



**UW PACC**

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

# **POLYSUBSTANCE USE IN THE TREATMENT OF OPIOID USE DISORDER WITH BUPRENORPHINE**

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# SPEAKER DISCLOSURES

- ✓ Any conflicts of interest-none

# OBJECTIVES

- ☐ Understand the benefits and risks of treating opioid use disorder (OUD) in the context of polysubstance use
- ☐ Understand interventions available for alcohol, benzodiazepine, and stimulant use disorder
- ☐ Discuss programmatic approaches to ongoing polysubstance use

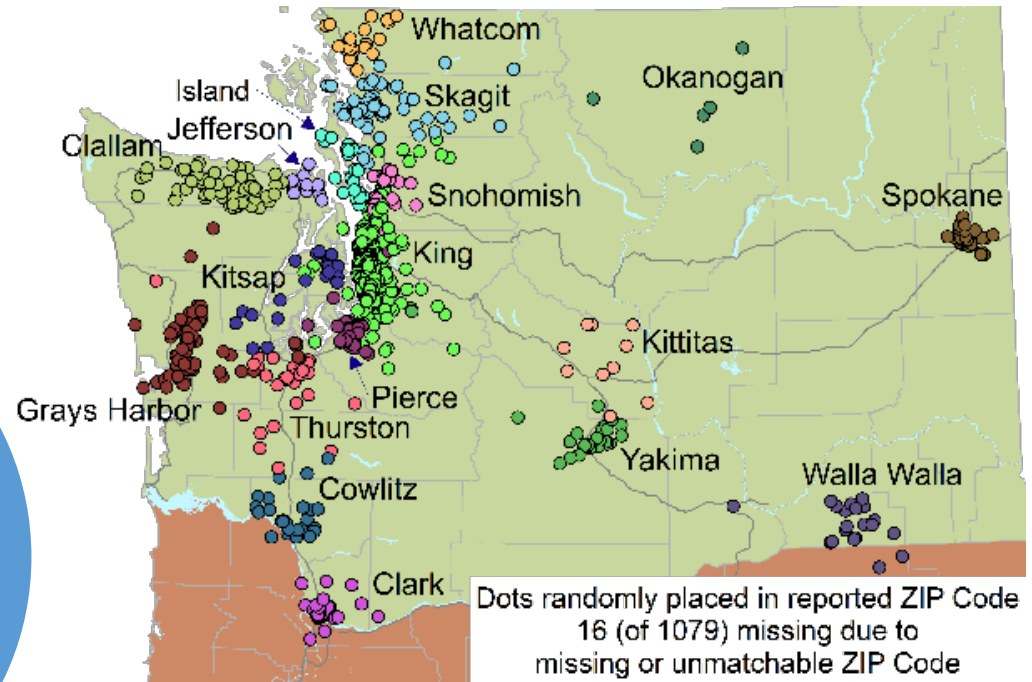
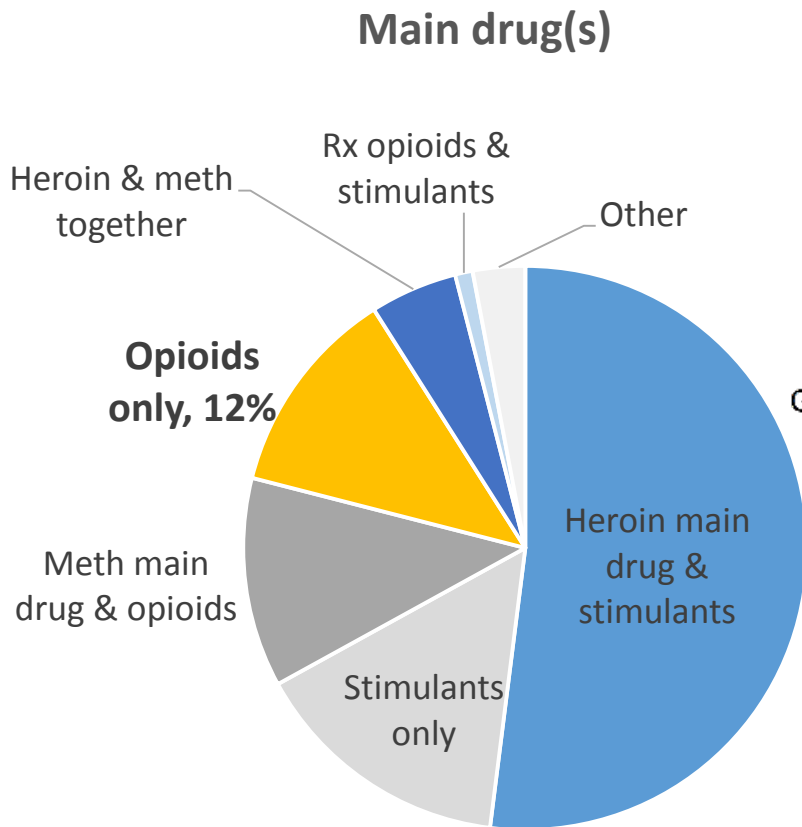
# POLYSUBSTANCE USE IS COMMON

Common in OUD patients:

- Up to 70% lifetime
- Cocaine (6-68%)
- Alcohol (25-49%)
- Cannabis (8-41%)

# BACKGROUND:

## 2017 WA STATE SYRINGE EXCHANGE SURVEY



*Note: Your local syringe exchange has been provided their specific data. State report to be released in December 2017.*

# WHY WORRY ABOUT POLYSUBSTANCE USE?

- A. Associated with greater psychopathology
- B. Increased levels of risky behaviors
- C. Poor treatment engagement
- D. Death
- E. A and D
- F. All the above

# THE POLYSUBSTANCE BIND?

*How do you weigh those risks?*

Treating in  
polysubstance  
context

Risks of  
untreated  
OUD

*Bias*



# BENZODIAZEPINES AND OUD

## TREATMENT-*THE RISKS*

Sample: All veterans (N = 32,422) in 2007 with OUD Diagnosis

Opioid/Benzo Rx Status	12 month Mortality Rate	24 month Mortality Rate
Prescribed	4.3%	8.3%
Not Prescribed	3.1%	6.2%
% Change	29%	27%

Sample: Swedish pts with Bup/Meth Rx's for OUD from 2005-2012 (N = 4501)

Sensitivity Analysis	
Benzodiazepine Prescriptions and Overdose Deaths	HR 1.53 (CI 1.11-1.96)



# Benzodiazepines and OUD Treatment

**Sample:** Admissions to Primary Care-Nurse Care Manager Program over 12 months (N=386)

## Benzo Misuse vs No Benzo Misuse

- No impact on treatment retention
- No impact on illicit opioid or cocaine use
- Prescribed benzos → more ED visits due to accidental injury (OR=3.75)
  - Worse among women
- No one died in treatment

**Takeaway:** Concurrent Benzos lead to more ED visits

# BENZODIAZEPINES AND OUD TREATMENT

Sample: Patients receiving first-time OUD treatment in the Ontario Addiction Treatment Centers (N=3850)

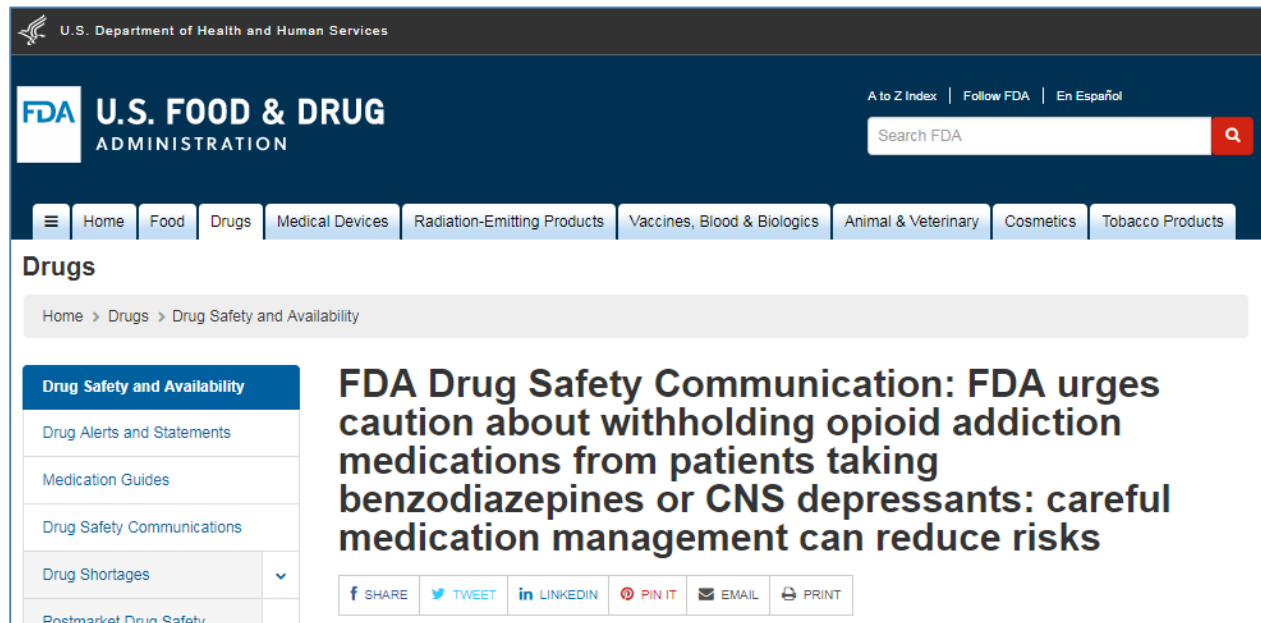
1-year treatment retention

- Benzodiazepine users: 39.9%
- Non-Benzodiazepine users: 44%
- *When > 75% urine positives for benzodiazepines → 175% more likely to drop out*

# RISK OF UNTREATED OUD

- >90% relapse in some studies
- Mortality rates
  - 0.7 per 100 person years ON MAT
  - 1.3 per 100 person years OFF MAT
  - Weeks 1-2 off treatment: 4.8 per 100 person years
  - Weeks 3-4 off treatment: 4.3 per 100 person years

# FDA ON MEDICATION MANAGEMENT



Implication: Concurrent CNS depressant use is not a contraindication to treating OUD with buprenorphine, despite the increased risk of mortality

# ALCOHOL AND OUD TREATMENT

- Can reduce levels of engagement early in care
- Associated with increased risk for death when combined with methadone and buprenorphine

# STIMULANTS AND OUD TREATMENT

- Notable in OUD treatment
  - Higher opioid use at baseline
  - Higher relapse rates
  - Worse adherence to Buprenorphine
  - Increased risk of dropping out

# CANNABIS AND OUD TREATMENT

Possible Impact	No Impact
4 Studies (N=1804)	7 Studies (N=982)
<ul style="list-style-type: none"><li>• Predict relapse</li><li>• Associated with opioid use</li><li>• Predict dropping out</li><li>• Women: more significant at baseline?</li><li>• Men: more significant if heavy user?</li></ul>	<p>No impact on:</p> <ul style="list-style-type: none"><li>• retention</li><li>• functional level</li><li>• drug use</li><li>• employment days</li></ul> <p>**Studies mostly included only</p> <p>**Cannabis Use Disorder by itself is problematic</p>

## Summary: Inconsistent Findings → Risks do not outweigh benefits

- Differing definitions of cannabis use
- Differing sensitivities of urine drug screen analysis
- Demographics
- Confounding issues → mental health

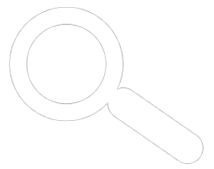
# OUD TREATMENT IMPACT ON OTHER SUBSTANCES

- May reduce use of other substances
  - Sample: African American Patients in Bup/Nal treatment at 12 months vs out of treatment (N=142)

	In Treatment	Out of Treatment
Days of Alcohol Use	1.44	7.12
Days of Cocaine Use	0.85	3.69

- Methamphetamines
  - Buprenorphine can reduce methamphetamine cravings





## CASE #3

41-year-old male on Bup-Nal 12mg-4mg, who is trying treatment for his opioid use disorder again.

After 6 weeks, he has missed one appointment but called to reschedule later that day. He works, has housing, and does not have psychosocial support. Urine drug screens have remained positive for buprenorphine/norbuprenorphine, methamphetamines, and cannabis only.

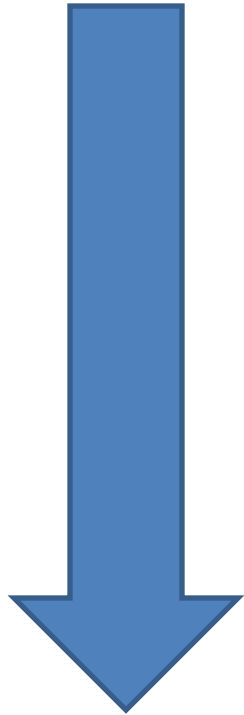
*What are some other approaches you could try?*

# NEXT STEPS

# IDENTIFICATION OF SUBSTANCES

- Ask the patient
- Presentation of patient
- Urine Drug Screens
  - Alcohol: EtG (Ethyl Glucuronide) - very sensitive (1 drink)
- Cannabis use disorder?
  - Use Cannabis Use Disorder Identification Test-Revised (CUDIT-R)

# INTERPRETING THE URINE DRUG SCREEN



- Is buprenorphine present?
- Any opioids?
- Any benzodiazepines?
- Any Alcohol?
- Any stimulants?
- Any cannabis?

## **Place in Context**

Is this consistent with history provided by patient?  
What has been the treatment trajectory?

# EVALUATION

- Why are they using it?
  - Opioid use disorder not adequately treated?
  - Another substance use disorder?
  - Psychiatric condition?
  - Stress management?
  - Others?



# EVALUATION:

## OD NOT ADEQUATELY TREATED?

- Concerning signs?
  - Intoxication
  - Positive urine drug screens
  - Withdrawal symptoms
  - Cravings
  - People, places, things
- Potential Specific Treatment Adjustments
  - Bup Dose Adjustment?
  - Med change?
  - Help taking their meds?
  - Increase/change psychosocial support
  - Ask: How can I best support you?

# EVALUATION:

## ANOTHER SUBSTANCE USE DISORDER?

- Concerning signs?
  - Intoxication
  - Positive urine drug screens
  - Withdrawal symptoms
  - Cravings
  - People, places, things
- Potential Treatment Adjustments?
  - Increase psychosocial support
  - Additional MAT?

# ANOTHER SUBSTANCE USE DISORDER?

## TREATMENT OPTIONS (CONT'D)

### 1. Psychosocial Support

- Critical for Alcohol Use Disorders
  - CBT
  - 12 step groups
- Critical for Stimulant Use Disorders
  - Only consistently effective approach
    - CBT
    - Contingency Management
- Safer Use Tips
  - Harm Reduction Strategies
  - <https://depts.washington.edu/harrtlab/resources/>



# ANOTHER SUBSTANCE USE DISORDER?

## TREATMENT OPTIONS

### 2. Medication Assisted Treatment (MAT)

- Alcohol MAT options
  - Acamprosate, Disulfiram, *Topiramate*, Gabapentin
- Cocaine MAT options
  - Disulfiram
- Methamphetamine
  - Bupropion, Mirtazapine (very modest)
- Cannabis
  - Gabapentin (for withdrawal)

# EVALUATION: PSYCHIATRIC DISORDER?

- Concerning signs?
  - Appearance
  - Mood
  - SI
- Potential Treatment Adjustments?
  - Use screeners
  - Treat as indicated (will discuss further during next session)
  - Treat anxiety and taper Benzo (see PACC talk from 11/1/18)

# EVALUATION: STRESSORS

- Concerning signs?
  - Homeless
  - Lots of unstructured time
- Potential Treatment Adjustments?
  - Clonidine augmentation?
  - Housing support
  - Vocational support
  - Legal support
  - Goals for week

# CASE #3, Continued

41-year-old male on Bup-Nal 12mg-4mg, who is trying treatment for his opioid use disorder again.

Week 12. Sporadically misses appointments. Still working, has housing, and no psychosocial support. Urine drug screens have remained positive for buprenorphine/norbuprenorphine, methamphetamines, and cannabis.

More information: he uses amphetamines daily to help with work, and cannabis 2 times a week to help “wind down.” Also admits to liking the high.

*What could be some programmatic approaches to try?*

# PROGRAMMATIC APPROACHES

- Build into workflow regular screens
- **Have a plan to address it**
- Be mindful of impact on other patients use
- **Staff support**

# TOOLS TO INCREASE SAFETY & REDUCE HARMS

## *(ADDING STRUCTURE TO YOUR PROGRAM)*

Program Change	Notes
Increase frequency of visits	For ongoing substance use, help build therapeutic alliance, help to problem solve earlier.
Reduce number of Buprenorphine Rx'd	To reduce risk of overdose and diversion.
Increase frequency of urine drug screens	Weekly? Help assess overdose and diversion risk.
Observed dosing	Does not have to be all the time, but could be for patients at high risk for diversion. Could be implemented on a larger scale if resources available→onsite pharmacy.
Observed urine drug screens	If concerns for sample tampering.
Pill counts and call backs	Ongoing withdrawal or use. Diversion?
Increase psychosocial support	If have supportive family (may need some psychoed). Onsite mental health. Med group visits. Peer group.

# TOOLS TO INCREASE SAFETY & REDUCE HARMS

## *(ADDING STRUCTURE TO YOUR PROGRAM)*

Visit Approaches	Notes
Setting goals every visit	
Using a measurement based tool	Brief Addiction Monitor, Short Inventory of Problems, Treatment Effectiveness Assessment
Reviewing Safer Use Sheets	<a href="https://depts.washington.edu/harrtlab/resources/">https://depts.washington.edu/harrtlab/resources/</a>
Prescribe and manage Benzo use	Outpatient taper. Use Clonazepam to taper and to be able to distinguish it from other benzodiazepine

# TOOLS TO INCREASE SAFETY & REDUCE HARMS

## *(ADDING STRUCTURE TO YOUR PROGRAM)*

### Potential Structure in Practice

Scenario	Notes
1: Low risk patient -occasional other drug use	Visits every month, random urine drug screens, no additional psychosocial support. Month long prescriptions.
2: Moderate risk patient -frequent other drug use -occasionally missing appointments	Visits 2 times a month with more frequent urine drug screens, 2 week prescriptions. Use measurement tool.
3: High risk patient -regular opioids and other substances -denying other drug use -missing appointments	Weekly? Weekly prescriptions and urine drug screens. Safer use tips review. Observed dosing at every visit (regular-if available). Combined psychosocial visits with mental health. Discussed in team meeting. Use measurement tool.
Diversion concerns	Observed dosing and urine drug screens. Call backs with pill counts. Weekly visits. Limited prescriptions.



# DISCUSSION



Are there any legal ramifications to keeping or discharging patients with ongoing illicit opioid and polysubstance use?

- None known
- Document treatment decision clearly
- Note WA State MAT Guidelines
- <https://www.hca.wa.gov/assets/billers-and-providers/Clinical-guidelines-coverage-limitations.pdf>

# DISCUSSION



What Are The Benefits To Keeping Patients in Treatment With Ongoing Polysubstance Use?

# DISCUSSION



Are There any Harms To Keeping Patients in Treatment  
With Ongoing Polysubstance Use?

# DISCUSSION



How does your clinic handle polysubstance use?

- Are you checking for it and how?
- If a person is found to be using other substances, what do you do next?