You need to know how much it costs.

There was initially, in Vermont, we were spending 5 or-- I think it was $3 or $4 million on drug testing because the clinicians were told this only costs $10, and so we were ordering it every day, except that it was $10 for each category in the drug screen. Millions of dollars were being spent on drug screens that were not being justified. Why are you doing it? How much is this going to cost? Three, what are you going to do with the results? To me, the best thing to do is, you've come up positive here-- We don't say dirty. We come up positive here. How are we going to address this together? What does it mean?

Then, prescription drug monitoring programs. This has expanded. These programs have expanded over the last 20 years. Methadone, as far as I know, as of today, methadone, since it is dosed, it is not prescribed from the methadone programs, is not included in the prescription monitoring programs. As a rule, or as a regular practice, everyone gets a prescription drug monitoring query every once a year, however you decide, so that you may see what's on board and integrating that into your routine practice.

Assessing risk for overdose and educating about naloxone use is also very important. If you're prescribing narcotics for pain, if you're prescribing a benzodiazepine for anxiety, or usually that's what they're for, social phobias, et cetera, and they mix it with something, what's the risk of overdose? Now, benzos don't respond to naloxone, but some people are being prescribed both together. Even if they're just being prescribed for pain, that doesn't mean that they're not necessarily at risk for an overdose.

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This video, which is on the NIDA CTN website, looks in-- This is for you to look at. I think it's very nicely done. It highlights key points and strategies for overdose prevention, because each person can be identified as having specific risks specific to them, and having a plan for addressing those risks and minimizing their risk of overdose. Then what happens if an overdose happens, and family to be involved in it, people being told who might be using substances, please don't use alone, and please make sure that you've tested your drugs for fentanyl, and please make sure that someone that you're using with has naloxone with them.

We mentioned about impairment assessment before. I gave a talk to our-- I live in Vermont, we have a little teeny town here, but we had a select board meeting, and I gave a little talk about some of the available resources on the NIDA CTN website, and held up-- I bought that day naloxone to show that I was living up to my word and I keep it. It's not supposed to be kept in a car, as I understand, but put it again in your key ring. Having people understand how to respond, and that'll be the next, I think, the next slide, please.

Patient-facing information. This is a video, which is, again, public domain, four steps to reverse an opiate overdose. You can't reverse it if you don't have the naloxone there, but how to respond, what to notice, what to do for patients and for their families. [coughs] Excuse me. Professional resources, screening for substance use, as with TAPS, supplying fentanyl test strips, and that everyone gets screened without judgment. We do this for everyone. One of the things to stress for responding to an opioid overdose is to be calling 911 as someone is giving the naloxone, because they want you to call so they can help you. Next slide, please.

I guess you're not seeing me, but anyway, medication as a wrap-up, and I'm hoping we're going to have lots of questions. Medications for opioid use disorder are safe and effective. It's important to know that. They are not substituting one drug for another any more than insulin is substituting, any more than any-- that, for example, for seizure disorders, hypertension. Medications are needed for a variety of chronic treatable diseases. They are safe and effective. Integration of screening and assessment for all substance use disorders should be a routine part of your patient management.

It's hard to manage a patient if you're not aware that they may be using substances, they may be drinking more than they say they are, and let's have discussions about this. There's lots of resources available, toolkits and other resources are available in public domain without cost. Next slide, please. That's a very fast and down-and-dirty introduction to medications for opioid use disorder and screening for substance use disorders in your primary care. I hope we have lots of questions, and look forward to hearing them.

Lisa Jacobs: Hey, Akiva. Hey, folks. We took Akiva off video because he was having some bandwidth issues, but I'm Lisa Jacobs. I'm one of his colleagues at Bizzell US,

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and we invite you to submit some questions through the Q&A feature at the bottom of your Zoom screen. While people are doing that, Akiva, I wondered if we might kick things off talking a little bit about the role of stigma in medication for opioid use disorder. You've been so great educating me and others about how stigma is really quite a barrier for people to receive treatment through medication. Is that something you want to talk about for a little bit while we're receiving questions?

Todd "Akiva" Mandell: Sure, we did talk about it a bit in terms of words matter. Words matter in a variety of ways, but specifically to the medication for opioid use disorder or people with opioid use disorders, to use respectful words, and your approach to them is not, "I'm worried about the junkie in the room or the heroin addict in the next room." People are afraid of being stigmatized and judged, and that's one of the reasons that you'll find that people run from your program to go somewhere else because they're afraid, and having-- This is the responsibility of everyone in the entire practice, again, from reception to anyone who might walk by a patient.

It's important that a patient feels welcome and not judged. As I said, one of the first things that will happen is they will run out of treatment, and they're waiting to be judged, and they have been judged, and people, for a variety of reasons, get judged. They're judging themselves tremendously and very harshly based on their own histories. They don't need us to help them do that. They need us to show where their positivities are, where their strengths are, and saying, "It seems that you have a substance use disorder. You might have an opioid use disorder. Let's talk about that, and let's address that and how we might do that."

I talked to Lisa about this the other day. One of the ways that I approach this is that I say to patients, while I'm asking you questions, I'm the pilot. When we come to actual treatment, I switch places with you, and I become your co-pilot engineer. You have to drive your own plane, but I'll help you. I'll provide-- You got to bring the nose up a little bit. You got to yaw a little bit to the side. You're losing altitude here, but you're in charge. "I can't do treatment for you, and this is an agreement that we're having together. I'm prescribing, here are my expectations of you. Here are what your-- Tell me what your expectations are of me as I do this," so that we're working on a treatment agreement, not a contract.

We don't use that term anymore either, but, "How do we agree to work on this together, and I'm so glad you're here safely." When I would see someone come back to treatment for the 50th time, before we had medications available for opioid use disorder, "I'm glad you're back safely, because I can't treat you if you're not here, or you're not alive. What are we going to do this time? Help me." Does that address it a bit, Lisa?

Lisa Jacobs: It does, and we're starting to receive some questions in the Q&A. Let's start with, one of the questions is more general. What's the current success rate in

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treating opioid addiction disorders? Do we have some current statistics on that, Akiva, that you may be able to share, or I can do some research in the background?

Todd "Akiva" Mandell: Historically, and this is something that people tend to flip around in their heads, without treatment, and I don't have the latest numbers, I apologize. Without treatment, people tend to be about 35% success rate. With treatment, it's over 75%. It's certainly a reason to, and it may not take the first time, but to think of how many people you're likely to lose, versus offering treatment to someone which betters their chances of getting better. The number that gets kicked around is somewhere between 75 and 80, I believe, success rate over time with the use of medications for opioid use disorder, versus 35 or less percent for people just trying to do that on their own.

Lisa Jacobs: Now, there's a question that came in about Subutex for pain management. Elizabeth Diaz-Casiano is asking if it's safe to use it as a maintenance drug.

Todd "Akiva" Mandell: The difference between Suboxone and Subutex, and those are trade names. Remember, it's buprenorphine and buprenorphine/naloxone. The naloxone was added to buprenorphine originally to try and deter it from being injected because of having naloxone with it, and avoiding blocking the response. Either product, the buprenorphine or the buprenorphine/naloxone, are both very safe and can be used for pain management. Certainly, buprenorphine in a different preparation was available for pain management before it was released in data 2004, the treatment of opioid use disorder. It can be used, it is used, and it is quite safe.

I don't have experience myself using it for pain management, but there have been downsides. It's been gone by the wayside, but you can't treat someone for more acute pain if they're on buprenorphine for pain management because of how it works on the receptors. There are ways of getting around that. If someone needs surgery or someone has an emergency problem, there are ways of getting around it. The buprenorphine products are used for pain management, but they're usually more spread out during the day.

Lisa Jacobs: Akiva, I'm not sure how we'll be able to address this question, but it's from Christine Bergerger Sally. Sorry for butchering your name, Christine. She's asking about best practices for dosages that she can share with her medical providers. I know there's some general guidelines, but I didn't know if that would be something you'd want to address.

Todd "Akiva" Mandell: I tried to allude to it in the body of the talk is that the dose ranges have changed. It used to be that no one was to get-- or rarely did someone need more than 16 to 18 milligrams of buprenorphine, that's not the same anymore. There are guidelines that are available on government websites that can describe it better,

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even the package inserts. Methadone, again, for starting methadone, the doses have been higher than they were when I was in practice. It used to be that someone, you never needed more than 70 milligrams, for example, way back when I was in training, which is a very long time ago.

Doses have been much higher, but they're also, why are we needing to go so high? Sometimes, especially my experience with methadone is that people can have withdrawal symptoms or that seem like withdrawal symptoms, they get sweaty at night. Opioids can cause sweatiness, it's not a withdrawal syndrome. Assessing someone, for example, in the morning before their methadone dose, are they in withdrawal? If they are, they should be coming in sweaty and green, looking seasick, and having a very difficult time, versus "I'm in withdrawal."

Having someone, for example, understand what withdrawal means, and to say, "Instead of saying I'm in withdrawal, tell me, understand what you mean by withdrawal. What are the symptoms that you're experiencing right now?" Breaking it down, the way you'd break down someone saying, "I'm depressed," "tell me what you mean by that. Are you hopeless, helpless, worthless, guilty? Are you having trouble sleeping? Are you having diurnal variation?" That you're breaking down their statement into something that's more manageable and more adjustable. The protocols have changed, but there's plenty of information out there, people are not practicing anymore, of exactly how to manage. There's a question in the chat room, I think, Lisa.

Lisa Jacobs: Let's take a look. Can you explain how naloxone works when taken with buprenorphine?

Todd "Akiva" Mandell: Oh, okay. The point, as I try to measure if I've already answered this, but the point of the buprenorphine/naloxone was to prevent injection of melting down and injecting that double compound. Naloxone is not absorbed if it's swallowed, and it gets broken down in what's called the first pass. It doesn't work that way. That's why when you're using buprenorphine under the tongue, it gets absorbed sublingually. That's the best absorption of it.

On the other hand, if it's injected with the naltrexone, it's to keep them from having a high, basically. That's what the combination was about. There are people who would say, "I'm allergic to naloxone. I have to take the single compound." All of that's worth discussing. There's not a lot of demonstration of real allergies to it, but the point was to prevent injection. That's the main reason it was given together.

Lisa Jacobs: Akiva, I think we have about three minutes left before we need to wrap things up. I'm not seeing any other questions in the Q&A and chat. Trying to think if there are some other things that we may want to end with for these folks before we let them go for the afternoon.

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Todd "Akiva" Mandell: I guess my final point. First, thank you all for being here. I hope it's been helpful and understandable. I hope I haven't gone too fast because this is a three-day seminar, basically boiled down to 45 minutes. Helping the patient work with you as a partner toward their treatment, using the proper language, screening everyone, not being punitive with the results of a drug screen, et cetera. Keeping an open mind that substance use disorders need to be treated.

Lisa Jacobs: Going once, going twice. Really appreciate your questions, y'all, from everyone who has been asking Akiva for his experience. I think Kayla is going to be taking us through and telling you a little bit more about upcoming events, and how you can let us know what you think of this educational event. Kayla, back to you.

Kayla Baker: Wonderful. Thank you so much, Lisa. Access more behavioral health substance use disorder integration technical assistance opportunities by emailing the team, visiting the TA portal, and scanning the QR code to subscribe to the Hub in Focus. Just a reminder that if you are interested in going deeper on behavioral health integration, be sure to register for a small group community of practice after this call. These CoPs will begin on July 22nd. The facilitators host up to 30 participants and staff members from any HRSA-supported health center can participate. We're adding the topics and registration links to the chat again for your convenience.

We offer behavioral health continuing education units for participation in BHSUD integration technical assistance events. You must attend the event and complete the Online Health Center TA Satisfaction Assessment form after the event. A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA Team via Smartsheet.

Please share your feedback on today's session. You must complete the assessment if you plan to claim continuing education credits. We appreciate your time to tell us about your experience today. The assessment will automatically open when you close this meeting and is also within the chat. The slides will be posted to the TA portal. These resources and references are included for further reading. Thank you all so much for your attendance. This does conclude today's webinar, and you may now disconnect.

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