PRESENTER: There is 10 US-based regional and six international HIV ATTC centers. We serve the states of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Like all the other regional ATTCs, we're funded by the Substance Abuse and Mental Health Services Administration, also known as SAMHSA.

This year we celebrate 25 years of funding and support from SAMHSA. This is the third webinar in the series. And all of these webinars are being recorded and will be available for viewing on the Great Lakes ATTC website, along with the PowerPoint slide.

A few notes for you to be aware of. Today's audio will be broadcast through your speakers. So please make sure that they're turned on and up. There's no call-in number for this webinar. You can use the chat and questions feature throughout the webinar to ask questions or add comments. And we'll also have Q&A session after the presentation.

Today's presenter, Dr. Matthew Felgus. I'll talk a little bit about Dr. Felgus. He's board certified in addiction medicine and psychiatry and has been treating people with substance abuse dependence for more than 20 years.

Before he went to medical school, Dr. Felgus was a drug counselor. So we brings that perspective to treating his patients. He has a clinical faculty appointment at the UW department of psychiatry and has been lecturing for the past 18 years on addiction issues.

Dr. Felgus received his Bachelor of Science degree in psychology from Penn State University, his medical degree from Hahnemann University in Philadelphia, and completed the psychiatry residency at the University of Connecticut, as well as a research fellowship in substance abuse at the University of Connecticut Health Center. He also has a private practice in Madison, Wisconsin, where he's been using buprenorphine naloxone for people with opioid use disorder since 2003. He's currently president of the Wisconsin Society of Addiction Medicine. And now I'd like to turn the presentation over to Dr. Felgus.

MATTHEW FELGUS: Hello, everyone. I'm just waiting for my slides to get up. Now hopefully, everybody turns out the earlier poll. I want to welcome everybody. I was very curious to see the backgrounds of the folks who are attending this conference.

Now it looks like we have another poll up. So please fill that out. As I'm looking, it looks like the

majority of the individuals who are attending the conference, it looks like all are master's level addiction primarily focused. And I welcome all of you. I'm very glad that you're here.

Initially, we thought that this webinar was going to be geared toward prescribers, either MD nurse practitioners, primarily primary care. And according to this, it looks like there are three primary care docs that are current on the webinar. So I'm happy to have everyone joining.

I do believe that there's going to be something interesting and worthwhile for all of you, no matter what your background. So what we're going to be talking about, warning signs of opioid misuse and treatment options in primary care. Although, this obviously, I believe is applicable from an informational perspective for folks in the mental health field, both as MD, PhDs, master's level.

I'm asking-- there is a poll right to this side of the slides I'm just looking and you not have to-- if this is not single answer, everything that you feel on is applicable. We're going to jump to this. Which of the following are warning signs that your patient could become addicted to the opioid medications?

So please answer, and like I said, there is more than one answer. Just go down. It's basically kind of a true or false. If you think that these are risk factors, then check on it. If you don't that these are risk factors, then do not check on it.

This talk is going to be divided into three parts-- so what to be aware of before your client or patient gets an opioid prescription, what to be aware of once within the first month of treatment with an opioid pain medication, and then what happens once you start to suspect that your client or patient is showing signs of an addiction. So there are eight possible warning signs that your patient could become addicted to their opioid medication. And I want to scroll down, because I want to see where people are at. And I'm trying to figure out.

So family history of alcoholism, drinking seven or more drinks per week, current high life stressors, history of high anxiety. Then on the next one, history of past trauma, history of alcohol dependence, concurrent use of a benzodiazepine, cannabis use two to three times per week. So I'm scrolling down. I don't know if you guys can see me scrolling or not, but I am just looking.

Now all of these across the board pretty much-- yep, they are all pretty even. Actually, you guys are pretty educated. The one cannabis use two to three times a week, not demonstrated

to be a risk factor.

Also, believe it or not, history of high anxiety, again, something that you would want to look into, but not as high on high evidence of a risk factor. So just again just gauging where everybody's at, and I'm going to be addressing all of these. So I'm going to jump in.

So before you start opioids, keep in mind that we're going to be talking about these risk factors, the things I asked you about in the poll-- past overuse use of central nervous system depressants-- a common ones alcohol, benzodiazepines, and opioids. So past overuse use of central nervous system depressants do increase the risk of opioid overuse.

Now other substances that individuals may be using, such as cocaine or cannabis, it's something that you want to be aware of when you're prescribing an opioid, that before somebody starts what we're willing to most look at is what are going to be the red flags. What do you prescribers, as well as the counselors, need to be educating the patients? History of family members becoming energized from opioid medication-- I'm going to speak a little more on this soon. But I would say most people who work with individuals who do abuse or have abused opioids will tell you that they get their energy from the opioid medications.

Now the majority of people who get pain medication will say that it makes them tired. It makes them feel clouded. It doesn't give them energy. Folks that get energized-- and this is even before anybody starts abusing opioid medication-- this is a brain wiring issue. This is a major, major risk factor for developing an opioid dependence.

So I am going to speak more about that. Greater than seven drinks a week. I know there's people from all over the country. We are based in Wisconsin or I'm based in Wisconsin, as is ATTC. Wisconsin has the highest per capita alcohol consumption in the country.

So some of you folks from other states, what's considered normal drinking in your state is less actually than what is considered normal drinking in Wisconsin. So greater than seven drinks per week is also-- again, this is a regular user of alcohol. Now when I talk about drinks, we talk about standard drinks. And I think this is actually very useful slide to share with clients.

A 12 ounce, it shows a can here a bottle as well-- so the 12 ounce beer. Somebody goes into a bar, they get a pint or even bigger. That's more than one standard drink-- so 12 ounces of beer, 5 ounce glass of wine. So if somebody is drinking a bottle of wine, that's five-- that's actually five drinks a day or a shot and a half of hard liquor.

So if somebody was filling up an eight ounce glass with four ounces of hard liquor and then topping it off with soda or juice, they may that that's just one drink. That's actually three standard drinks. This schematic above the standard drink, no more-- and when I first saw this, I was a little confused.

So we talk about no more than four drinks a day for men, no more than three drinks a day for women, or for individuals over-- they day 66. I'm not sure quite where they got that number. You can say 65, 66, what people typically think of as seniors.

So three or four drinks, depending on your category, is considered a binge, however, even if you're not binging, if you're going over more than 14 drinks per week for males, 7 per week for females and for seniors. And that's not so much a body size issue, because there are women who are larger, and you can weigh more than men. But it's more a result of the amount of enzyme to break down alcohol with the average male versus the average female has in their stomachs.

So it's not about body weight when they talk about these weekly amounts. And it's not really about gender. Well, it is about gender, but it's more about what's going on in your gut and how you break down alcohol. So I just put this up, because standard drinks really means different things to our clients and our patients than they do to us.

So this is an important premise, again, for somebody who is trying to assess whether somebody is at higher risk before they are being given an opioid prescription. So for those of you who are drug counselors, if your client is talking about having a surgical procedure, this is as relevant for you, as it is for folks that are actually prescribers. Higher risk factors does not mean your patient is intending to abuse their opioid medication.

Obviously, after surgery, sometimes it is necessary to utilize opioids, even in an individual that have had a past history of abuse. And there are some people that are willing to attempt to not have opioids after surgery, but the it really depends on the surgery quite honestly. And doctors and nurses will often push this idea of, oh my god, if you're having your rotator cuff repair, that's an extremely painful surgery.

The important thing to keep in mind, nobody starts using anything planning to develop an addiction. And since the majority of you are addiction counselors most of you probably realize that shame is a large part of the process of having an addiction. And people start feeling like

they're weak, they're bad. They just really start doing all kinds of negative self-talk.

But the reality is, even if somebody has had a problem with another substance before they start opioids, nobody plans to become addicted to anything. Educating the patient-- and this is equally true for somebody you know as a counselor versus as a physician-- educating that they are at higher risk in a nonjudgmental way can make a major difference. Because the time to really make a difference and to stop an addiction from developing is to provide education before somebody develops that addiction. That's obviously not always possible to do, but almost ideal.

So I do want to say a little more, the whole idea of becoming energized by opioids. Most people become tired, nauseous, cloudy after taking an opioid. Some people do become energized.

This appears to be a genetic variation. It runs in families. It will occur at the first exposure.

A patient of mine, who was on opioid replacement, told me a story about her nine-year-old-- very quiet, reserved child with no substance involvement. And he had a tonsillectomy. He was in pain.

The doctor had given her some low dose Vicodin. And here he was having a problem later that night. She gave him the Vicodin.

This kid's nine years old. His personality totally changed. He started saying, I feel great. I just want to jump up on the table and dance.

This was absolutely out of character for this nine-year-old. She told me about this. She was a little bit freaked out. She called the doctor, told me about it a couple weeks later.

And what I told her was he wasn't ready for the conversation that he was at higher risk. He was having no involvement. He was in first grade and in a private religious school.

And I said, when he's a teenager, you are going to have to have that conversation with him. This child has the wiring to develop a problem with opioids. He's going to need to know that before he gets-- before he has anything that anybody would prescribe in an opioid for once he gets past his tonsillectomy.

Mom was keeping control of the medication. He did not have any more after that episode.

Again, education to this risk factor is key to preventing addiction.

Again, this does not mean that somebody that has this wiring, this is the luck, the bad luck of your genetics. If it makes you feel good, this is human nature. If something makes you feel good, you're going to do it again and again. And this is a major risk factor for addiction to opioids.

My patients will often say-- these are my patients on opioid replacement-- they'll say they had no idea this could happen to them. They were upstanding citizens. They were not-- they were not doing the things that-- again, people have these prejudices in people that have addictions-- the crimes, all of those other factors that we-- the stereotype of somebody with an addiction.

These people were flawed. And that oftentimes led to them not getting help for their addiction for a very long time, because they did not want to believe that this was something that was happening to them. They were just-- well, it was kind of making them feel a little good, or helping them sleep, or helping them be more productive. And they were employed and with families, and how could they possibly have a problem with this? And we know this in the addiction field, it can happen to anybody.

And primarily, I'll put this our for prescribers, because folks in mental health or in the addiction field, you are going to have more than three minutes to have this conversation. But I think this is a good thing even the folks in addiction and mental health fields, if you do work with primary care docs, this is important. This does not take very long.

Before somebody gets handed their first prescription, this can come from the doctor, the nurse, or even a counselor, if you know that your client is going to be going in for a surgical procedure, if you or your child-- if this is an issue where the parent is the one that you're talking to feels energized after taking this medication, you need to call the office and let us know. This shows you may have the brain wiring to develop an addiction to this type of pain medication. It is based on genetics, and it isn't anything you are doing wrong.

It is not about willpower or character. It can happen to anybody with this type of brain wiring. And most people do not know they have it, until they take this kind of prescription. However, this means you need to be cautious with any opioids.

Never take extra. And if you can, have somebody else holds it for you. That did not take very long at all.

And primary care doctors are busy. Surgeons are busy. If doctors would have this conversation with their patients before starting somebody on their first opioid prescription, it is my very deep clinical and personal belief that people who-- there are less people that would develop the addiction to these types of medications.

It's never a bad idea to have an opioid contract. The majority of physicians tend not to do this. I wish they would. So again, we know in the field, we have to take people where they're at. And same thing is true of physicians.

It's never a bad idea. If you are considering doing this, if you are a prescriber or work with a prescriber, some of the parameters of a good opioid contract-- no early refills. When you prescribe, you need to give folks the same amount-- the amount that-- if you're giving them a week and you're going to say, you can take this up to four times a day, they need 28 pills, not 30, not 60. You really want to give people the right amount.

Specific frame of the initial fill, ideally one week or less. It doesn't always happen like that in primary care or surgery. One to two weeks is probably safer. Longer than that, you do have the potential to run into some problems, especially if somebody is unaware that they have the risk factors.

Being clear about a reasonable timeframe based on what they are having going on, what they need the opioid prescription for, you do need to be clear. If somebody is getting opioids for a surgery, the average surgery five days is in time of the acute pain. Obviously, there's surgeries that are more complicated than that. There's chronic pain conditions.

I do mention that for chronic conditions that somebody is getting an opioid prescription for pain, I think it is essential the expectation of other modalities of pain control. Opioids alone is not the only answer for a long-term condition. It should be understood that no doctor shopping will be allowed.

So obviously, your patients may have more than one doctor that are treating or treating more than one condition, but if somebody has another doctor, no new controlled substances-- no benzos, no stimulants-- that are not already going on during the time that they are-- that you are giving them this opioid prescription-- contacting the office for any abnormalities, lost prescription, I took a few extra, I'm getting energy after I use this, or I'm just feeling better than I ever have in my life-- and that patients understand working with agreement can lead to the

discontinuation of their prescription. How to minimize abuse of medication? Again, well, obviously with avoiding medications with potential for abuse whenever possible, education-- I've been stressing this-- and then limited use-- so five pills per month for panic attacks.

I'm not talking about opioids here. I'm talking about benzodiazepines. The majority of benzodiazepines are prescribed by primary care docs, rather than psychiatrists.

A lot of people are surprised to hear that. That's also true for antidepressants as well. More primary care docs than psychiatrists are prescribing anxiety medication and depression medications.

So this is a more generic-- just an illustration of limiting use if somebody is worried about having a panic attack and a doctor is prescribing a benzodiazepine, they probably do not need it every day. Using small quantities for that risk is minimizing the likelihood of abusing substances.

Using the PDMP-- now I'm not sure how much the counselors-- the counselors that I work with do not have access to the PDMP, even though they would, I think, very much like to. But as a prescriber or as the advocate for prescriber, that's the state monitoring. And I think they pretty much have it in every state now, where you log on. In Wisconsin, it's actually required no doctor can give a controlled substance to a patient without checking the PDMP to make sure that there aren't other controlled substances.

But looking at shorter time frames and sometimes the frames are subtle. So if you're giving a 30 day prescription and somebody is filling every 25 days, but then there's never a time where it's 35 days-- so if somebody fills 25 and then 35, because they went on vacation, OK, not so much of a red flag. But if you're seeing 25, 25, 27, never 30, this is a warning sign-- other opioids in addition to the ones that are being prescribed and surprises, oh, I forgot to tell you when you look at the PDMP and you find that there's a new prescription for Xanax to go along with the opioid.

So here's another poll. And now we're moving into the next phase. So I pretty much said what I want to say about prior to starting opioids.

Now once you start opioids-- so your patient has gotten a prescription from a prescriber. And they are now into-- they're now taking it. So poll question. Your patient returns for one month follow-up and requests removal of the opioid prescription. Which is the following are risk

factors?

So if five folks can answer the poll to the side-- continued use of greater than seven drinks a week, reporting increased energy or great mood, complaining of depression, an ongoing prescription for a benzodiazepine, pain is not improving, high anxiety, going through a divorce or a recent job loss, or feeling withdrawal when they try to lower the medication. So yeah, if people could answer that-- and OK, continued alcohol use. I'm kind of following along.

So this one's a little more interesting. The first part of a one in two, it was a little across the board. And it doesn't look like too many people were stumped about all of those risk factors other than the low level cannabis use.

So it's a little more varied here. So I'm just going to continue to scroll down. This is good. So actually, OK, it doesn't look like anybody else is answering. So I will.

So what's very interesting-- I just wanted to double up. So there are two answers. This seems the highest percentage of results and reporting the increase in energy. And thank you for listening, because that's what I've certainly been stressing. So that one has a very high result.

And interestingly enough, the other one actually that has an equally high result, feeling withdrawal when they try to lower their pain medication. That is actually not correct, because anybody who has been on an opioid medication for over three weeks is going to have withdrawal symptoms. They are going to feel the effects of coming off of their opioid medication.

So the question is not whether or not they're feeling withdrawal, the question is what are they going to do about it? Because there is going to be discomfort. If somebody has a major surgery, they've been given pain medication for, let's say, a month, they are going to feel it when they stop their pain medication.

Now, not everybody that feels those withdrawal symptoms is going to continue to use. They're just going to say, wow, I'm feeling pretty terrible for a couple of days. I better just sleep this off, and they get through it. And that's actually what happens to most people on longer term, which is greater than three week opioid prescription, like I said, for any condition.

So again, not trying to stump you, just trying to educate. So as far as risk factors, every single one of those. So there were eight possibilities. The first seven are actually all risk factors. So I'm going to speak more about this.

So other than feeling withdrawal, all of these other ones are risk factors. That doesn't mean that everybody that's experiencing any of these are going to become addicted to the opioids, but these are all risk factors after being on an opiate. Things can change.

One of the things to keep in mind, anybody who is meeting an opioid pain medication for a month or more, by definition they're pain is not improving. Pain that it's not improving can absolutely cause an increase in mental health symptoms. That doesn't mean an increase in mood.

I write mood, anxiety, and sleep here. That means more problems with their mood, either more depression, more mood mobility, higher anxiety, decreased sleep, an inability to work or perform their usual activities, loss of social supports-- if you are in pain, you're not engaging in your life in the way that you normally do-- relying on the opioids to cope with any of the above. So if you just put yourself in somebody's shoes, who is either through surgery or just a medical issue, a pain that is not improving, things are not getting any better, they're on this pain medication, their life is changing from what they are what they were before the pain.

It is very easy. Opioids are numbing agents. It is very easy to start just letting yourself numb out, because things are not feeling very good.

So what I'm going to hopefully do on-- the results of the poll really do show that there is-- would that there's definitely room for education. So what I hope will happen is if anybody has any challenges, once I get through my webinar, please, I want to hear from you. If I'm seeing anything that does not make sense or does not correspond to what you know in your experience, either personal or professional, I absolutely want that to be part of a discussion.

So talking about depression, as I've said, before opioids are central nervous system depressants. Excuse me. Everything the pain causes-- incapacitation, isolation, chronic pain-- can all lead to depression. Opioids numb emotional pain, as well as they numb physical pain.

So it is important to screen for lowering of moods. So I do encourage a screening before somebody starts on an opioid and even if they were not showing depression at the time they got the opioid. If somebody is taking an opioid for a month or more, they need to be rescreened for making sure that there is not any mood lowering going on for all of those above reasons.

Now the other thing that you want to keep an eye on is anxiety. I have dealt with many patients in the course of my career, both as a drug counselor and as an addiction psychiatrist, who were high-functioning people, who were typical in lay terms called the type A's. They were pretty driven, like to be in control. That's a lot of us in the medical field, but something happened to them that was out of their control, either they were in a car accident, or had an accident at work, or some type of unexpected surgery that laid them off more than they were planning to do.

I have had many patients that I've worked with that was the first time that they ever had a panic attack. And this is a very rare phenomenon. It makes sense if you think about it, birth of an anxiety disorder. This is not how everybody develops an anxiety disorder, but this is an important subset of individuals that would never have said that they had high anxiety or that they met the criteria for an anxiety disorder prior to the event that they led to their need for pain medication.

So feeling powerless as a result of any of those incidents, plus previously high-functioning does equal risk of panic attacks or general anxiety. This feeling of powerlessness for somebody-- that type A person is extremely upending, and in many people can lead-- certainly can lead to high anxiety. As we have mentioned several times, opioids are wonderful numbing agents. And individuals with anxiety, depression, as well as past or present trauma, there's sometimes an event that caused the need for opioids. It is traumatic.

People want to be known. It's actually very rational. And I think sometimes we do have to think about it a little differently, because it's not irrational if somebody who's feeling terrible, that if they're losing something like a pain medication, that numbs out that terrible feeling. It is unfortunately going to be reinforcing.

Self-medication as a pathway to addiction. Although, the individual is not trying to get high. And those of in the new addiction field, I'm sure you've seen this. I certainly have, where there are people who are abusing opioids, because they love the high.

There are also people that wind up becoming addicted to opioids, not because they're focused on the high, but because it's actually alleviating-- it's not really alleviating-- but it's numbing out some of the mental health symptoms that they're having. And that's actually a substantial population.

Warning signs. I'm going to say a bunch about this. This is important to keep in mind.

Anxiety causes increased perception of pain. Depression causes increased perception of pain. Trauma causes increased perception of pain. And chronic insomnia causes increased perception of pain.

So what's going to happen if you just put all that together, somebody having any of those issues, is going to make them higher risk to want to take more of their pain medication to try to-- I'm going to put this in quotes-- "treat some of these above condition." It doesn't treat any of them. It makes them worse. But in the short-term, it actually does feel like it's numbing them out.

So as I mentioned before, more warning signs-- somebody is filling early consistently or a patients calling for referrals and they're making excuses why they can't come into the office. I am not an advocate of filling pain medication over the phone. I think somebody needs to come in for those prescribers that are on the line, either they have their nurse or somebody just eyeball them just to make sure that things are not looking concerning.

And more warning signs-- resistance to other modalities for pain treatment. So doing biofeedback or seeing a counselor or even a non-opioid medication. If somebody is not open to anything other than taking an opioid for their pain control, major warning sign.

Also using other drugs. Random UAs are never a bad idea. Not all substances come out on random UAs, unfortunately. But again, and this does not mean that they're addicted or abusing their opioids. But again, we're looking we're looking for red flags. We're looking for warning signs.

Couple of things to keep in mind. This will not be a surprise to the addiction counselors in the audience. Maybe a little more so than some of the physicians, but the opioid epidemic would not have taken off as it did without patients selling their opioids. And this is continuing to happen. It's a lucrative way to supplement one's income. Other than being tipped off, there is no reliable way for an MD to know who is selling or fully prevent such selling. Therefore, all we can do as prescribers is not overprescribe and not refill without patient contact, ideally in person.

OK, so-- now, this is going to address, "Doc, I'm trying to cut down my pain pills, but I'm going into withdrawal." And this is the one that the majority of people thought was a warning sign. Anybody-- and I'm not saying that it's not, but anybody who is cutting down on their pain

medication, if they've been on that for three weeks or more, is going to have some opioid withdrawal symptoms.

Now, I'm going to talk a little bit about the difference between withdrawal and anxiety because when somebody is going into withdrawal, how do you know? Is this opioid withdrawal or anxiety? It is an extremely common presentation to have both.

There is a high degree of overlap, and I've got a graphic I'm going to show you that demonstrates this. There is a high degree of overlap between withdrawal and anxiety symptoms. And while anxiety is not responsible for the opioid epidemic, it is a major barrier for individuals to stop using.

So on this schematic-- this is-- you open up a book or you get online-- signs and symptoms of opioid withdrawal. This is basically what you're going to get. Elevated blood pressure and heart rate, sweating, chills, hot flashes, restlessness, dilated pupils, muscle aches, GI symptoms-- cramps, diarrhea, nausea, vomiting, feeling like you're dying, tremor, yawning, goose flesh, runny nose, watery eyes, and bone pain. So that's opioid withdrawal. I think everybody gets that.

Now, we're going to open up our mental health textbook. Here is the symptoms of anxiety. So I'll toggle back and forth, but look at this. And this is not out of an addiction. This is just out of a mental health textbook.

Increased blood pressure and heart rate, heart attack feeling or chest pain, shortness of breath, smothering, choking, the room is closing in, feeling out of body, numbness, depersonalization, swelling, chills, hot flashes, restlessness, GI-- cramps, diarrhea, shaking, tremor, inability to concentrate, dizzy, lightheaded, tingling, fear of dying, going crazy, losing control.

So I think people get what I'm saying. And this surprises a lot of people. Many people who feel like they are going into withdrawal are experiencing a spike in anxiety rather than actual withdrawal.

So how do you figure it out? Take a good history. It is going to be important. Again, although there's going to be exceptions. There are some people who would swear they never had anxiety before the accident that caused them to need pain medication. And that may be accurate, but trying to get a history-- is this somebody with a past history of anxiety?

Asking family, friends, is this somebody anxious? Sometimes the person, the individual will say, no, I'm not anxious, and everybody around them is nodding their head and giggling and pointing, going, oh, you've got to be kidding. They've got a ton of anxiety.

What are the symptoms when somebody is abstinent? Now, are they high strung when they're not using? Symptoms before they started the opioid. And looking for physical evidence. That is probably your best bet. Anxiety does not tend to cause goose flesh or the runny eyes or nose.

So if it is cold in the room or if someone has an upper respiratory infection, obviously all bets are off, but trying to look at the physical evidence will give you a little more of a hint. And even then, sometimes it is hard to distinguish between anxiety and opioid withdrawal. But it is important to, again, just do the education.

So now we're moving into part three of the talk-- Your Patient May be Addicted to Opioids-- Now What? And this is probably where the drug counselors jump in. Encouraging honest, open dialogue.

One of the things that I have seen happen too many times is when a prescriber suspects that their patient is addicted to their opioids-- they keep asking for refills or they're wanting early refills, or just there's abnormalities on the PDMP-- one of the things that oftentimes prescribers will do is say that's it-- I am just cutting you off. I'm not advocating for this.

Your patient may be addicted to opioids. Encouraging honest, open dialogue is critical. So somebody is running out early, you do want to find out how much are they taking. And how much are they taking maybe more than what you are prescribing, because they could be supplementing. So encouraging an honest dialogue. If you're going to cut them off cold, that is not encouraging an honest dialogue.

Please do not cut off their prescription at the first sign of a problem, because they will often turn to the street for other pills or for heroin. And this is not hard to get. The prescribers listening into this, we want to be part of the solution, not part of making the problem worse.

So screening. Your patient may be addicted to opioids. Screening for the big four. What I refer to when I say the "big four" when I give talks-- it's an easy way to remember anxiety, depression, trauma, or insomnia. There are available screens. I list some of them, but there are many more. And I do not write there are good trauma screens as well.

But screening at the beginning of somebody's opioid treatment is not enough. You need to screen at the beginning. You need the screen after a month if the prescription is going to need to continue. And you need to screen again if you're suspecting that there may be an addiction here. But you're trying to see if any of those four are going on.

Referring to pain treatment-- and when I say "pain treatment," I mean in addition to opioid prescriptions. I am a big advocate of these therapies that, you know, we call alternative therapies, but a lot of the-- at least our local HMOs in Madison, Wisconsin will pay for neuromuscular therapy. Some of them pay for acupuncture, massage. This is not a complete list. Biofeedback, neurofeedback. There are many excellent alternative therapies. People need to be doing something else besides just taking an opioid.

Referring to counseling is also critical. And doing those screens may help you figure out if, you know, should you make a referral to mental health counseling or addiction counseling? The bottom line is it's very hard to find an addiction counselor, even if they're not certified for it, who is not asked to do anxiety treatments. And the addiction counselors are treating mental health. Many of the mental health counselors are treating addictions. So that the divisions aren't as great as they were.

For the physician, good boundaries, and at that point, you have to have a pain contract, if not already in force. That pain contract should say no early refills under any circumstances and slowly lowering the dose of the pain medication. So you're not kicking the patient to the curb at this juncture. There obviously does come a point where you can't continue to prescribe, but I would say at the first hint of a problem-- I've seen this happen too much-- please do not do that.

Opioids and depression. This is a hand in hand. Depressed opioid users often cannot maintain sobriety if their depression is not treated. So for the primary care docs in the audience, if you are suspecting a depression, even in an individual who is abusing their opioid, it is OK. The SSRIs-- it's going to make them have to work a little harder-- I'm talking about the antidepressant-- but it is not dangerous, and it may be the difference between being able to come down on their opioid medication and not.

Because if somebody is dealing with a depression and they stop their opioid medication, remember the opioid is numbing out their mood-- they are going to feel worse. And if they do not have the coping tools, they're going to relapse because they don't have another way to

cope with it, even though they're trying not to use-- they're just looking for relief for their depression. So this combination is important to keep in mind.

The other thing that's important to keep in mind-- opioid abusing and depressed individuals will often have their use brought to attention before their depression. So everybody is giving all this attention to their use when the driver of their use is the depression. So please do screen and don't neglect the mental health.

Anti-anxiety. I do want to say something about benzodiazepines, not because I think these are a good idea, but because they are so commonly used in private practice, among primary care and psychiatrists, including among people who are on opioids. They give immediate relief. They are addictive. They bind in the same area of the brain as alcohol, which is important-- very important to keep in mind for individuals that have had alcohol issues, either present or past.

Numerous studies have contraindicated benzodiazepines in people with PTSD because they can be disinhibiting and make some of the PTSD symptoms worse. There is a higher risk of respiratory depression. These can be life-threatening if you mix them with opioid medication.

There is a debate among addiction professionals even on whether or not there is a safe way to use benzodiazepines. You may hear more than one opinion. My opinion is it is not recommended. I do not recommend using benzodiazepines with individuals on opioids, either short term or chronic.

People have asked, so I have made a list of non-addicting anxiety medications. You can use these either as needed or scheduled. There's advantages and disadvantages to both. Now, some of you may wonder-- the first medication on the list is gabapentin. And gabapentin has actually gotten some press as this is a medication that people are abusing and become addicted to as well.

What I will say about that-- we as prescribers cannot be naive to the potential for patients to abuse so-called non-addictive medications. Anything that lowers anxiety, people are going to overuse. Some of these medications are banned in certain corrections facilities-- clotiapine, at least in Wisconsin, in many counties, they won't even use that because people were starting to sell them and overuse those. So again, with caution, I feel confident in recommending any of the medications on this list. If anybody is abusing any of these medications, then they need to go to the next one.

But like I said, there are plenty, and there are other medications that aren't even on this list. These are just some of the more common ones. But anxiety is very treatable with medications that are not benzodiazepines.

I also make a list of some of the medications for insomnia. Any of the Z medications-- you know, the Ambien, Lunesta, Sonata-- the Zs are their generic, but those are the brand-- those are all highly addictive medications. I have been surprised at the number of physicians who are not aware that things like Ambien and their cousins Lunesta and Sonata-- there are many primary care docs who do not know that these are addictive medications. These are addictive medications. This is my list of non-addicting medications for insomnia. And again, anybody can overuse any medication that's going to lower anxiety.

I'm going to show a little bit about medication-assisted treatment for opioid dependence. We have several options-- buprenorphine, which people commonly-- it's buprenorphine/naloxone, actually, but the active ingredient, buprenorphine, which is an opioid, people commonly know that as Suboxone.

Naltrexone, which is either in a pill form or the injection. The injection is Vivitrol. And methadone. Now this is not going to be an inclusive discussion. This is just going to be an overview to, you know, each of these have positives and negatives.

So starting with buprenorphine. Why use buprenorphine? It is effective. It's proven treatment in reducing opioid use. It does keep clients in treatment, so that's kind of the carrot as opposed to the stick. It is a blocking agent for other opioids.

Is less likely to be abused, but not impossible. I'm going to say more about that because this is part of the controversy around buprenorphine. The law enforcement and corrections-- some of those individuals are very against the idea of buprenorphine because they are seeing it abused. And I will say more about that.

So what are the disadvantages of buprenorphine? Over-reliance on medication versus recovery tools. This is true for anything across the board. Medication alone is not enough to treat whatever it is. Whether it is pain, whether it is addiction, whether it is depression or anxiety, you need to do more than just take a medication.

Opioid replacement may be started at a higher relative dose than the amount used and

patients may appear stoned. And this is accurate. I have seen people that are using 40 milligrams of oxycodone a day get put on 16 milligrams of Suboxone. 40 milligrams of oxycodone a day is about the equivalent of 4 to 6 milligrams of Suboxone. So you can overuse this. This is an opiate. People get tolerant pretty quick, but you can get high off of buprenorphine. I mentioned it is possible to abuse this.

And there is also a belief among some prescribers that this is lifelong treatment. Now, there is controversy. The addiction counselors tend not to like this idea. The primary care docs who become certified in buprenorphine, now, many of them do believe they know how to get people on buprenorphine, but they don't know how to get people off of buprenorphine.

So they'll just tell patients, well, this is just something-- don't worry about it. You're doing OK. You're working. Why not let this be a lifetime medication? That's probably for another webinar. I do not agree with that. It needs to be a long-term treatment, but not lifelong.

Real brief again, buprenorphine dosage range. People can take as low as 0.25, which is cutting a 2 milligram into an eighth, up to over 24 milligrams a day. Research shows that the receptors are saturated at 16, so yeah, people can form their conclusions. The manufacturer does not recommend over 24 milligrams a day for any reason.

And there's different ways to do it. Quick detox. Some people will go into rehab and then get more involved treatment. Quick detox as an outpatient very rarely works. I do not recommend that. There's the slow taper, which is over three years versus when I say maintenance-- lifelong.

A slow taper, which takes five to six years, which is actually the average in my practice-- some people do look at that as maintenance. The difference between maintenance and a slow taper is the people on a slow taper are very slowly coming down on their Suboxone. People on maintenance can be on the same dose for 10, 15 years. So that's the biggest difference.

Half life of buprenorphine/naloxone. So the half life of most of these products-- Suboxone, some of the others-- there's other ones out there-- there's one called Zubsolv-- there are several of them-- the half life, 22 to 40 hours. In the average person, it's 35 hours.

Only once daily dosing is needed. I have seen people take their Suboxone twice a day. I've seen three times a day. I had one patient that was taking it four times a day. That is not necessary. When people do that, they are doing that-- they're basically replacing how they

used to use their opiate of abuse with the Suboxone. It's not necessary.

For some people that are also using it for pain control, they may take it twice a day because the pain control is not 24 hours. Over 24 hours, just the withdrawal-- the keeping people out of withdrawal is over 24 hours. So again, keeping that in mind when you look at how people are prescribed their Suboxone. It is safer in overdose. It is best if used as part of a treatment plan, not just by itself.

Yes, you can get high if not opioid dependent. There is diversion of buprenorphine. The law enforcement folks know this very well. That's why some of them are not in favor of using buprenorphine as medication-assisted treatment.

For people who are not dependent on opioids, it will get you as high as any other opioid. So it is a party drug for those without an opioid habit, for people that just use on the weekends. It can be used to prevent opioid withdrawal in those using. So somebody who has no intention of stopping-- they're using heroin, they can't get it that day, they may take a little bit of Suboxone on the day they can't get it to keep them from going into withdrawal.

Or as a self-detox. There are a lot of people, before they come to see me, they've tried to detox themselves using Suboxone or any buprenorphine product. Unless you know what you're doing, it usually does not work, mainly because people don't know how to step themselves down. They step themselves down too quickly, and they wind up going into a withdrawal that they can't tolerate, and they wind up relapsing.

So injectable naltrexone. I'm going to say a few things about that. Blocks the effects of opioids for a month. Honestly, it's probably a little less than a month, but most insurances are covering it every 28 days.

More and more residential treatment is offering this option at discharge as well as corrections facilities-- that you can get a shot that actually, from a safety concern-- they've done studies on this-- there are less overdoses among people who do get that shot coming out of either residential treatment-- if they're not using another medication-assisted treatment product-- coming out of residential or coming out of corrections.

It is an alternative to replacement therapy. You cannot mix Vivitrol with methadone or Suboxone. The Vivitrol to put you into withdrawal. It is a very good option for motivated individuals.

More on the benefits. It's not an opioid. It cannot be abused. It's got no street value. And it does save lives. I mentioned that it will prevent overdose in that first month.

What are the disadvantages? It's expensive. More insurances are covering it. The state insurance in Wisconsin does cover this, which I think is a wonderful thing. Some of the private insurances-- there's been struggles getting covered from some of the private insurances. I hope as education increases, that will become less and less. Because it's expensive. This is not something that the average patient is able to afford on their own.

It's not an opioid, and it does not numb people out. And again, this is talking about those other conditions that people are using opioids for. There's a lot of consumers who are not interested in naltrexone because it's not going to give them that opioid, numbing out feeling.

For some people, it may be done under duress, that they're not really wanting this, but this is a condition of their probation or early release. Those folks-- whenever you're forcing somebody to do something, they're going to try to find a way around it. Patients may try to overcome the block as the injection wears off and overdose.

So the injection starts to wear off in about three weeks. So between that third and fourth week, before you're due to get your next shot, I have seen people try to use, and I've seen overdoses because your tolerance is lower when you haven't been using for a while. So if you use what you used to use or you're trying to use more to overcome the naltrexone block, you can kill yourself.

The other disadvantage is pain medication will not be as effective. If somebody has an accident or emergency surgery and the treaters are not aware that somebody is on naltrexone, they're not going to understand why-- again, somebody could wake up in the middle of the general anesthetic for setting their leg after being in a car accident.

I had an individual who was a firefighter who was interested in naltrexone, and there was a lot of debate among the team. He works in a high-risk profession. His risk of injury is high. And being on naltrexone, it is possible-- it's not easy-- it is possible to overcome the naltrexone block in the hospital, but it's not an easy proposition. So this is one of the disadvantages. Folks should probably wear some kind of medical ID bracelet.

So in summary, almost always underlying substance use-- the big four. Anxiety, trauma, depression, insomnia. These need to be treated in order to provide the best treatment

possible. So to summarize, the next few slides are just clinical pearls of experience. Addiction is a disorder of brain wiring. Shame is part of addiction.

We cannot make anybody ready for treatment. The best we can offer is compassion along with good boundaries. That's very true for folks in primary care. Each patient has to walk his or her path. And their success or failure is not our responsibility.

Now, some people may say, OK, that sounds a little harsh. There is a high rate of burnout in the addiction field. And I know the majority of the folks on this webinar are actually in the addiction treatment field, according to your survey. I get asked a lot-- having been in the field for almost 30 years now, I get asked a lot, how have I not burned out after all this time?

The reason I have not burned out-- and I didn't do this on purpose, but early on in my career, I realized that the best I am is a guide. I cannot make anybody get abstinent, stay abstinent. All I can do is guide. I can offer my best recommendations. I can offer my best treatment. But in the end, I don't have any control over what somebody does.

I have had patients who have overdosed. I feel horrible about that. I've had patients who have died. And all I can do is my best. And we all have to deal with that in this field.

Final thoughts. Nearly all individuals who become addicted are trying to numb something and need our help to learn to feel again. And this is a process. And it's not quick. There's a lot of habits that need to be undone. Medication alone will not solve the issue of substance abuse and addiction, but may be one piece of the puzzle. And I say this-- I say this to my patients.

Final thoughts. Healing is a slow process, and relapse is the rule rather than the exception. The medical profession has a lot to learn about the above, and the majority of MDs are not trained in treating addiction. And this is important to keep in mind, I think, for those of you who are physicians and also those who are not.

So that concludes the slide presentation. I'm looking at some of the comments. This will be available. And I believe now we are going to move into the question and answer, so I will turn it over to my colleagues.

PRESENTER: Thanks so much, Dr. Felgus. We do have several questions for you. And the first one goes back to the beginning of your presentation. Can addiction to alcohol in a family make a person also addicted to opioids?

MATTHEW FELGUS: Wait, say that again. That was a question? Can addiction--

PRESENTER: Yes. Yes.

MATTHEW FELGUS: Can addiction--

PRESENTER: Can addiction to alcohol in a family also make that family increase risk of addiction to opioids?

MATTHEW FELGUS: Well that is one-- so the answer to that is yes. Because if somebody-- and we don't-- at some point, I think we're going to have the genetics more figured out than we do now. What is the connection?

Now, we do see clinically that folks that have had an issue with alcohol are more vulnerable to developing an addiction with opioids. But I also have many patients who have an alcohol problem who say I can't understand how those people abuse opioids. And I have people who are on opioids who say I can't understand why anybody would ever get addicted to alcohol.

So the answer is yes, those folks are higher risk, but it is not a definite. So there's the brain wiring component, whether there probably is a little bit of-- there's a relationship, but the other factor to that is people with a family history of alcohol dependence probably also have a higher incidence in their family of things like depression, anxiety, trauma. And again, we see that and the research does show that. And those are also risk factors for opioid dependence.

So there's not a clear of genetic risk, but at the beginning, somebody who has that family history, if they're are needing to use an opioid, they probably need to be more cautious than somebody who does not have that family history. It's a higher risk then.

PRESENTER: Thanks, Dr. Felgus. Next question. What do you recommend for non-opioid pain medication?

MATTHEW FELGUS: That is a little bit out-- I am not a pain specialist. I'm an addiction and mental health specialist. So there are other medications. This is probably more the province of the pain specialists. One of the things that I'm aware of, they do use medications like gabapentin and Lyrica for pain.

Some of the antidepressants, honestly I wish they worked better than they did. Duloxetine-- the brand name for that is Cymbalta-- has been marketed as helping pain in addition to depression. I've seen it help for some people, but honestly my experience is, more people, not

helpful for pain than helpful.

So I would have to defer that question to somebody who does specialize in pain treatment. But I would want to stress that the best treatment for chronic pain are the non-medication modalities. Medication is just probably a smaller piece of the puzzle for chronic pain.

PRESENTER: All right, great. Next question. What is the best way to find a psychiatrist or substance use disorder doctor when a person is on Medicare?

MATTHEW FELGUS: You know, that's very much a challenge very much in my area of Madison, Wisconsin. I don't believe that Medicare puts out a list. Unfortunately, your best bet would be to be calling different treatment programs.

Now, as a rule of thumb, the larger the system, the more likely they are to be Medicare providers. The majority, at least of the addiction-- there's not a lot of addiction specialists in private practice, at least in the Madison area-- I don't know any of them who are Medicare providers, unfortunately. The Medicare providers are the bigger systems. So you are probably looking for a bigger system.

But unfortunately, I don't think there is a database on that. I think you need to call the treatment specialists one at a time and ask. So I'm sorry there's not a better answer for that.

PRESENTER: Thank you. Dr. Felgus, have you had any experience with red-headed people requiring more medication or having a lower pain threshold for pain?

MATTHEW FELGUS: That is interesting. Clinically, I have not seen that to be the case. I would have to defer that a little and say that there are risk factors. And again, that was, I think, a different webinar. There are higher risk factors for people being more sensitive to pain.

And again, as a mental health specialist, I know that underlying depression, anxiety, trauma, insomnia problems do make individuals at risk for having a lower pain threshold. I'm not familiar, honestly, with if individuals with red hair are also genetically more vulnerable to having lower pain thresholds. But again, I think anybody who does have a lower pain threshold does have to be careful because those folks may wind up needing higher doses of medication. But I have to say no, I'm not I'm not familiar with that, but I certainly can't say that that's not the case. That's an interesting question.

PRESENTER: Thanks, Dr. Felgus. Next question. AAP released a position paper in 2016 on MAT for opioid

use disorder for adolescents, indicating that MAT for this group is underutilized. Have you observed increased uptake or acceptance among practitioners since release of this paper? A future presentation similar to this one specific to adolescents would be very helpful.

MATTHEW FELGUS: I would agree with that. The answer to the question is yes. I have seen more acceptance among treating adolescents. Now, when I first started-- I've been prescribing buprenorphine since 2003. Probably for the first 10 years that I was prescribing, there was debate-- there were programs that would not accept anybody under age 18. And for a very long time, and I don't know if this is still the case, the methadone clinics would not accept anybody under 18 for the methadone program, with very rare exceptions.

Now that, I think, has relaxed. And I've also seen it relax among the buprenorphine prescribers. And I think necessity has dictated that. Teenagers are overdosing and dying as well. If we do not address this group, we're going to be seriously losing a generation of young people. So to answer that question, yes, there has been more acceptance.

Some of the concerns with treating adolescents have been some of the things that I mentioned in that, you know, the idea of putting a teenager on opioid replacement for life is a daunting prospect-- they have a very long life ahead of them-- and things like that. But what I would say to that, there is more than one model. I would never-- I don't tell any patient in my practice when they start on opioid replacement that this is something they'll need to be on for the rest of their life. So I think-- there's a little bit of conflict in the field, but the short answer to that question is yes, and if we are not treating opioid-dependent adolescents with the best treatments that we have, we're not doing good treatment. We're going to be losing people.

PRESENTER: Thanks, Dr. Felgus. I'll see if we have some more questions coming in. We've got a lot of thank you, lot of great comments about your presentation.

MATTHEW FELGUS: I appreciate that, and I also appreciate if I said anything that anybody disagrees with, I think it's important to have healthy debates in this field, so I would encourage, if anybody's still listening, if there's something that they really disagreed with that I said, I would also appreciate hearing from anybody with those opinions as well.

PRESENTER: We did have a comment from one participant who mentions, I actually had clients abuse gabapentin. They'll take more than prescribed and then get high on this medication.

MATTHEW Yes. And I would concur. I would concur with that. I do prescribe gabapentin. I have had

FELGUS: patients in my practice that I would tell them they could take up to three, which is a 900 milligram dose, which is a low dose of gabapentin. And they come back in and they tell me, well, I'm taking 4,000 milligrams a day. And at that point, we will have the discussion, and now it is time to look for other anxiety medications. This is risky. So yes, this is a medication that can be-- that people have abused.

I would say any of the medications that lower anxiety-- I mentioned this in my talk-- I have had people abuse just about every medication on the list of the medications I gave for anxiety except buspirone. And I wish buspirone-- that's another one I wish it worked better than it did.

So I do not want to discount that, and I'm very aware that there are prescribers and counselors that are very against the idea of anybody being on gabapentin. And what I would say is that it is a useful tool in the toolbox. The majority of people that are taking it are not abusing it. And again, when I'm working with somebody, I make the clinical determination if the benefit outweighs the risk. I do educate people.

So I do not want to discount it. I would never argue otherwise. But I do think that it is-- I think gabapentin is an important tool in addiction treatment. We absolutely do have to be careful. The same could be said of Seroquel, of clonidine, of hydroxyzine. Even of Benadryl-- diphenhydramine. I've seen people abusing all of those things. So we just-- we need to stay awake and get people off of medications that they're overusing.

PRESENTER: Thanks for that answer. I see there are a lot of attendees that are typing, so we may have some more questions coming in. A lot of you have asked about the presentation slides and the recorded webinar. They will both be available on the Great Lakes ATTC website within the next few days for download at any time.

We have a comment here from one of the participants. I appreciate your comments on the goals for future tapering off rather than into perpetuity, which some addiction specialists advocate.

MATTHEW FELGUS: Thank you for that. There is controversy among the addiction specialists. I'm involved with ASAM, the American Society of Addiction Medicine, and I was at the annual conference in the spring, and the consensus there among the addiction specialists is that-- don't even talk about trying to get people off of this. This is a medication for life. And I was not the only one in disagreement. There was a subgroup of addiction specialists who are not at all comfortable with that mindset.

But the reality is, it is not an easy proposition to get somebody off of buprenorphine. Because what happens is as you get somebody off of buprenorphine, their mental health symptoms can become more prevalent. If the prescriber does not know how to treat the mental health symptoms, they're just going to see somebody who's struggling a lot more and not able to get off of the opiate replacement, so they're just going to go back up.

I'm giving several presentations on the idea of getting people off of opioids, one at the statewide conference in Wisconsin Dells in October, and I'm doing another one at the Wisconsin Society of Addiction Medicine-- that one's at the end of September. So hopefully I'm not getting in trouble putting a plug out for other conferences, but I do talk about this topic often because I think it is so important and there's not agreement in the field around this at all.

PRESENTER: Yeah, there's definitely a lot of discussion in the news on that very topic. Well, it looks like we've covered all the questions that have come in. And I don't see any additional questions. Any closing comments that you'd like to share with the audience, Dr. Felgus?

MATTHEW FELGUS: I thank all of you for coming in, for being interested, for sharing your comments. And like I said, I think it is so important to keep the dialogue going with this. I feel like I've said everything I need to say, and I just thank you at ATTC for the opportunity to do this, and for everybody for participating.

PRESENTER: Thanks so much. I'm sure you'll be hearing from the Great Lakes ATTC and perhaps from some of our participants in the future.

MATTHEW FELGUS: Excellent.

PRESENTER: I'm going to leave the chat box open for a few more minutes for folks that might want to converse, but then we'll wrap up at 1:30 exactly. Thanks, everyone.

MATTHEW FELGUS: Thank you all.