



UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

ADDRESSING PSYCHIATRIC POLYPHARMACY IN OUD TREATMENT

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

GENERAL DISCLOSURES

UW PACC is also supported by Coordinated Care
of Washington

SPEAKER DISCLOSURES

- ✓ No conflicts of interest
- ✓ I have some patients on way too many meds
- ✓ I have a patient on methadone and clonazepam

SPEAKER ACKNOWLEDGEMENT

Special thanks to Dr. Lora Jasman

PLANNER DISCLOSURES

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Anna Ratzliff MD PhD has received book royalties from John Wiley & Sons (publishers).

OBJECTIVES

1. Describe a strategy to assess current medication regimen
2. Develop a plan for reducing polypharmacy

CASE 1

- 49yo M with severe Alc use disorder and sequela (pancreatitis, cirrhosis, subdural hematoma), severe Meth use disorder, and OUD. PTSD-childhood and adult trauma. History of auditory hallucinations. ED visits eclipsed 200/year. Now in assisted care and much more stable → 1 ED visit/month.
- Current medications
 1. Bup-Nal 16-4mg qday
 2. Sertraline 200mg qday
 3. Gabapentin 400mg TID for anxiety
 4. Prazosin 6mg qhs for NMs
 5. Quetiapine 100mg BID
 6. Hydroxyzine 50mg TID prn

Question: Can I wean off any of these medications?

CAN/SHOULD I WEAN OFF SOME OF HIS MEDICATIONS?

- A. Yes-Start with *Gabapentin*
- B. Yes-Start with *Hydroxyzine*
- C. Yes-Start with *Sertraline*
- D. Yes-Start with *Prazosin*
- E. Yes-Start with *Quetiapine*
- F. No-never he is stable
- G. No-not right now

QUESTION: CAN I WEAN OFF ANY OF THESE MEDICATIONS?

- Complicated
 - Correct diagnosis?
 - Adequate medication trials?
 - Little history to go on
 - Limited time in primary care
 - Limited access to mental health

QUESTION: CAN I WEAN OFF ANY OF THESE MEDICATIONS?

Step 1: Provider Assessment

- *What medications would you (the provider) like to stop?*
 - Risks/Benefits
 - Minimal or no evidence for use
 - Check bias

QUESTION: CAN I WEAN OFF ANY OF THESE MEDICATIONS?

Step 2: Patient Assessment

- *Take a medication history → what is essential?*
 - What will be least disruptive if I stop it?
 - May give you clues about diagnosis

What Questions would you ask?

1. Why was this medication started?
2. What has this medication done for you?
(keep it neutral)
3. How are you taking the medication?
4. Other symptoms?

CASE 1

- 49yo M with AUD, MethUD, OUD, PTSD, auditory hallucinations(?). Now stable in assisted living facility.

Question: Can I wean off any of these medications?

- Current medications
 - Bup-Nal 16-4mg qday
 - Sertraline 200mg qday
 - Gabapentin 400mg TID
 - Prazosin 6mg qhs
 - Quetiapine 100mg BID
 - Hydroxyzine 50mg TID prn

What medications would you like to stop?

CASE 1

What medications would you like to stop?

Provider Assessment

- Current medications

- Bup-Nal 16-4mg qday

- Comment: Essential

- Sertraline 200mg qday

- Comment: PTSD sounds likely. SSRIs 1st line.

- Gabapentin 400mg TID

- Comment: needs assessment. Can be helpful for protracted withdrawal, anxiety evidence is questionable, potential sedation issues.

- Prazosin 6mg qhs

- Comment: Plausible. Can be helpful for PTSD related NMs. Dose is reasonable.

- Quetiapine 100mg BID

- Comment: needs a focused assessment. What is the indication? Significant short-term and long-term side effects.

- Hydroxyzine 50mg TID prn

- Comment: needs assessment. Potential interactions with Quetiapine and prn medication use is questionable.

GABAPENTIN AND ANXIETY/PTSD

- **GAD:** no trials (yes for Pregabalin 150mg-600mg)
- **SAD, Anxiety NOS:** helpful, but small short trials
- **PTSD:** limited evidence for NMs and sleep disturbance, (Pregabalin is not recommended in VA PTSD guidelines as augmenting agent due to very low quality of evidence).

GABAPENTIN AND OUD

- In people with untreated OUD in Appalachia (N=503), 15% reported using Gabapentin “to get high.”
- N=401 at opioid detox center, 81% used to treat pain
 - Other: get high, increase effects of heroin, substitute for opioids, help with opioid w/d
- Concomitant use with opioids increases risk of opioid OD and death.

Stein MD et al, 2020; Smith RV et al, 2015; Gomes T et al, 2017

QUETIAPINE

- Evidence for: Bipolar disorder, Psychotic disorders, Depression, OCD, PTSD
 - PTSD: has been found to be effective in 12 week RCT, N=80
 - VA does not recommend due to lack of strong evidence
- Risks: metabolic, akathisia, EPS, TD, Prolactin elevation, Sedation, Anticholinergic, QTc prolongation...

CASE 1

What medications would you like to stop?

Patient Assessment

What Questions would you ask?

1. Why was this medication started?
2. What has this medication done for you?
3. How are you taking the medication?
4. Other symptoms?

- **Current medications**

- Bup-Nal 16-4mg qday

“This really helps.”

- Sertraline 200mg qday

“I don’t know what this is doing.”

- Gabapenting 400mg TID

“I think this helps my anxiety.”

- Prazosin 6mg qhs

“This helps my NMs.”

- Quetiapine 100mg BID

“I need this to sleep.”

“I am tired during the day.”

- Hydroxyzine 50mg TID prn

“I don’t have auditory hallucinations.”

“I take this 3/7 days when I feel anxious.”

CASE 1: PUTTING IT TOGETHER

- 49yo M with AUD, MethUD, OUD, PTSD, auditory hallucinations(?). Now stable in assisted living facility.

Question: Can I wean off any of these medications?

Meds	Indications/Risks	Pt Assessment
Gabapentin 400mg TID	?PTSD, Sedation, Polypharmacy. Unlikely to OD on it.	Thought it helps his anxiety.
Quetiapine 100mg BID	PTSD-likely helpful. Psychosis? Significant side effects. Minimize exposure.	Helps with sleep, but with daytime fatigue. No hallucinations.
Hydroxyzine 50mg TID prn	Prn use of anxiety. Another sedating med. Sporadic use.	Sporadic use.

CAN/SHOULD I WEAN OFF SOME OF HIS MEDICATIONS?

- A. Yes-Start with *Gabapentin*
- B. Yes-Start with *Hydroxyzine*
- C. Yes-Start with *Quetiapine*
- D. No-never he is stable
- E. No-not right now

CASE 1: PUTTING IT TOGETHER

- 49yo M with AUD, MethUD, OUD, PTSD, auditory hallucinations(?). Now stable in assisted living facility.

Question: Can I wean off any of these medications?

My Proposed Plan

1. start tapering Gabapentin now
 - least disruptive and has the most questionable evidence base for its use
2. Then stop hydroxyzine
3. Taper to lowest effective dose of Quetiapine, with the ultimate plan to try to come off of it.

CASE 2

- 37yo M with severe OUD discharged from inpatient treatment after 3 weeks. Presents for ongoing Buprenorphine maintenance treatment, and medication management for his co-occurring Generalized Anxiety Disorder. The patient has used both illicit and prescribed benzos in the past. This is his first time using Bup-Nal.
- Current medications
 1. Bup-Nal 24-6mg qday
 2. Clonazepam 2mg TID

Question: Should the Clonazepam be continued?

SHOULD I CONTINUE THE CLONAZEPAM?

- A. **Yes**-she is stable right now
- B. **Yes**-the combination of Bup and Benzo's are not that dangerous
- C. **Yes**-but lower the dose
- D. **No**-the combination of Bup and Benzo's are dangerous
- E. You have it all wrong

BENZODIAZEPINES AND OUD

- There is no evidence that benzodiazepines have a unique role in treating anxiety disorders in OUD.

ANXIETY DISORDERS AND OUD

- Use the typical antianxiety/antidepressants medications with efficacy for the specific anxiety disorder.
- Therapy is going to be most effective.

WHAT IS THE BEST WAY TO TAPER BENZODIAZEPINES IN OUD?

TAPERING ILLICIT BENZO USE IN OUD TREATMENT

- Outpatient, Long Island City, NY, RCT, Placebo
- N=19 on Methadone Maintenance
- Intervention
 - Gabapentin for benzo w/d (up to 1200mg TID)
 - Abstinence oriented therapy
 - Psychoed to reduce illicit benzos on own
- Results: no difference vs Placebo
 - Both groups reduced their use the same
 - No benzo w/d complications
 - Retention 50% at week 8

IF YOU ARE PRESCRIBING THE BENZOS?

- Assess for what they are treating
- Weigh risks and benefits of ongoing treatment
- *Consider planned taper*
- Treat underlying condition as needed



Effective Treatments for PTSD:
Helping Patients Taper
from Benzodiazepines

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/59_PTSD_NCPTSD_Provider_Helping_Patients_Taper_BZD.pdf

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- D. **No**-the combination of Bup and Benzo's are dangerous
- E. You have it all wrong

CASE 2: PUTTING IT TOGETHER

- 37yo M with severe OUD and GAD. Pt wants to stay on Clonazepam. No illicit opioid use. On Clonazepam 2mg TID and Bup 24mg qday.

Question: Should the Clonazepam be continued?

My Proposed Plan

1. Planned taper
2. Assess and treat for co-occurring anxiety disorder
 - Ideally refer to therapy

CASE 3

- 25yo F with OUD and a past diagnosis of Schizoaffective disorder. On intake her urine drug screen is positive for opioids, THC, methamphetamine. Presentation at clinic is notable for some mild drowsiness, indurated conjunctiva, and depressed mood. Her induction on Buprenorphine is uneventful and she is at now at 16mg Qday.
- 2 weeks after induction, she starts to come late to appointments, misplaces her meds necessitating early refills, and endorses auditory hallucinations and paranoia. Drug testing: meth, Bup, THC
- Current medications
 1. Bup-Nal 16-4mg qday

Question: What would you do next?

WHAT WOULD YOU DO NEXT?

- A. Test for meth and wait it out
- B. Start Olanzapine
- C. Refer for inpt psych
- D. Start Risperidone
- E. Other

RISPERIDONE & METHAMPHETAMINE USE DISORDER

- Open trial, VA, Meth dependence, N=11, 34
- Oral (3-4mg qday) x 4 weeks and IM (25mg) x 8 weeks.
- IM included 8 weekly ind relapse prevention sessions
- Results
 - Reduced methamphetamine use
 - Oral: 13/30 days → 0.125/30 days
 - IM: 4/7 days → 1/7 days
- Other study results
 - Reduced psychosis
 - Reduced cravings

Meredith CW et al, 2007 and 2009; Wang G et al, 2017

CASE 3

- 25yo F with OUD and a past diagnosis of Schizoaffective disorder. Presenting with psychosis and positive urine drug screen for meth and THC. On Bup 16mg qday.

Question: What would you do next?

My Proposed Plan

1. Start Risperidone 2mg qday
2. Continue until at last resolution of psychosis
3. Reevaluate schizoaffective diagnosis to determine long-term need for this medication. (Low suspicion right now.)

QUESTIONS?

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