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The Opioid Epidemic and Emergency Visits

An interview with Brian S. Fuehrlein, MD PhD

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If a patient has overdosed on opioids ...can you describe your approach to the emergency including the exam, medications, observation and discharge-transfer?

As the director of a psychiatric emergency room at VA Connecticut and Yale, I assume the care patients after medical stabilization. Medical stabilization often includes Narcan administration and other possible treatments. While I am not generally directly involved in the Narcan administration, I will frequently see patients soon after (days to weeks) a Narcan reversal. I have a very clear approach to these patients. My approach to a patient post Narcan reversal is aggressive and assertive. In my mind, I may be the last physician that this patient sees alive. I am very aggressive when discussing the severity of the illness and the critical need for treatment. When developing a treatment plan I am very assertive. I will spend as much time as I can with the patient attempting to motivate them for treatment. When a patient has already required a Narcan reversal (and hence nearly died), they are high risk for this to occur again. This is as critical of a patient that I care for.

We generally refer to opioid overdoses as accidental, but do you have an idea of what % of the patients are depressed, wanted to die, or had passive suicidal ideation? Do you formally evaluate them for concurrent psychiatric illness at some time after you save their lives?

All patients who present to the psychiatric emergency room receive a thorough psychiatric and substance use assessment. The prevalence of co-occurring psychiatric illness with opioid use disorder is very high. By the time the opioid use disorder has progressed to the point of intravenous use leading to Narcan reversal, there are typically many psychosocial consequences and stressors. In addition, these patients are often young (<30). These severe consequences, which often occur quickly, may lead to feelings of hopelessness, helplessness and passive SI. While I do not know firm percentages, in my experience the majority of those with severe opioid use disorder suffer from comorbid anxiety and/or depression. A lower percentage, but still significant amount, experience passive SI and will report things like “I was not trying to kill myself, but if I were to never wake up the world would be better off without me”. I would say that a small but significant percentage is actively suicidal at the time of the overdose with intent to die.

Patients will often have a history of multiple overdoses. What is your approach and ideal post rescue plan? Do you transfer them to a locked unit or give them a follow up appointment? What happens to a person who is given Narcan and rescued by an EMT?

I tend to be as aggressive and assertive as possible while discussing the severity of the illness and the dire need for intensive treatment, especially in a patient who has had multiple overdoses. I attempt to motivate every patient who has experienced an overdose to be initiated on medication assisted treatment (MAT). If agreeable I will start buprenorphine in the VA/Yale psychiatric emergency room. Initiating buprenorphine in an emergency room setting is difficult in practice. Given the resources available at the VA we are able to do it. This practice is based upon a recent study at Yale that showed that initiating buprenorphine in emergency setting results in patients more likely to be connected to treatment. I also educate every patient about the need for a psychosocial support structure. I am a proponent of AA/NA programs and I discuss with all patients the importance of meetings/sponsorship. The goal for all patients who present post overdose is to initiate them on buprenorphine, transfer them to our substance use treatment program (either inpatient or IOP level of care) and then to attend 90 meetings in 90 days. Unfortunately, many patients request discharge without willingness to engage directly in treatment. While state laws differ, in CT it is often hard to commit patients involuntarily specifically for substance use. If the patient is actively or passively suicidal or manic/psychotic, etc., we can often commit them on a psychiatric commitment. But if the risk stems primarily from ongoing substance use, we are often unable to hold the patient and force treatment upon them. We try very hard to motivate them for treatment. We will also engage their family to help with the motivation. But many patients are discharged to home with outpatient followup only. We will prescribe a Narcan rescue kit, educate about harm reduction strategies, provide an appointment to see mental health within 7 days and place a followup phone call the day after discharge. But we are often unable to do more unless the patient is willing.

What is your suggestion for the role of Vivitrol in post Narcan care?

I attempt to motivate all patients with opioid use disorder, particularly those post overdose, to initiate buprenorphine in the psychiatric emergency room. The first line treatment is buprenorphine, unless there is a reason/contraindication. For example, if adequate trials of buprenorphine have demonstrated its lack of efficacy in that patient, or if there was an intolerable side effect or adverse reaction. Methadone is generally the second line agent that is used following a buprenorphine failure. Following a methadone treatment failure (side effect, etc) then Vivitrol is the third line agent. Veterans at the VA will have an assigned outpatient treatment coordinator. We will collaborate with the outpatient team to determine the appropriate management of the opioid use disorder. We are able to initiate buprenorphine or vivitrol in the PER but methadone initiation is deferred to the opioid treatment program. It is critical that patients with OUD are initiated on maintenance medication (one of the 3 mentioned) AND referred to a treatment program AND AA/NA.

Can you compare patients that you would suggest for methadone vs Suboxone vs Vivitrol? What doses, how do you decide…? How long do you suggest MAT plus therapy and when to stop?

In general buprenorphine is the first line, methadone is second line and vivitrol is third line, though this depends greatly on the individual patient. At times, methadone is the first line agent if the patient requires the structure of the opioid treatment program or if the severity of the addiction is such that high dose methadone is preferred. In general, buprenorphine is appropriate for the majority of the patients that I see in the psychiatric emergency room. Duration of MAT therapy remains debated. It depends on many factors and is an individual decision between the physician and the patient. In my opinion, a very important consideration when deciding whether to stop MAT is the patient's commitment to a recovery program. If the patient is going to daily meetings, has a sponsor and is completing step work, I am more likely to endorse a

plan of tapering down the buprenorphine than the same patient who is relying solely on the buprenorphine for sobriety. Other considerations include IV use, previous OD with Narcan administration and other high risk behaviors. These would make me more likely to recommend longer term use of buprenorphine. In addition, the decision to stop MAT would depend on factors like cost, side effects, etc. OUD is a deadly illness that requires long term treatment. When the illness is severe, high risk behaviors are present and the buprenorphine is not causing problems, I am unlikely to recommend tapering it off.

Are you seeing opioid overdose and addicts concurrently using MJ, alcohol, cocaine, methamphetamine, other? Can you give us a sense of how many patients just use one drug or just are addicted to one drug? Do you do drug testing on all patients in the ED?

Yes, we perform urine drug screens on all patients who present to the PER. In my experience there are several groups of patients with OUD:

- In my experience the most common group of patients with OUD also have a history of other substance use disorders. Most common would be MJ, alcohol, cocaine and sedatives. While this group has struggled with an addiction to multiple substances, the opioids are the clear drug of choice. Many patients in this group will set all other drugs aside and only use them occasionally once opioids are discovered.
- The second most common group with OUD continue to use other drugs concomitantly with the opioids. They may not identify opioids (or any of the others) as a clear drug of choice. This group will often speedball (mix opioids and cocaine). They also may unfortunately mix alcohol or sedatives with opioids, which is an unfortunate combination.
- The least common group has OUD with no other history of substance use.

Methamphetamine is not as common in the northeast and hence for regional considerations I do not see it commonly. As a resident in Dallas, TX, methamphetamine use, with or without opioids, was common.

Do you have a protocol for switching someone from Suboxone to Naltrexone?

In the PER we do not generally complete an opioid detox and hence do not generally switch from buprenorphine to naltrexone. We either initiate and titrate buprenorphine for maintenance or transfer to a local rehab or detox facility for completing detox.

Do you have an Opioid Detox protocol that you'd use in the hospital or ED?

First, we try hard to not detox OUD patients. Patients with OUD should be on MAT and we use the psychiatric emergency room (PER) visit as a means to initiate buprenorphine. We aggressively recommend buprenorphine initiation. If agreeable we generally will start buprenorphine 4mg in the PER once withdrawal symptoms are moderate (COWS >8). We will then repeat the 4mg dose if indicated for a maximum dose of 8mg on day 1. The patient will then spend the night in the PER for observation. On day 2 we titrate up to a maximum dose of 16mg if indicated. At that point the patient is ready for movement to the next level of care. Occasionally, patients will require a second night in the PER to titrate the buprenorphine up and for complete stabilization of withdrawal symptoms. Once at a stabilizing dose the patients will generally move to our 21-day substance use treatment program. While in the program the buprenorphine is titrated as necessary. Upon completion of the program the patient is referred to the buprenorphine clinic in conjunction with a psychosocial program. If the patient is unwilling to attend the 21-day program, and buprenorphine is initiated in the PER, the patient is discharged from the PER and seen daily in the outpatient detox/stabilization clinic until an appointment is available in the buprenorphine clinic. Given the resources at the VA we are able to initiate buprenorphine in the PER with confidence that a plan on

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the backend is achievable. If the patient is unwilling to be on maintenance therapy then an opioid detox is completed. This is done with either buprenorphine or symptom-driven. Typically for detox, the patient is transferred to a local detox facility that the VA contracts with.

You have worked in both the inpatient and residential drug free drug programs and now Yale in ED and MAT, can you give me a sense of what lessons you have learned from each and how each might have a role and limitations?

Residential programs are a very important part of the recovery process but are not a cure for addiction. I often encounter patients who have completed our 21-day treatment program multiple times, each time having relapsed almost immediately after completion. When patients and/or families expect that years or decades of use will be cured after 21 days in a program they will naturally be disappointed. "Treatment begins when you leave the program" is a very important tenet of recovery. A good residential program will introduce/reinforce recovery principles and motivate the patient to continue this process after completion of the program. Without a solid aftercare program, residential programs are destined to fail. Regarding the emergency room, many providers may not see the emergency room as an ideal environment for a discussion about recovery. Every patient that I see in the PER will hear about the importance for long term treatment and the need for a solid recovery program. I will discuss long term strategies including MAT, NA and other treatment options. Even with patients who present to the PER frequently, I always spend time discussing the importance of a solid foundation of recovery and the need for MAT. Even in the context of a busy emergency room, there is always time for a brief motivational interaction which may make a real difference and save a life.

Are you seeing Meth or Cocaine emergencies and/or overdoses? What is your approach?

Methamphetamine is not a common drug of abuse in this region of the country. Cocaine is incredibly common and it is commonly abused in the powder form or in the form of crack. It is often used in conjunction with opioids (speedballs). When cocaine overdoses occur (rarer than opioid overdoses) the patient is seen and stabilized in the medical ER prior to transfer to the PER. With patients who are using cocaine at levels so dangerous that it leads to overdose, I am aggressive and assertive the way I am with opioids. The difference with stimulants is the lack of MAT. Hence the reliance on a psychosocial treatment becomes more important. Patients are referred to the substance use treatment program to begin the recovery process. They are then referred to AA/NA, contingency management, CBT for addiction or other psychosocial support programs.

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