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

Bias

Risks of untreated OUD
# BENZODIAZEPINES AND OUD TREATMENT - THE RISKS

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

<table>
<thead>
<tr>
<th>Opioid/Benzo Rx Status</th>
<th>12 month Mortality Rate</th>
<th>24 month Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed</td>
<td>4.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Not Prescribed</td>
<td>3.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>% Change</td>
<td>29%</td>
<td>27%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Sensitivity Analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepine Prescriptions and Overdose Deaths</td>
<td>HR 1.53 (CI 1.11-1.96)</td>
</tr>
</tbody>
</table>

Abrahamsson T et al, 2017; Watkins K et al, 2017
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 $\rightarrow$ 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

Shuman-Olivier Z et al, 2013
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

Franklyn AM et al, 2017
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

Weiss RD et al, 2011; Cornish R et al, 2010
Implication: Concurrent CNS depressant use is not a contraindication to treating OUD with buprenorphine, despite the increased risk of mortality.

Source: https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm
ALCOHOL AND OUD TREATMENT

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

Kreek MJ, 1984
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

<table>
<thead>
<tr>
<th>4 Studies (N=1804)</th>
<th>7 Studies (N=982)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Predict relapse</td>
<td>No impact on:</td>
</tr>
<tr>
<td>• Associated with opioid use</td>
<td>• retention</td>
</tr>
<tr>
<td>• Predict dropping out</td>
<td>• functional level</td>
</tr>
<tr>
<td>• Women: more significant at baseline?</td>
<td>• drug use</td>
</tr>
<tr>
<td>• Men: more significant if heavy user?</td>
<td>• employment days</td>
</tr>
</tbody>
</table>

**Studies mostly included only

**Cannabis Use Disorder by itself is problematic

### 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)

<table>
<thead>
<tr>
<th></th>
<th>In Treatment</th>
<th>Out of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Alcohol Use</td>
<td>1.44</td>
<td>7.12</td>
</tr>
<tr>
<td>Days of Cocaine Use</td>
<td>0.85</td>
<td>3.69</td>
</tr>
</tbody>
</table>

• Methamphetamines
  – Buprenorphine can reduce methamphetamine cravings

Salehi, M et al 2015; Monico, LB et al 2018
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: OUD 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?

Heikman P, et al, 2017
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/

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

Kowalczyk W et al, 2015
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)

<table>
<thead>
<tr>
<th>Program Change</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase frequency of visits</td>
<td>For ongoing substance use, help build therapeutic alliance, help to problem solve earlier.</td>
</tr>
<tr>
<td>Reduce number of Buprenorphine Rx’d</td>
<td>To reduce risk of overdose and diversion.</td>
</tr>
<tr>
<td>Increase frequency of urine drug screens</td>
<td>Weekly? Help assess overdose and diversion risk.</td>
</tr>
<tr>
<td>Observed dosing</td>
<td>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.</td>
</tr>
<tr>
<td>Observed urine drug screens</td>
<td>If concerns for sample tampering.</td>
</tr>
<tr>
<td>Pill counts and call backs</td>
<td>Ongoing withdrawal or use. Diversion?</td>
</tr>
<tr>
<td>Increase psychosocial support</td>
<td>If have supportive family (may need some psychoed). Onsite mental health. Med group visits. Peer group.</td>
</tr>
</tbody>
</table>
# TOOLS TO INCREASE SAFETY & REDUCE HARMS
*(ADDING STRUCTURE TO YOUR PROGRAM)*

<table>
<thead>
<tr>
<th>Visit Approaches</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting goals every visit</td>
<td></td>
</tr>
<tr>
<td>Using a measurement based tool</td>
<td>Brief Addiction Monitor, Short Inventory of Problems, Treatment Effectiveness Assessment</td>
</tr>
<tr>
<td>Reviewing Safer Use Sheets</td>
<td><a href="https://depts.washington.edu/harrtlab/resources/">https://depts.washington.edu/harrtlab/resources/</a></td>
</tr>
<tr>
<td>Prescribe and manage Benzo use</td>
<td>Outpatient taper. Use Clonazepam to taper and to be able to distinguish it from other benzodiazepine</td>
</tr>
</tbody>
</table>
## TOOLS TO INCREASE SAFETY & REDUCE HARMs
*(ADDING STRUCTURE TO YOUR PROGRAM)*

### Potential Structure in Practice

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Low risk patient</td>
<td>Visits every month, random urine drug screens, no additional psychosocial support. Month long prescriptions.</td>
</tr>
<tr>
<td>- occasional other drug use</td>
<td></td>
</tr>
<tr>
<td>2: Moderate risk patient</td>
<td>Visits 2 times a month with more frequent urine drug screens, 2 week prescriptions. Use measurement tool.</td>
</tr>
<tr>
<td>- frequent other drug use</td>
<td></td>
</tr>
<tr>
<td>- occasionally missing appointments</td>
<td></td>
</tr>
<tr>
<td>- regular opioids and other</td>
<td></td>
</tr>
<tr>
<td>substances</td>
<td></td>
</tr>
<tr>
<td>- denying other drug use</td>
<td></td>
</tr>
<tr>
<td>- missing appointments</td>
<td></td>
</tr>
</tbody>
</table>
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

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?