Opioid Response Network

Polysubstance Use & Integrated Treatment:

From Single-Substance Models to Person-Centered Care

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Opioid Response Network

Working with communities.

- The SAMHSA-funded *Opioid Response Network (ORN)* assists states, tribes, organizations and individuals by providing the resources and technical assistance they need locally to address the opioid crisis and stimulant use.
- Technical assistance is available to support the evidence-based prevention, treatment and recovery of opioid use disorders and stimulant use disorders.

Contact the Opioid Response Network

- To ask questions or submit a technical assistance request:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org

Substance Abuse and Mental Health Services Administration (SAMHSA)

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Learning Objectives- Part 1

- Understand how addiction treatment evolved from single-substance to polysubstance-informed models
- Identify clinical and behavioral health considerations in polysubstance use, including assessment challenges

Learning Objectives- Part 2

- Apply integrated, trauma-informed strategies—including MAT, collaborative care, and recovery supports
- Use screening tools and practical strategies to support individuals immediately

The Problem: Why Now? – Part 1

1980s Reality:

- Heroin users averaged 5.0 other illicit substances[1].
- But largely unrecognized.
- Treatment systems organized around single drugs.

Discussion:

How has polysubstance use changed in your practice over the past 3-5 years?

The Problem: Why Now? – Part 2

2024 Reality:

- 81% of opioid users have multiple substances monthly[2].
- 90% of fentanyl tests contain co-drugs[3].
- Polysubstance is the norm.

KEY STAT: Fentanyl + stimulant deaths increased 60-FOLD (2010-2021)[4]

Discussion:

How has polysubstance use changed in your practice over the past 3-5 years?

Driver 1: Drug Supply Contamination & Fentanyl – Part 1

The Scale:

- Fentanyl is 50x more potent than heroin[5]
- 90% of fentanyl-positive drug tests contain other substances[3]
- Many don't know they're mixing drugs
  - *(especially stimulant users unaware of fentanyl)[6]*

Discussion:

How does unintentional polysubstance exposure change your assessment approach?

Driver 1: Drug Supply Contamination & Fentanyl – Part 2

Geographic Variation:

- Northeast = Cocaine + Fentanyl
- West = Methamphetamine + Fentanyl
- *Your local supply determines the polysubstance patterns you see.*

Discussion:

How does unintentional polysubstance exposure change your assessment approach?

Driver 2: Drug Supply Contamination & Fentanyl – Part 1

The Statistics:

- 66.7% of people with OUD have co-occurring mental illness[2]
- 28.6% with serious mental illness
  - *(depression, PTSD, bipolar)[2]*

Discussion:
Why might someone choose polysubstance use over seeking mental health treatment?

Driver 2: Drug Supply Contamination & Fentanyl – Part 2

How Polysubstance Becomes Coping:

- People use multiple substances to manage:
  - Anxiety, trauma, pain, insomnia, mood disorders[7]
  - Barriers to mental health care → polysubstance becomes the coping mechanism

Discussion:

Why might someone choose polysubstance use over seeking mental health treatment?

Driver 3: Pharmacological Complementarity & Speed of Transition – Part 1

Intentional Mixing for Effect:

Opioid + Stimulant: Balance the high; manage comedown[7]

Stimulant + Depressant: Manage jitteriness; increase euphoria

Discussion:

Why do you think the gap between first and second drug use is shrinking so dramatically?

Driver 3: Rapid Transition Timeline[4]

1990s: 6.8 years between 1st & 2nd drug

2020s: 1.5 years between 1st & 2nd drug

This represents a nearly 5-fold acceleration in substance exposure.

Discussion:
Why do you think the gap between first and second drug use is shrinking so dramatically?

Assessment Challenges: Why Traditional Screening Falls Short – Part 1

Challenge 1: Knowledge Gaps

- Patients may not know what they consumed (adulterants, street names)

Challenge 2: Overlapping Symptoms

- Which drug causes what? Withdrawal vs. intoxication?

Challenge 3: Denial & Minimization

- Especially with alcohol, cannabis, benzodiazepines

Assessment Challenges: Why Traditional Screening Falls Short – Part 2

Challenge 4: Limited Testing

- Urine screens don't catch emerging drugs (xylazine, nitazenes)

Challenge 5: "Primary Substance" Blindness

- Asking only about primary substance misses 80% of the clinical picture

Screening Tools & Polysubstance-Specific Questions – Part 1

Quick Tool Comparison:

NIDA Quick Screen[5]	1-2 minutes | Initial screening
ASSIST[8]	5 minutes | Comprehensive assessment
PHQ-9 + GAD-7	5-10 minutes | Mental health screening

Discussion:

How would you adapt these questions for YOUR setting? Why would that change matter?

Key Polysubstance Assessment Questions – Part 1

Question 1:

"Which substances do you use most often? Rank them."

Question 2:

"Do you use them together on the same day, or separately?"

Discussion:

How would you adapt these questions for YOUR setting? Why would that change matter?

Key Polysubstance Assessment Questions – Part 2

Question 3:

"When did you start using [substance]? What was happening in your life then?"

Question 4:

"If you were going to quit, what would be hardest for you?"

Discussion:
How would you adapt these questions for YOUR setting? Why would that change matter?

Medication Interactions & Withdrawal Complexity[9] – Part 1

Withdrawal Severity by Substance:

OPIOIDS: Moderate withdrawal (uncomfortable, not life-threatening)

Management: MAT (buprenorphine, methadone)

ALCOHOL: SEVERE (seizures, hallucinations, death risk)

Management: Benzodiazepines, medical monitoring

Discussion:

How do you currently manage withdrawal decisions? Why might polysubstance withdrawal require a different approach?

Medication Interactions & Withdrawal Complexity[9] – Part 2

BENZODIAZEPINES: SEVERE (can last weeks; seizure risk)
Management: Slow taper over weeks, medical monitoring

CRITICAL INTERACTIONS:

- Opioid + Benzo = Respiratory depression (death risk)
- Opioid + Xylazine = Naloxone-resistant
- Alcohol + Any CNS depressant = Heightened OD risk

Discussion:
How do you currently manage withdrawal decisions? Why might polysubstance withdrawal require a different approach?

Levels of Care & Matching the Person – Part 1

OUTPATIENT: 1-2x per week | Stable, with support system, low risk

INTENSIVE OUTPATIENT (IOP): 9+ hours per week | Structured, but go home at night

RESIDENTIAL / INPATIENT: 24/7 onsite | Medical detox, severe poly + instability

Discussion:
How do you currently decide which level of care for polysubstance clients? What factors shift your decision?

Levels of Care & Matching the Person – Part 2

OPIOID TREATMENT PROGRAM (OTP):

Daily dosing + counseling | Severe OUD with polysubstance

CORE PRINCIPLE:

Start low, step up as needed. Not the other way around.

Discussion:

How do you currently decide which level of care for polysubstance clients? What factors shift your decision?

Medication-Assisted Treatment (MAT) for Polysubstance[10] – Part 1

BUPRENORPHINE:

Partial opioid agonist with ceiling effect

- ✓ Good for opioid + stimulant; reduces OD risk
- ⚠ Monitor benzodiazepine co-use carefully

METHADONE:

Full opioid agonist

- ✓ For severe OUD; better for pain
- ⚠ QT prolongation risk; harder to withdraw

Discussion:

Why might buprenorphine work better for polysubstance use than methadone? How does that change your prescribing?

(MAT) for Polysubstance[10] – Part 2

NALTREXONE IM:

Opioid antagonist (injected monthly)

- ✓ Blocks opioid euphoria
- ⚠ Requires 7-10 day opioid washout (high relapse risk)
- ⚠ Not ideal for active opioid use

KEY POINT: No single MAT works for all polysubstance patterns. Individualize.

Discussion:

Why might buprenorphine work better for polysubstance use than methadone? How does that change your prescribing?

Behavioral Interventions & Collaborative Care[11] – Part 1

EVIDENCE-BASED INTERVENTIONS:

CBT (Cognitive Behavioral Therapy):	Identify triggers for each substance; develop coping
MI (Motivational Interviewing):	Resolve ambivalence; build intrinsic motivation
Contingency Management:	Incentivize negative UAs and adherence

Discussion:

Why does one clinician alone struggle with polysubstance complexity? How could you build or strengthen collaboration in your agency?

Collaborative Care Team[11] – Part 2

WHY ONE CLINICIAN CANNOT DO THIS ALONE:

- MD/NP: MAT, medical stabilization, physical health
- Counselor: Individual therapy, coping skills, engagement
- Psychiatrist: Co-occurring mental health (depression, PTSD, bipolar)
- Social Worker: Housing, benefits, employment, family
- Peer Specialist: Lived experience, recovery modeling, mutual support

Discussion:
Why does one clinician alone struggle with polysubstance complexity? How could you build or strengthen collaboration in your agency?

Trauma-Informed Care & Recovery-Oriented Approach[8] – Part 1

THE CONNECTION:

- 50-70% of people in SUD treatment have trauma history[8]
- Polysubstance often = self-medication for PTSD, shame, dissociation
- Multiple drugs manage multiple trauma symptoms

Discussion:

Why does person-first language matter more in polysubstance treatment? How might shame be compounded?

5 Core Trauma-Informed Principles[8] – Part 1

SAFETY: Predictable, no shame, freedom from coercion

TRUSTWORTHINESS: Transparent, consistent, staff model safe relationships

PEER SUPPORT: Connect with others in recovery; reduce isolation

Discussion:

Why does person-first language matter more in polysubstance treatment? How might shame be compounded?

5 Core Trauma-Informed Principles[8] – Part 2

COLLABORATION:

Individuals are partners in treatment, not passive recipients

EMPOWERMENT: Focus on strengths, resilience, restore agency and choice

PERSON-FIRST LANGUAGE MATTERS:

"Person with OUD" not "addict" | "Returned to use" not "relapsed" | "UA with substances" not "dirty test"

Key Takeaways: What You Can Do Monday Morning – Part 1

- Use comprehensive screening (ASSIST or NIDA Quick Screen)
  - *instead of single-substance focus*
- Ask explicit polysubstance questions:
  - *together or separate? frequency? drivers? barriers to quitting?*
- Know withdrawal management by substance
  - *understand when you need medical oversight*

Key Takeaways: What You Can Do Monday Morning – Part 2

- Offer MAT as first-line treatment
  - *understand drug interactions; avoid dangerous combinations*
- Build trauma-informed, person-centered teams
  - *one clinician cannot address polysubstance complexity alone*
- Use person-first language; destigmatize; believe recovery is possible

Key Takeaways: What You Can Do Monday Morning – Part 3

- Integrate mental health, housing, peer support, and medication
  - *into treatment plan for every client*

The Path Forward

Polysubstance use is complex.

But so is recovery.

With integrated treatment, trauma-informed care, and hope in every interaction, you help people rebuild their lives.

Thank you for the critical work you do.

ORN Evaluation Survey Link

The grant that provided funding for this training requires that we request you to complete the brief survey linked below. Your feedback is important and provides support for this type of work to continue. Scan the QR Code to access the SAMHSA feedback survey.

The survey will ask about your satisfaction with the training program you just completed as well as some basic demographic information. Your responses will help the Opioid Response Network improve the services they provide.

Thank you in advance for completing this survey!

OPTIONAL: Case Discussion #1 – Complex Presentation – Part 1

SCENARIO: Maria, 38 years old

- Uses: Heroin + Fentanyl + Methamphetamine + Alcohol (3-4 drinks daily)
- History: Sexual trauma, lost custody of children 2 years ago
- Current: Homeless, using with partner, no insurance
- Recent: Last overdose 2 months ago (reversed with naloxone)

- *How would you assess for trauma safely without re-traumatizing?*

Discussion:

Small-Group Discussion (skip if time is short)

OPTIONAL: Case Discussion #1 – Complex Presentation – Part 2

DISCUSSION QUESTIONS (continued):

- *How would you address competing needs (housing, custody, substance use)?*
- *Why might traditional single-substance treatment fail for this client?*

Discussion:

Small-Group Discussion (skip if time is short)

OPTIONAL: Case Discussion #2 – "Functioning" Polysubstance Use

SCENARIO: James, 52 years old

- Occupation: Accountant, employed full-time, stable housing
- Uses: Alcohol (nightly, 4-6 drinks) + Benzodiazepines (escalating) + Occasional opioid painkillers
- Presentation: Minimizes use; never sought treatment
- Family: Wife concerned about mood swings, forgetfulness

- *DISCUSSION: How would you open this conversation non-judgmentally?*

Discussion:

Small-Group Discussion (skip if time is short)

References – Part 1

[1] Volkow, N. D., Collins, F. S., & Baler, R. D. (2020). Polysubstance use in the U.S. opioid crisis. Nature Molecular Psychiatry, 26, 41–50.

[2] SAMHSA National Survey on Drug Use and Health. (2018). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.

[3] Substance Abuse and Mental Health Services Administration. (2025). Fentanyl and polysubstance involvement in overdose deaths. SAMHSA Publications.

[4] Gomes, T., Greaves, S., Tadrous, M., Mamdani, M. M., & Paterson, J. M. (2020). Polysubstance involvement in opioid overdose deaths. Molecular Psychiatry, 26, 41–50.

References – Part 2

[5] National Institute on Drug Abuse. (2023). Fentanyl. https://www.drugabuse.gov/publications/drugfacts/fentanyl

[6] Davoli, M., Carvalho, M., Krotulski, A. J., et al. (2023). Knowledge, attitudes, and behaviors related to the fentanyl-adulterated drug supply among PWUD in Oregon. International Journal of Environmental Research and Public Health, 20(3), 2038.

[7] Nicholson, S., Greville-Harris, M., & Knowles, K. (2020). Patterns, contexts, and motivations for polysubstance use among people who inject drugs in the U.S. Northeast. Drug and Alcohol Dependence, 215, 108186.

[8] Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. PEP14-CONCP). https://store.samhsa.gov

References – Part 3

[9] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

[10] SAMHSA. (2016). Medications for opioid use disorder (Treatment Improvement Protocol TIP 63). HHS Publication No. PEP16-02-01-006.

[11] National Institute on Drug Abuse. (2018). Principles of drug abuse treatment for criminal justice populations. https://www.drugabuse.gov/publications