MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Cases: Polysubstance Use Management

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Disclosures

Medical Consultant:

MAP Health Management Peer Recovery Specialists

PATH CCM

MCSTAP Massachusetts Consultation Service for the Treatment of Addiction and Pain

Case 1

- 30 yom with primary severe opioid use disorder, cocaine use/use disorder, benzo use
- MDD, GAD, PTSD, ADD
- Frequent incarceration, homeless, ER visits, involuntary commitments
- Multiple overdoses, abscesses, endocarditis
- Stabilizes on buprenorphine/naloxone for a few weeks, then frequent lapses with IV heroin, cocaine, benzodiazepines
- Taking buprenorphine as Rx (16 mg) but frequently runs short before fu, takes benzos mostly to try to treat opioid withdrawal
- Injecting in neck, re-using needles, sharing works
- Adamantly opposed to MMTP or other treatment
- Family will not take him home unless sober

You (choose all that apply):

A) Involuntarily commit him, DC buprenorphine because too risky with ongoing benzo , cocaine use, and repeat ODs

B) Assess buprenorphine dose and advance as necessary, assess living situation and other co-morbidities, explore reasons he's opposed to MMTP, educate about risk reduction (injection and OD), recommend closer follow up

C) Continue to see him but DC buprenorphine

D) Discharge him from care

Communication and Trust

Celebrating Progress

Celebrating Progress

"I walk out of here and I feel good about myself… Instead of getting chastised for relapsing, and feeling bad about it, we actually talked about it…. I take something away from it positive instead of just feeling bad about it. Like how I screwed up again…then I just feel bad and then how do I deal with feeling bad? I end up using drugs."

RELAPSE  FAILURE

Wakeman, Kehoe, Simon et al. J Subst Abuse Treat. 2019 Dec; vol 107:1-7.

What About Polysubstance Use?

- Participants Who used Cocaine Had:
- Reduced self-reported opioid use from 94% to 27%
- 6-month treatment retention of 59%
- No significant difference in retention or opioid use compared to those who didn't use cocaine

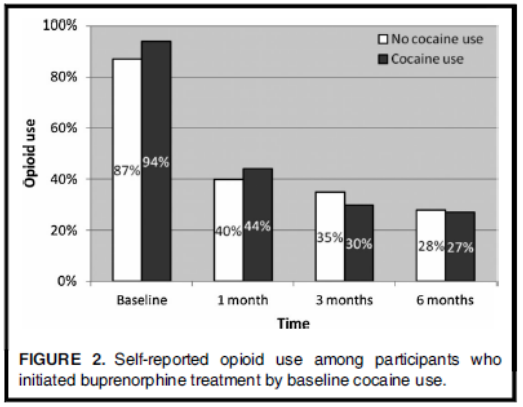


FIGURE 2. Self-reported opioid use among participants who initiated buprenorphine treatment by baseline cocaine use.

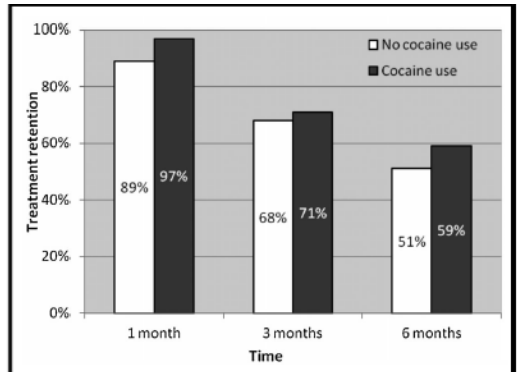
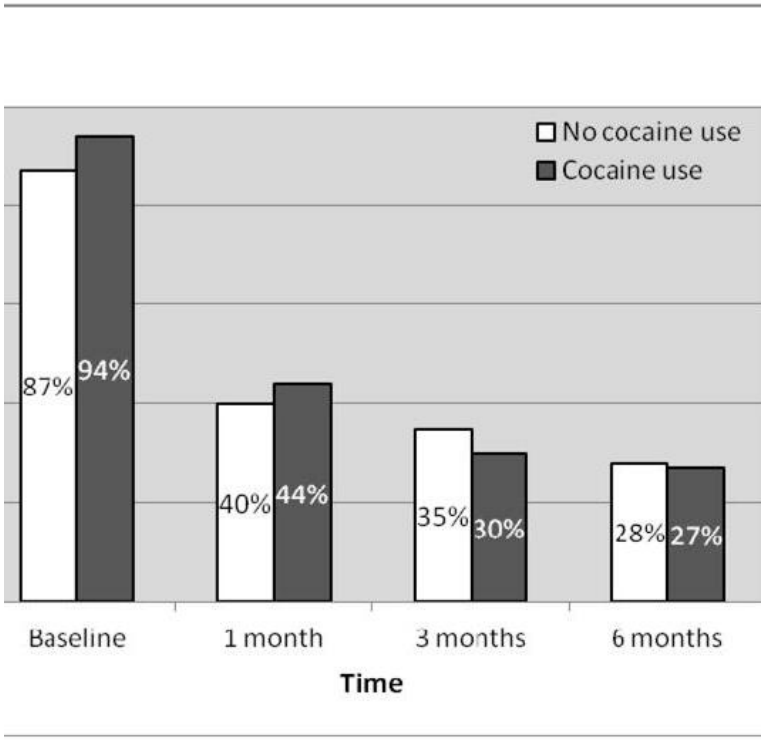


FIGURE 1. Buprenorphine treatment retention by baseline cocaine use.

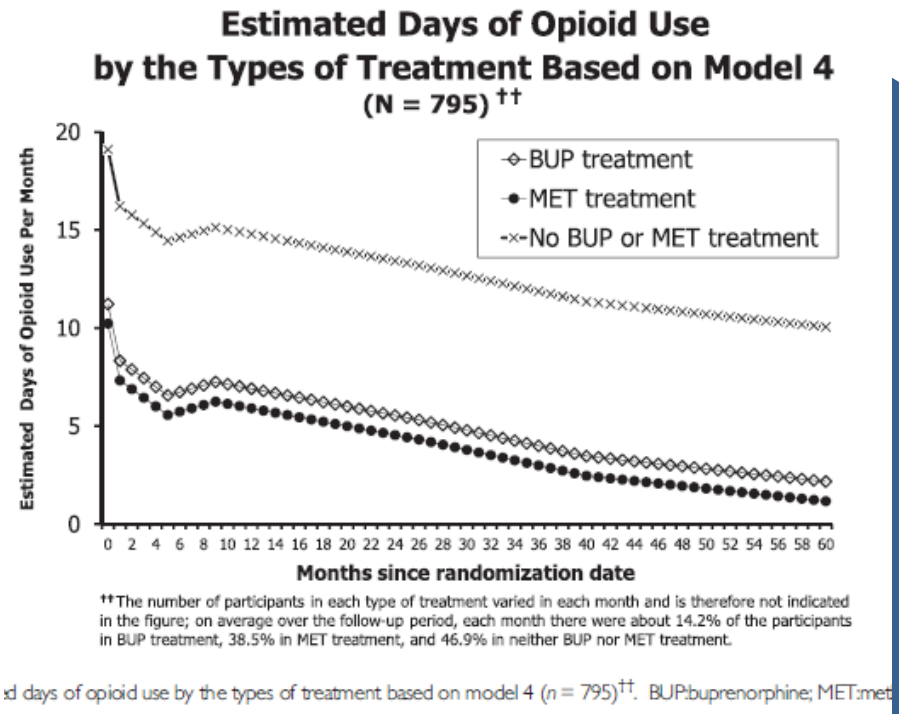
Cunningham et al. Am J Addict. 2013 Jul-Aug;22(4):352-

Opioid use by baseline cocaine use , treated with buprenorphine

- Buprenorphine Rx for pts using cocaine vs. no cocaine
- Followed for 1,3,6 months
- Same treatment retention rate
- Same reduction/improvement in opioid use
- Overall cocaine use improved



Cunningham, C. O., et al. (2013), Buprenorphine Treatment Outcomes among Opioid-Dependent Cocaine Users and Non-Users. Am J Addict, 22: 352–357



d days of opioid use by the types of treatment based on model 4 (n = 795)††. BUP:buprenorphine; MET:met

Early Use During Treatment Expected and Remission Can Take Time

Hser et al. Addiction. 2016 Apr;111(4):695-705.

Abstinence is Not the Only Marker of Recovery

[The FDA] intended “to correct a misconception that patients must achieve total abstinence in order for MAT to be considered effective.”

-Alex Azar

Health and Human Services Secretary,

Feb 25, 2018

Why Teach about Safe Injection Practices?

- OUD is a relapsing illness
- People often use together
- Lowers risk of infection to person and public – blood borne illnesses
- Cost effective
- Reduces overdose death
- Congruent with other education and tools we share to reduce harm

Case 2

- 32 yom severe OUD in sustained remission on buprenorphine, stimulant use (crystal methamphetamine)
- ADHD, GAD, PTSD, multiple ODs
- Was Rx buprenorphine at a clinic that required counseling during work hours he could not keep
- Now maintaining on lower dose non-Rx buprenorphine the past 2 months, but cravings persist on 8mg daily and fears relapse. Has felt better on 16 mg daily but cannot afford it
- He'd like to engage in care that will allow him to work
- Using crystal meth recently as it abounds where he lives and trying desperately to avoid fentanyl, so figures meth is safer. Can take it or leave it

You (choose all that apply)

A) Tell him you are not comfortable managing him given history of diversion/illicit buprenorphine, lack of engagement in therapy and crystal meth use

B) Explore what level of care he thinks he can do, start him on his own Rx buprenorphine at 16 mg, see him back for follow up and encourage he take his medication as prescribed

C) Tell him you and he should keep an eye on the crystal meth use as it may be a primary disorder, but time will tell and should not withhold buprenorphine, discuss safety

D) B and D

What About Diversion?

- Happens
  - Poor access to care
  - Sub-therapeutic dosing
  - Helping others
  - Can be a way to help get people into care
  - Not to get high
- Best way to decrease diversion is to increase access to care
- Short Rx and closer interval fu
- Open communication

Fox et al. J Subst Abuse Treat. 2015 Jan;48(1):112-6
Johnson Int J Drug Pol 2014
Launonen Int J Drug Pol 2015
Monico JSAT 2015

Case 3

- 60 yof with severe AUD in remission for years, chronic pancreatitis Rx oral opioids
- Increasing tolerance to opioids, but no other concerns for OUD
- Has been drinking EtOH in response to pain when out of meds, and now suffers acute pancreatitis and need for EtOH supervised withdrawal and acute exacerbation of abdominal pain
- Admission tox screen: + EtOH, buprenorphine, + fentanyl
- She tells you she is only drinking because of the pain, particularly when out of pain meds
- She tells you her neighbor gave her oxycodone when she ran out of her Rx and could not reach MD, and is shocked to hear about fentanyl

You (choose all that apply):

A) Confront her about her tox screen, tell her you will never Rx a controlled substance to her again, and she has violated your contract

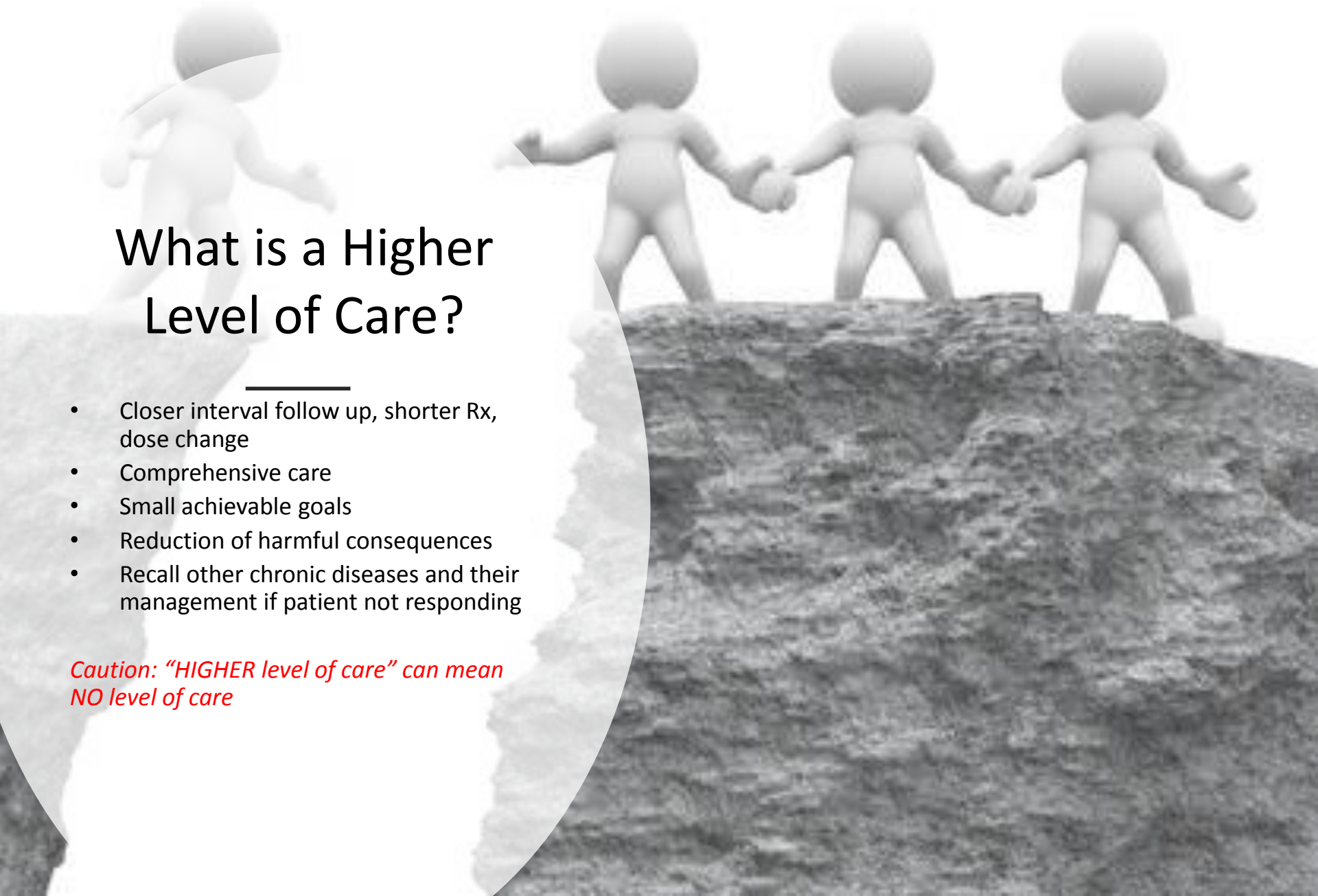
B) Express your concerns that she may have received pressed fentanyl/counterfeit oxycodone, review safety and overdose prevention

C) Offer to prescribe buprenorphine for pain with close interval follow up, as well as AUD treatment

D) Refer her to an inpatient residential treatment facility and start oral Naltrexone

E) B and C

What is a Higher Level of Care?



- Closer interval follow up, shorter Rx, dose change
- Comprehensive care
- Small achievable goals
- Reduction of harmful consequences
- Recall other chronic diseases and their management if patient not responding

Caution: "HIGHER level of care" can mean NO level of care

Case 4

- 40 yom with severe OUD on 80 mg methadone at your OTP, frequently tests positive for fentanyl, and intermittently positive for cocaine and benzodiazepines
- Never seen impaired
- He tells you he has ongoing opioid cravings

You (choose all that apply):

A) Decrease his methadone dose given toxicology results

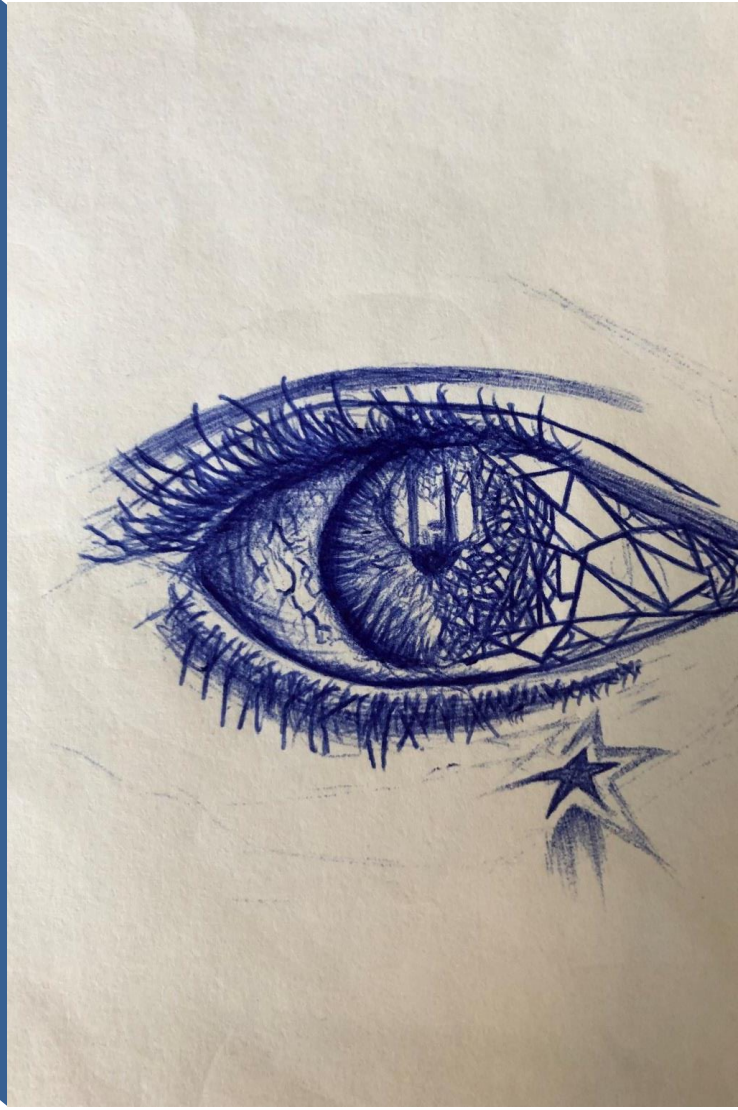
B) Increase his methadone dose, follow toxicology, offer increased support

C) Mandate transition to buprenorphine

D) If ongoing cocaine and benzodiazepine use, assess further for need for treatment

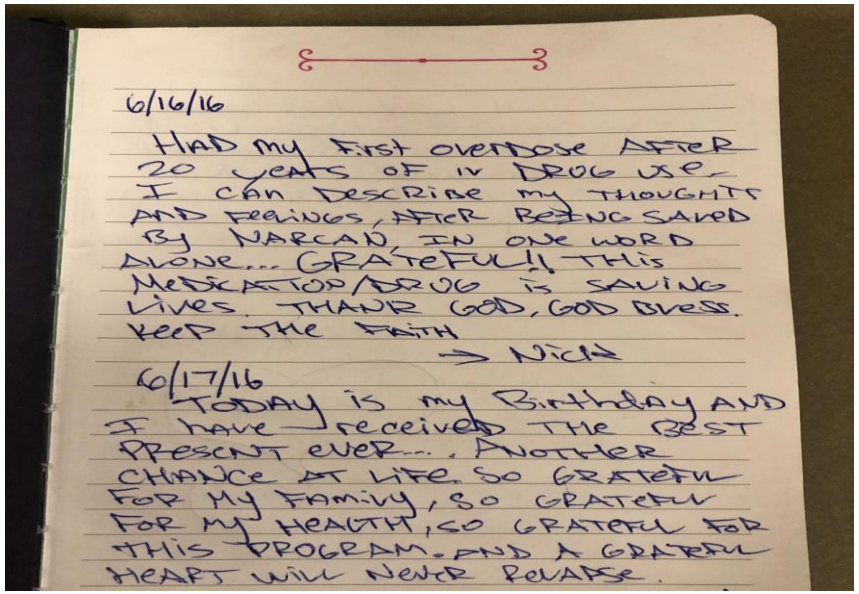
Reducing Negative Consequences

- Congruent with other chronic disease management
- Critical to management of other chronic disease management
- Safer substance use
- Safer injection or use practices
- Intranasal Naloxone for overdose prevention
- PrEP, PEP
- Immediate access to pharmacotherapy



Artwork from Bridge Clinic patient, printed with permission 2018

Naloxone



6/16/16

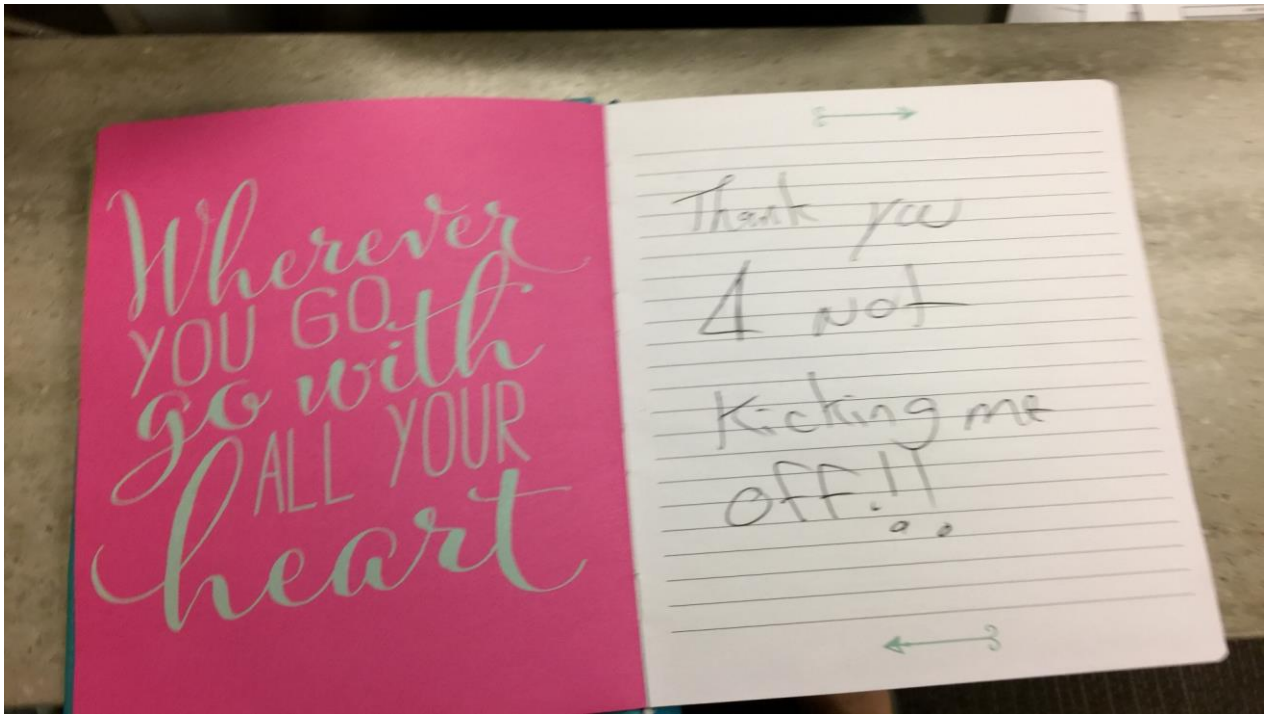
HAD MY FIRST OVERDOSE AFTER 20 YEARS OF IV DRUG USE- I CAN DESCRIBE MY THOUGHTS AND FEELINGS, AFTER BEING SAVED BY NARCAN, IN ONE WORD ALONE... GRATEFUL!! THIS MEDICATION/DRUG IS SAVING LIVES. THANK GOD, GOD BLESS. KEEP THE FAITH

→ Nick

6/17/16

TODAY IS MY BIRTHDAY AND I HAVE RECEIVED THE BEST PRESENT EVER... ANOTHER CHANCE AT LIFE. SO GRATEFUL FOR MY FAMILY, SO GRATEFUL FOR MY HEALTH, SO GRATEFUL FOR THIS PROGRAM. AND A GRATEFUL HEART WILL NEVER RELAPSE.

Letter from MGH Bridge Patient, printed with permission, 2016



Letter from MGH Bridge Patient, printed with permission, 2017

Your Case?

Feel free to post a clinical challenge or question in the chat about a patient using multiple substances

Thank you!

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