# OTP Session 5 Transcript

**Gretchen Shoemaker:**

And we have two wonderful presenters here with us today. We've got Megan Hudson. Meg is a clinical nurse educator with Boston Medical Center's Grayken Center for Addiction Training and Technical Assistance. It's a mouthful and a psychiatric mental health nurse practitioner at Boston Medical Center. Her current clinical area of practice involves management of both primary and substance induced psychotic disorders.

Prior to obtaining her MSN and she worked as a nurse care manager in the Stimulant Treatment and Recovery Clinic (START Clinic), where her work integrated harm reduction, infectious disease treatment, medical addiction groups, and co-management of stimulant use disorder and mental health conditions. Meg has supported the dissemination of the Start clinic model across Massachusetts, and she leads and participates in trainings related to stimulant use.

Also joining us today, we have the amazing doctor Alfredo Gonzalez, who is a board certified doctor in internal medicine and addiction medicine with ten years in primary care and 15 years in addiction medicine practice. He currently serves as the medical director for High Point Treatment Centers Opioid Treatment Program in Plymouth and New Bedford, as well as the medical director for the START Clinic in New Bedford.

So we've got great company here today. Before we get into the presentation, I'll just talk about some objectives for this session.

Here are some learning outcomes. We are hoping that you all will leave today with these four things: Being able to identify at least two unique needs for patients in the OP who also use stimulants. Identify three physical and two psychological symptoms of overamping. We hope that you'll be able to recall the AGRO+ mnemonic and how to implement it in the OTP setting. And finally, recognize at least two strategies to improve the OTP experience for individuals with stimulant use disorder. Now we can get into some fun polling.

**Jen Miller:**

right, I don't know if all of you are familiar with Menti, so if you could either go on your computer to Menti.com or scan the QR code here, you will be able to follow along with the slides.

And we're going to have some interaction later on, so I really would appreciate it. I'll

have the slide up again the next few moments where Meg is going through some of the slides you don't need it for, but it is easy to have up on your screen. And I will have this, the instructions up again later.

All right. I'll turn it over to Meg.

**Meg Hudson:**

Thank you, Jen. Really excited to be here with you all today, and so grateful for the incredible work that you all do in the OTP settings and whatever you might be coming from. So, like Gretchen said, I am a psych nurse practitioner here at Boston Medical Center. I primarily work in our psychosis clinic, and I do that at Boston Medical Center. I also do it in the home setting. And so coming at it from a couple of different angles in terms of, pharmacologic and behavioral de-escalation in a, in a variety of settings. So what we're going to do as we talk today a little bit specifically about overamping, and management of overamping.

So we're gonna start with a psycho stimulant review. So we can go to the next slide. And the reason that I want to talk about a psycho stimulant review, to kind of to start it is to remember that polysubstance use is the norm. It's the rule, it's not the exception. And we can see that here that overdose deaths involving cocaine are on the rise, as well as methamphetamine, which is our yellow line there.

And so it's helpful for me to know, you know, both as a provider in terms of my, like, clinical overview, when I'm looking at patients, charts and making a treatment plan, but also when I'm doing teaching with patients, and talking to them about, you know, substances that might be cut with something else. Certainly the folks that you all are seeing in the OTP are coming to you, for methadone treatment, but talking to people about other substances that they might be using and then whether or not there are other substances within those other substances.

So just bearing in mind that, you know, whether knowingly or unknowingly, we're looking at poly substance use pretty much across the board. And so what are psychostimulants on the next slide we have them, that, you know, psychostimulants are what we really refer to as uppers. And there's a whole range of those, and they have a whole range of symptoms that we might see.

You know, they could be legal, they could be prescribed, they could be illicit or non-prescribed and based off of what the stimulant is that the person is using and how they're using them. So a whole host of responses that we might see both physically and psychologically. And so what we're going to primarily be talking about today in terms of overamping is cocaine and crystal methamphetamine. But bearing in mind that there's, there's quite a variety of stimulants and psychostimulants that people might be using and, and recognizing that there are a variety of routes is really important, because it's definitely a myth that I see, among different practices that that there's, there's, a thought

that stimulants can only be used maybe by snorting or insufflation or smoking, but they can be really can be used any way.

So I'd like to talk to my patients about that because it will come into play with overamping. And yeah, we can go to stigma. So we all know in the work that we do that, you know, substance use disorders are highly stigmatized. I think stimulant use disorders are really highly stigmatized in, in what I see in my practice.

So we can go to the next slide and we'll see a couple different clips that, that are real. About people who use stimulants. And what I'm gonna point out to us, as, you know, providers and people that are taking care of, of those with stimulant disorders, is what kind of a picture this paints of a patient or a person that you might encounter.

And so, you know, I look at the one about the top like "Meth in Miami Valley: users are violence, paranoid and psychotic." Paints a really specific picture of a very specific person in a very specific presentation. And so, you know, I, as a clinician, think about that in terms of like the words that we use and the way that we describe, patients and, and, and being mindful of whether or not those are rooted in stigma or bias and whether or not they're, they're medically accurate, and whether or not they're going to set the patient up for success, in subsequent care, you know, what we're documenting in people's charts and the kind of reports that we're giving to people. And definitely when we talk about overamping, we'll get into this on the next slide, which we can actually go to now, is, you know, the language that we use surrounding overamping. And perhaps if we're giving a report to another provider and saying, hey, this person came in and is overamping and this is their presentation, they might get different care if we say, you know, they're violent, they're paranoid, they're psychotic. And if you have a second, if you can go to the next slide, we have some examples of alternative language. And definitely at the bottom, these are the two that I see the most in my practice in terms of stimulant use disorders. And overamping, you know, instead of saying that somebody is violent or aggressive, what I might say is this is somebody who's exhibiting protective behaviors or maybe a trauma response has been elicited. And just being really thoughtful and mindful about the language that we're using, whether or not it's medically accurate, and whether or not there's stigma there. You know, when we think about, you know, those clips that we had seen on the last slide, clips that people might be seeing that they, you know, resonate with or that they're worried that their treatment provider is going to see them in this way.

So, so kind of can't be understated I think the importance of, of using preferred language. We have a QR code there. If people want to take a Words Matter pledge and, is something that I think about a lot in my practice and try to, talk to other providers about and I do think that it makes a big difference in the kind of care that people get, so we can move on and we're going to talk about what overamping is.

And we can go to the next slide. We're going to look at kind of like a spectrum here of overamping. You know, similar to other substances. Right. Alcohol, opioids, there's a, tends to be a desired outcome. Right. When, when we're using a substance that there's

something that the person is, is after with that substance. And with stimulants it tends to be like a euphoria.

Maybe, or a hyper sexuality, depending on the setting that this person is using in. And, and there's a, there's a point where we actually flip from the desired outcome to an outcome that's not actually desired. And that's where we kind of move into overamping. And so we've got, you know, all the way at the end there like wakefulness and tachycardia.

You know, we talked about at the beginning of this, there's, there's a host of, of stimulants and there's a host of ways that we might use them. And so that might be something more akin to like a coffee that you have or a couple cups of coffee in the morning. And then as we move along, we're starting to move into maybe like cocaine or crystal methamphetamine.

And perhaps this is somebody who's been awake for days and using for days, and now we're starting to move into a space that's, more, evidenced by like, confusion and psychosis. And on the bottom there we have in the read physical symptoms that we might see. So bruxism is like a jaw grinding, choreiform movements or, you know, uncontrolled movements of the body.

There could certainly be circulatory collapse. And so we want to intervene here at this point of overamping. And you all certainly integrate space to do that if you see people coming in.

And so we can move to the next slide - a little bit more physical science of overamping. So again, it's really the got, an interesting thing that's very physiological and it's also very psychological. So physical symptoms that we might see with overamping, you know, somebody might come in and say like, oh my God, I'm having the worst headache. Or you might notice some clenching in the jaw. You might notice some uncontrolled movements. This might be somebody and oh, this might be somebody who perhaps if you take their vital signs and you're maybe touching their arm, you might notice that this is somebody who's really warm to the touch, perhaps hasn't been sleeping in a while.

And then, you know, psychological symptoms are very prominent in overamping and often looks like, paranoia. Typically in my practice, and my experience of people overamping, I tend to see delusions that are more rooted in feeling persecuted by other people. So what that might look like is somebody saying, like, people are out to get me, there's a chip in my phone. The FBI is looking for me. It often tends to be that way. And that's just anecdotal. That's just my own experience. And the reason that I like to point that out for people, is because as you're working with people in the beautiful work that you do every day, you know, building that rapport and that sense of trust, and this is a place where I'm safe, that I know that there are people that care about me, that that can really help you in this moment of overamping. Because those persecutory delusions are so common, it can be really helpful to already have a well established therapeutic

relationship.

And so we can go on to the next slide. And here we have a QR code that has a, a provider's guide to overamping if people are interested in it. And, you know, recognizing it, like we said, to kind of recap physical and psychological, and we definitely want to intervene and be able to talk to people about what might lead up to overamping. Which we'll get into a little bit, but also recognizing that overamping is really unpredictable in my, in my experience, I feel like it's quite abstract, where sometimes I feel like other medical conditions or even psychiatric conditions that I respond to, or tend to be a little bit more concrete, but overamping is quite unpredictable. And so, having, like I said, having that therapeutic relationship and having a good frame of how we're going to respond to this is really helpful through this course, maybe, of somebody coming in really escalated and then starting to come down.

So we're going to move now into risk factors and prevention. So, on the next slide, when we think about what are risk factors for overamping, it can be helpful to think of this like the five D's. You know, we've kind of touched on this, that there are a host of different types of stimulants people could use.

They could use them many different ways. Those definitely play, play a part. Like, what is this person using? How are they using it? How much, how often? Like have they been awake for a really long time? Have they been using for days? That person is going to be more likely to experience overamping. You know, it's not on here, but has this person experienced overamping before?

And then disorders and diseases. You know, if we think about the way that our body metabolizes substances and drugs, right, is is this somebody with chronic kidney disease, do they have a harder time metabolizing cocaine, perhaps? Things like that might also contribute. So so again, it's helpful in the moment thinking about what might have contributed to the overamping. But also as we're working with patients or thinking about their risk for over, these are things that we could start to look at and maybe start to adjust with people to reduce the risk. Because, you know, the fact of the matter is that overamping is is, you know, like I said, it's it's it's abstract, it's unpredictable for us. And that can feel stressful. But it's really, really scary for the patient. So this is great, a great opportunity for us to intervene.

So in the next slide, we'll talk a little bit more about just basic prevention. One of the best things that we can do is just take a break. We can get somebody to take a break and, and, you know, thinking about the OTP setting might be a good place for that break to happen, right? If people are coming in and they're standing in line and perhaps they're chatting with you or things like that, not necessarily that they've reached this point of overamping, but it's a structured point in their day. In the stimulant treatment clinic, yeah, we run some groups, and that people will come in and have some water and they'll have a snack and they sit down with us for a while. And that is really important. Just seeing a break in use can significantly reduce the risk of overamping. And then then other things that we can do, you know, hydration and rest and nutrition

and things like that, are all really helpful.

And why is this important? On the next slide, we have a graph of how this actually reduces criminal legal involvement, which I think is really fascinating. There's a significant reduction in number of concurrent using days that correlate with the reduced risk of interaction with the criminal legal system. And that makes sense, right? If we think about what happens when people are using stimulants or when they've experienced overamping, and perhaps, like we said, they're paranoid, they're experiencing persecutory delusions, they're exhibiting, protective behaviors, meaning that they think people are coming after them and they need to protect themselves. This might be somebody who, if they come across someone who doesn't understand what's going on, they might get into trouble and they might interface with the police when actually what they need is intervention for their overamping. So we actually have seen that, that, that taking a break is helpful in reducing interactions with law enforcement. So another good teaching point for people, and something that we can be looking out for.

On the next slide, just another thought of ways to reduce risk of overamping is changing the delivery method that the person is using their stimulants through. So if this is somebody who's only injecting, you know, perhaps they might be open to smoking, or perhaps they might be open to snorting. There might be things that we could do that might in that way, maybe this is somebody who's not ready to take a break, but they could change their route maybe every couple of times that they use. Or maybe they consistently change their route. Just different things that we can start to do to work with people and really meet them where they're at to help reduce their risk of overamping.

And so we'll move on here. Now, we kind of identified that we've defined it. So what do we do when it happens? So on the next slide, the first thing that we want to do is is make a decision, Right. So when this happens or has happened to me in the START clinic, I have somebody who comes in and I've seen those signs. Right. This person comes in, they're tachycardic, they're hypertensive. They've been up using for days. They're paranoid. They're experiencing persecutory delusions. I recognize that they're overamping. And what I'm going to do is I'm going to make a decision. Am I going to keep this person here with me and then START clinic? Or, you know, outpatient clinic? Or am I going to move them over to the emergency room? And so things that I'm looking for are, you know, on intake as well as throughout my time with this person, and that I might say they're going to be safer in the emergency room than with me right now. You know, any EKG changes, meaning like any, any indication that their heart is not beating the way that I expect it to. Do they have uncontrollable hypothermia or their body is really hot and it's not coming back down? But uncontrolled movements that aren't getting better, they're not going away. Hypertensive crisis, things like that. Those are things that I'm going to I'm going to move our person over to the emergency room.

But when we do this in the ambulatory setting, which most often, in my experience, is what we did on the next slide, we have kind of a flow of what this looks like. And so right away I've identified that this person is overamping. And right then I'm going to start to incorporate behavioral interventions. And that's going to look like perhaps moving this

person out of the waiting room and into an exam room. So might be, you know, implementing some verbal de-escalation, perhaps getting them in training or something to eat, and then perhaps some pharmacotherapy if this person is agreeable with it. Which I have a little bit more on another slide, but in essence is, first line agent of benzodiazepine. It's an orally or a second line agent, an antipsychotic.

And so in the next slide we'll talk about our AGRO plus mnemonic, which really is, you know, on the left side, we talked about how, you know, we're going to implement behavioral de-escalation right away. The way that we do that can kind of be boiled down into this AGRO plus. And I think it's really helpful. Actually, to simplify it to this degree. It's been really helpful for me, because as we've established overamping can be really unpredictable. And so it can be helpful in a moment to say, okay, I'm going to assess what's going on with this patient, what's brought them in, how do I help them best right now? How am I feeling? And what do I need to support me right now? Because if we start to get really stressed and we start to get really escalated, it's probably going to stress the patient out more. And we're going to think about our, our, you know, interactions with the patient, how we're responding, how things are working. We want to be calm and confident, but we don't want to accidentally reinforce delusions. We're going to observe how things are working or not working. And we're going to offer positive reinforcement to this person and, and kind of continue doing all of these things as we work with them.

And so on the next slide, we have behavioral de-escalation. And I know we're going through a lot of content. So I appreciate you all. Behavioral de-escalation on the next slide. You know, of course. Right. This is somebody that we said is is exhibiting the protective behaviors. We want to make sure that everybody is safe. And so recognizing that this is somebody who's scared and maybe thinks that people are out to get them, we just want to be mindful of that, that this isn't somebody that we like corner into a room or move really quickly towards because they understandably, they're already scared. That's probably going to be scary. So we want to be thoughtful about the way that we're kind of moving about the room or the clinic, to protect the safety of the person as well as the safety of ourselves and, and our coworkers.

And so a little bit more on the next slide about management with medication that we used in the stimulant clinic, which, you know, is in the family medicine clinic at Boston medical center. We had these medications stocked there, which is lorazepam, 0.5mg to one milligram with really good effect for people, you know, great effect in starting to come down. Blood pressure coming down, heartbeat coming down. You know, somebody who maybe hasn't been able to sleep in a while, actually being able to sleep. And so there have been many times that I've had people with me who I've given, you know, maybe a milligram of Ativan and they've actually been able to sleep for a little bit and wake up and do much better.

We do have, olanzapine POA as a second line antipsychotic, second line agent for overamping. In our clinic. I will say, just again, in my experience, there was, I think maybe one time that I've moved from the first line lorazepam to the second line

olanzapine. And that was in a gentleman who had actually a persistent psychosis. But most often the lorazepam really addresses quite well all the things that are contributing to that person experiencing overamping. So we have great results with that.

So we're going to talk a touch more about protective behaviors too. I've mentioned it quite a bit. But protective behaviors on the next slide are things that people might instinctively do to keep themselves safe. So again, if this is somebody who feels like people are out to get them or people are trying to kill them, they, they're going to do what they need to do to keep themselves safe. Right? That's what we all actually would do if we think that we're really in harm's way to keep ourselves safe. And so I think that it can be helpful just to keep that in mind, both in terms of our language, but also in our approach with patients and kind of our perspective of what's going on that this is really scary for people.

And we can help them really well with, with a lot of these interventions. And make a big difference for them in the exhibition of these protective behaviors. And so on the next slide, we have a quote from Albert Einstein, just a little bit bigger because it was in smaller font. On the other one, you know, kind of just touches on that, that these are basic needs that we all have.

And in these times of overamping, where this maybe somebody who's been awake for days, maybe is lonely, definitely is scared. It can just be really helpful to like, boil it down to simple, basic human compassion. And that is really, really, really helpful for me and engaging with people who are experiencing overamping, coming at it from a very humanistic but like, medically excellent and informed approach.

And so I'm going to touch on psychosis and then, and then I'm going to pass it over. The question that I get a lot from people, which is why I want to touch on it, what, psychosis, they're experiencing paranoia, maybe hallucinations, delusions, you know, overamping, but like, what if it keeps going? So on the next slide, what we want to look at with this is happening.

And, and, you know, this can be something that maybe we're seeing as somebody coming in not necessarily overamping, but like perhaps this is somebody who we see self-dialoging sometimes. What I really want to know in the setting of stimulant use is like, is this happening only with active use, or is this persisting in the absence of stimulant use?

And a couple things could be happening there, that I'm happy to talk about so much more. In terms of like long term psychiatric diagnosis since but what we want to do is think about, you know, again, is this happening just with the stimulant us? Is it persistent? In both of those options we want to think about, like, do they need an as needed antipsychotic medication to help them out?Or may they actually need a long term medication to help them better. And so perhaps we can connect with our, you know, behavioral health partners and, or, you know, if we have the resources within our clinic to do it. But, but it can be another really helpful way to reduce risk with

overamping, and, and make life a lot smoother for people.

So on the next slide there, there's a great validated screening tool that I love called the PQ-16 or the Prodromal Questionnaire. And this assesses for the, the prodrome of psychosis or the symptoms of psychosis that we might see start to come in as somebody is developing like a frank psychotic episode. And I really like this tool because, it can actually be really neutral. I find to go through with patients, that I can say, you know, just as I would assess for another condition that I'm going to go through some of these questions. And as I've gone through with people I have, I have seen some, like internalized shame lift when people have said like, oh my gosh, I had no idea that anybody else experienced that, you know, things that maybe they didn't want to disclose. That, then we can talk about. And I'm able to then say like, oh my gosh, I you're experiencing quite a few of these symptoms. And based off of these other answers you gave, I can see that you're experiencing a lot of distress. And like I'd love to talk to you about, options that we can that we can implement to help you with this.

So my last kind of content heavy pieces, in my case, for long acting injectable antipsychotics, just to have in mind for people that you might see coming in, that, that are exhibiting, persistent psychosis that maybe you do a PQ-16 and you're like, wow, this person really is exhibiting, significant symptoms. That's causing them a lot of distress.

You know, when we look at it through the lens of stimulant use, we do have evidence that there there is actually an overall reduction in methamphetamine use for people who are on a long acting injectable antipsychotic. Which again, when we think about overamping is a fabulous thing, right? Because we've got somebody with, a monthly, bi monthly injection managing their psychotic symptoms. But now we've also reduced their methamphetamine use. And then, you know, can definitely engage people in care a little bit better. So just something to think about.

And then on the, it just kind of wrapping things up on the next slide. Stimulant disorders are definitely on the rise. And so we want to be we want to be screening people for them, in a non biased way. Episodes of overamping definitely important to remember physical and psychological and be sort of assessing for all of those things so we can respond appropriately. And then, you know, responding appropriately with pharmacological and behavioral health interventions really reduces negative outcomes for people. And, you know, implementing harm reduction and all those great things that you all do is really helpful.

And people do recover. And I will say that in my practice, I've seen many people where the first time we met, they were experiencing improving. And now, you know, a year or 2 or 3 years later are doing really, really, really well. So it could be a great opportunity. As scary and intimidating as it might seem to sort of engage people well, after we take good care of them, get them, you know, plugged into longitudinal treatment. So with that, I'm going to pass it back over. We're going to go through some more interactive things with Jen and Doctor Gonzalez.

**Jen Miller:**

Great. Thanks, Meg. All right. So again, if you guys wouldn't mind logging in to this awesome Menti presentation here, you should be able to scan the QR code with your phone or go on to Menti.com, to, log in. And I see some people. Thumbs up. That's great, I love it. All right, so as you're coming into this, again, use the code Menti.com 74766 8310 please put in where are you coming from today? Where are you on our lovely BSAS map? You can actually click the map on your phone and tell us where you're coming from today. I'd love to see where folks are.

And I give it a second. And I know people are still getting logged in. There we go. We're getting there. We're getting up there. I think we have about 20 people in this session or maybe more from what I can see. So I'm going to wait for the numbers to climb just a little bit here. It as I'm doing that, I would ask Doctor G, could you share a little bit about the clinic, that you're, you know, the especially the co-location?

**Dr. Alfredo Gonzalez:**

Right. Can everyone hear me? Yes, yes. Well, thank you for inviting me to join this, the topic and discussion. It's a challenge, for sure. I am, have a medical background in both of the OTPs that I work, are co-located in a behavioral treatment setting. So, in Plymouth to have a CBHC. So I have access to psychiatry. And in New Bedford also is an outpatient behavioral health clinic. And that's also co-located with the START clinic. So two different practice environments. And I guess the key to this topic, I think, is really understanding that there is a spectrum that we see, all of us who work in the, in the OTP setting, we see patients who are clinically stable and use cocaine all the time.

And then we see patients who are on the other spectrum who are sort of always on the edge of overamping. And so, fortunately, it's, it's, it's, it's more common to see the patients who are on the, on the, milder spectrum of that. But, you know, from time to time we see the patients who, for whatever reason, are using too much, using IV, been using for days and days and days and end up just being, you know, crashing. So, I think that from my perspective, it's always good to understand that we're working in, in teams and now with final rule changes, really our job is to sort of identify clinical stability. So in the end, since we are seeing so many patients with polysubstance abuse, and we obviously are, know what, what's in their drug screens. I think that at the MDT meetings, we are always sort of kind of trying to tease out the patients who may be receptive to, being referred to, a psychiatrist or a START clinic, per se, because I think that in the end, if we can, reduce the, the, the, the harm of IV use, and or chronic daily use that would potentially we're going to see less overamping in these settings. And so I feel like having, you know, good referral sources and understanding that from the methadone perspective, our primary job is really to address the methadone situation. But since we see so many, polysubstance and or other concurrent medical conditions that we're always sort of acutely aware of, of trying to make patients or not make patients, but sort

of give good advice, so that these patients can get better care and have less traumatic experiences in their life.

So, you know, I think that, OTPs, probably in, in the state of Massachusetts and all over are all a little bit different. And so I think that the, the key message that I have is really to identify your referral sources and make sure that that you have a, a good idea that just episodic care, episodically taking care of somebody with methadone who has polysubstance abuse and has the risk of overamping is is really not enough.

And so, I'm, I'm sitting here in Philadelphia at the National Convention for Mental Wellness. And, I think that one of the points that I've heard over the past two days really is this idea of case coordination and trying to not be so siloed in the way we take care of patients. But at the same time, understanding each of us and our limitations. And so we're able to provide an OTP setting versus the START clinic versus, a CBHC is, is is a little bit different. But at the same time, those are the parameters we have to work under. So, I'm going to leave it there for now and, and we'll, let Jen do some interactive stuff. And maybe again, I appreciate Meg.

And for your expertise and your presentation, I think that, obviously we see overamping in many clinical settings and, it's a very important to identify and and by that, by identifying and identifying that we can, you know, assist in making the right referrals.

**Jen Miller:**

That's a great segue Doctor Gonzalez, thank you so much. Because we are going to ask you, how many of you have patients who use stimulants?

So again, you can go in and icon and type in that code. You'll be able to interact with us. You can click which one. Are all of your patients using? 50%? Less than 50? None I'm sure. Maybe we don't know. I know when I was an OTP clinician long, long time ago, I would say most of my patients had, would come back positive with, cocaine or other stimulants. So. And that was 10, 15 years ago, so I can't imagine it's changed too much. If anything has gotten bigger. All right. We're getting some people 50%, almost all “other”. If folks are saying other, can you put that in the chat? And someone could tell us, is it less than is it, and then maybe Gretchen, if you can share with some people who are saying, “other” are sharing.

**Gretchen Shoemaker:**

So far, nothing in the chat. Okay.

**Jen Miller:**

All right. Well, I mean, 50% is still I mean, some of your clinics are really large, right? I mean, some of you are seeing thousands of patients and, you're seeing hundreds, right? Like it's that's even 50% being the first. That is still a large amount of your population who might be consuming stimulants. And it keeps growing. I like how it grows. It's pretty cool.

All right. Our next question is, what kinds of stimulants do you think your patients are using? Or were they using, you know, meth, cocaine, crack cocaine, other amphetamines, not as prescribed. So that's like your pressed pills, like Adderall and other things like that. And I don't know about you, but caffeine is my number one. So, and then others that I mentioned that you've been hearing from, from your patients, and I see that there might be some chats coming in. But I can't see them.

**Meg Hudson:**

It looks like some combos in the chat. Okay. Some combos, especially between, cocaine and crack cocaine.

**Jen Miller:**

Yeah. Yeah. If you can't use this and you put it in the chat, that's fine. I think between the team and mag and others, we can. We can figure it out. But it sounds like a lot of you are seeing mostly cocaine or crack cocaine. And I guess, Doctor G, what would you say from from your experience, are you seeing in the different settings? Right. Because you have the two different clinics, you know, you have your group that has the CBHC and your group that has a START clinic. What is there a difference there?

**Dr. Alfredo Gonzalez:**

So from there, there is a difference in from Plymouth to New Bedford. But I think in terms of poly substance use that we see mostly cocaine, mostly crack. And not so much methamphetamines yet. You see it from time to time in the detox, but, thankfully because I, you know, obviously that's that's probably worse than all of them put together.

**Jen Miller:**

Great. Yeah. I do think that there's a difference also by region, I will say, I think in Massachusetts I think there's a, there's like different waves of what substances are more popular or more accessible. And I will say that you will probably be seeing

methamphetamines in your region if you are not already. All right. We'll move on to the next question.

All right. So how are your patients using stimulants? I know Meg and Doctor Gonzalez talked about like dose and talked about administration and how it impacts how somebody might be experiencing overamping. So where, how are folks, you know, when you talk to them, how are they using substances?

Multiple substances at once. Yeah I can see a lot of folks. And there's probably some in the chat. I don't know Meg if you want to hollow those out for me.

**Meg Hudson:**

Yeah. Some multiple routes. One that just came through is injection and inhalation.

**Jen Miller:**

It's interesting. You know, I'm glad to see the smoking, to be honest, just in terms of, you know, safety and, and things like that. I'm glad that people have access to hopefully safer smoking supplies at some places. All right. We're going to jump right into some case scenarios now. And so, Doctor Gonzalez and Meg are going to help us out a little bit and we're going to have some interaction with the audience.

So we have a case. So we're in, we're in an OTP. You know, you're in your clinic, we've got a 20 year old cis-gender black male who presents to the clinic in a highly agitated state. When you see, the patient displays profuse sweating, dilated pupils and exhibits rapid speech. His heart rate is significantly elevated and appears to be paranoid. He's expressing concerns about being followed by unknown individuals. On further questioning, he reports some recent stimulant use, specifically the inhalation of a large quantity of cocaine. Despite feeling exhausted, he has been unable to sleep for the past three days, he reports feeling overwhelmed and unable to cope with his current state.

So how do you think we could implement what Meg was talking about - ur AGRO+? I don't know, Meg If you could pull up and put it in the chat what it stands for, or someone from the team. I know I don't have the slide ready right now. But yeah. Locked in. How? And this is a type your own response.

So you can type in, you can chat in your response here. And it is anonymous. So there is no wrong answer. I ask the patient if you'd like a snack or water. Yeah, I'd love it. And then put it in the chat. If you can't we will, we will. We'll yell it out. If you can't get into the Menti.

Now imagine if this person's coming in there in your dosing line. How are you going to support them in your dosing line? Or if they're in front of the nurse at a window, right.

That might present differently than if they were at the front desk.

**Meg Hudson:**

Somebody put a check vitals in the chat.

**Jen Miller:**

Ok, Yep. Check. Vitals. Okay. Study body language to see if your interactions are helping them calm down. That's a big one, right? After you offer to bring them to START for assessment, if you have a START clinic, that is probably the coolest one. Check vitals. Yep okay, great. Because there's risks there, right? What if he's not? Maybe it's not the cocaine. What if he's having a medical incident? Right. Are there any others in the chat?

Not so far. Okay. Do we, you know, move to a private space? Great. Yes. Yeah, I like that. You know, thinking through how your clinic is shaped, right? There's different levels sometimes, or there's different access points. And that person might have to go through a large crowd to get, like, thinking through, like, in your own space. How would you support somebody who might need some extra help? And I don't know if, Doctor Gonzalez, if you want to share a little bit how in the, in your OTP is how you would, might do it.

**Dr. Alfredo Gonzalez:**

Yeah. I mean, this is a sounds like a semi emergent situation here. So, I mean, I think that our focus really would try to be on getting into a private space and doing some vitals. We don't have an EKG, but we could certainly take a temperature and, and, and if we are identifying the red flags that we probably would step this patient to the emergency room based on the presentation. So I think that, you know, a 28 year old, can have a heart attack from using a lot of cocaine, and certainly something that he's not complaining of chest pain. But, again, this is a scenario where if you don't act in a, in a, in a in a way that is a little bit more emergent, you may have a really bad outcome. So I think that, you know, trying to get a patient out of a public space in this, in this scenario would be appropriate. But again, each OTP in is, is a is a challenging environment. And there may be a lot of people there may not be a lot of people, but this scenario is, you know, thankfully a little uncommon. And but, I would I would certainly try to rule out any red flags for, step up and care.

**Jen Miller:**

Great. Thank you. All right. We'll go, on to the next one, because I wanna make sure we have some time for questions. So our second case is a 31 year old, single Caucasian female, with three children. The patient enters the clinic and asked to meet with the nurse. The front desk staff notices the patients fidgeting in their chair, keeps staring out the window as if they're looking for someone. The nurse comes to the waiting room and approaches the patient. Patient reports that they think someone's after them and that they've been tracking them, and they've potentially hacked their phone. She feels like someone's watching her from the outside the building, and has, and feels like something bad is going to happen to her and her children. So how can we support this patient who's feeling some feelings of paranoia, who's actually asking for some help right now by asking for the nurse.

So what do you think? Like, what would you guys do?

Again, type into the chat or type in the Menti. Well, we'll get the responses up.

**Meg Hudson:**

Somebody in the chat said, take to a private area. Can she talk with a counselor? I would suggest an emergency room evaluation. Does she have a psych or mental health care provider?

**Jen Miller:**

Yep. Yeah. I like, everyone's supporting and reflecting and validating. The person might be scared. Yeah. The nurse who's most familiar with the patient. I like that one. Yeah.

**Meg Hudson:**

I also love I'm happy that you came in today. Great. Agreed. We got another one in the chat. Support. Validate. Bring her to a safe space. Ask her if she feels safe. Or ask to see a provider or a psychiatric provider.

**Jen Miller:**

Yeah. Great. And I think there's one more question that we want to ask is, what do you think these resources, these patients need? What are your within your OTP or in the community? What do you think. Besides, you know, I mean START clinic would be great if we all had one co-located or one in our region, but not everyone does. So what

are some other resources that you think you would support these clients with?

You can feel free to use the chat if you can't get into Menti. Support groups, like that one. Yeah, this is a word cloud, so the words will get fun. All right, primary care provider. Great. Case management. Recovery coach. Yeah, I like that one. Therapist. Psych. Yep.

**Dr. Alfredo Gonzalez:**

I will just, want to add, you know, as I see these responses, I think that, you know, part of our job and maybe part of our role is really educate the greater public and even in terms of caregivers, because we're hyper focused on, on polysubstance abuse and opioid use disorder. And as we start to learn about these new treatment ideas in terms of prevention, especially with the stimulants, that not all providers may feel comfortable with that and or may not know about it.

So I think that, case coordination, in terms of outreach to their providers, if the patient will let us do that, I think is, will goes a long way because, you know, we may know what we think the answer is, but if we refer somebody to somebody's primary care and they don't have a clue as to what we're talking about or what we actually think, might benefit, then we're really not doing anything other than just sort of punting the problem somewhere else.

So case coordination in terms of collaborating with, with, with providers, I think can go a long way as well.

**Jen Miller:**

Thank you. I was going to ask you. you jump right in. So I love that. And I think there were some things in the chat. Anything else we want to share? Meg?

**Meg Hudson:**

Definitely for both of them. You know, coming from a psych perspective, these are two people that I would be looking at and thinking about, like, particularly our last friend who's feeling really paranoid and people are out to get her. From a safety perspective, I really worry about that. If people feel an increased need to protect themselves. And so I would be looking at, like, patterns of use of all their substances or particularly stimulants. And I would be assessing for, you know, is this an episodic, episodic psychosis in the setting of stimulant use. Do they have a persistent psychosis? Is there something that we could do to intervene here to give this person a little bit more support so they don't have to feel this way, whether or not they're using stimulants?

**Jen Miller:**

Right. And, Doctor Gonzalez, anything else you'd like to add about any of these cases?

**Dr. Alfredo Gonzalez:**

No, the second case, you know, she's an active patient of ours, and she continues to come to the OTP. We've known her for about six months. During that time, she started out in the outpatient department with psychiatry, ended up in the ATS unit. Not not long after that, spent about a month in the ATS CSS environment. Ended up being referred over to the OTP and the START clinic. Was put on some preventive medication, topamax, which she did quite well for, a few weeks. And then we lost her to follow up in terms of medications, but she continues to join as she continues to dose with us every day. And she is actively engaged with the START clinic, even though we continue to see the stimulant in her urine. She feels super supported. And, she just reengaged with a psychiatrist. And so she's sort of back on her meds. And during the time that she was medicated with topamax, she actually did stop. And we had some stimulant free urine, which was great. And so it's a longitudinal sort of relationship we have with these folks, and we have to meet them where they are. And, you know, you know, this is a chronic relapsing disease. And, and so, it's nice to, to see the patients feel supported, even when they're not doing great. So I think that that's been sort of what, what I take out of her case and, you know, that's what I have.

**Jen Miller:**

Awesome, I really appreciate you sharing that. And really glad to hear that she's doing well. So we wanted to give a quick overview of what the START clinics are.

Stimulant Treatment Recovery Teams are an outpatient program for people wanting to change their use of stimulants, including methamphetamine, crack cocaine, and other. Care is provided in a multidisciplinary team. As you can see, one of ours is actually co-located with an OTP. Others are co-located with, behavioral health or mental health, or soon to be in a, fairly qualified health center.

To learn more about those, you could scan today's QR code. We will also send this out. We're going to have a virtual open house on May 22nd. You could go to the one that's in your region or closest to your region. Because we can do some virtual options. We can do some telehealth and support for folks.

So, we'll make sure that this slide gets out to you all after the convening. If you don't have your phone right now, but we'd love to have you join the open house. And then I think we just have a few more resources that will come in. We have some drop in office hours - stimulant focused Thursdays afternoon. That's hosted by Grayken TTA, and then we have some harm reduction short videos which are around safer smoking,

injecting and, boofing and booty pumping, which I think is important to help your clients use safer if they are going to continue to use, and then we have some more TA fun things.

Questions. What questions you all have for us? We talked to you for a while. You can put them into this chat here, or you can put them into the chat. Otherwise, I think I'll stop sharing and let people see each other. What questions we got?

**Gretchen Shoemaker:**

We haven't received any in the chat, but please feel free to come off mute and ask your questions verbally while we're here. We've got about four-ish minutes just to chat before we need to transition.

**Jen Miller:**

I will say the one thing that we didn't highlight about the START clinics is that they have a component called the Cool Down Space, which allows for someone to be in a separate area to cool down, literally.

Now, you could think about how you could model that in your OTP. It could just be, you know, one of the counselors offices that's not using, so I think that those are things that we can think about in the future.

But I do see a question, “what psych meds do folks find most helpful for stimulant use?” So I'll turn it over to the professionals.

**Meg Hudson:**

It's a great question. And unfortunately, there's not one clear cut answer I wish that there was. But it it really depends on whether or not this person is experiencing that episodic psychosis in the setting of their use, or if they do have, you know, persistent psychosis, whether or not it's a primary kind of disorder or, you know, from those stimulants, for, for episodic psychosis with stimulant use.

I do like to use, olanzapine, just like what we use, in over, in the outpatient setting. I like olanzapine because it's fast acting and it's usually pretty well tolerated. And it comes in and orally disintegrating tablet. So I can give it to people that they can, like, keep one in their pocket. And if they start to experience psychosis, even if they don't have a bottle of water, they can take it.

Other, you know, short term meds that people could use, are certainly. Hello, paradigm. Sometimes, you know, if I'm thinking that this may be somebody that I might be

transitioning to a longer term medication, I might be looking at risperidone because that has a little easier transition into a long acting injectable. But there is some cool evidence for, you know, stimulant specific.

There are some cool studies on olanzapine as needed for methamphetamine induced psychosis and then reduced emergency room visits, and reduced use overall. So I wish there was a simpler answer, but I'm happy to talk about it at any time. And it depends on all the things.

Baclofen or other meds attempting to control cocaine cravings. Doctor Gonzalez, feel free to jump in if you'd like to. Is certainly there. Certainly. There's evidence for it. Primarily in the stamina treatment clinic. We use topiramate. I think that if if something is the right fit for your person with their overall regimen, and you have found it helpful in your practice, I think that's a good option, depending on the person.

**Dr. Alfredo Gonzalez:**

Yeah, I'll I'll just add to that. I still see a lot of baclofen being used. So baclofen topiramate and I think specifically for the cocaine treatment arm not forgetting about untreated ADHD or patients who are self-medicating. I think that that's a huge population, specifically for the cocaine side. So I think that, and that's probably part of, the outreach that, hopefully is occurring across the board for, anybody who's treating, psychiatric conditions.

I think that that, at High Point, I'm fortunate that we have a psychiatric team and, and but they are also embedded in our clinic. So I think that there's been a lot of, education as that went in. And so I do think that's the second part that I think, we should not forget.

Another one of the thoughts on Wellbutrin and Naltrexone slash vivitrol for that use disorder. I love it. I think it's fabulous for methamphetamine use disorder. Really, really great robust evidence that shows that high dose Wellbutrin around 450mg, and naltrexone, particularly in muscular 380mg is the vivitrol injection every 21 days. Is is quite effective for methamphetamine use disorder.

The complicated thing is that you are OTPs and people need you know, some of those medications are not going to to bode well for folks who are very stable on their methadone, or other amyloid. So, but the evidence is there for it. And there are people that I have worked with that, can't take vivitrol and so will still do high dose will be trained with good effect.

Another one you can do is March as a pin or reamer on. It will do for for methamphetamine cravings and do that around 30 to 45mg. Again with with really great results.

**Gretchen Shoemaker:**

Thank you all for joining us today. I hate to cut things short, but I'm just going to send over links for our next two sessions coming up. Thank you Meg. Thank you, Doctor Gonzalez and Jen. What a great conversation. I really appreciate everybody joining us for this session. Coming up. We have two different sessions for our last hour of the day.

We've got Providing Culturally Responsive Services to BIPOC Populations or Innovative Strategies for Patient Centered Care: Supporting Wellness. So please follow those links in the chat to join our next session. Thank you. Thank you all. Thank you, thank you, thank you so much. Welcome.