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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

ADDRESSING POLYSUBSTANCE USE WITH MOUD

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project ECHO

SPEAKER DISCLOSURES

- ✓ No conflicts of interest to disclose

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GOALS:

1. Understand the prevalence and consequences of polysubstance use in MOUD
2. Become familiar with the fundamentals of screening for polysubstance use
3. Review principles of treating co-occurring polysubstance use, with a particular focus on benzodiazepines

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BASIC DEFINITIONS

Let's review terminology…

- *How do you treat **PSA** in patients with **OUD** on **MOUD** (especially if taking **BZDs**)? Can I Rx **BUP** or **MTD** or will that cause an **OD**?*

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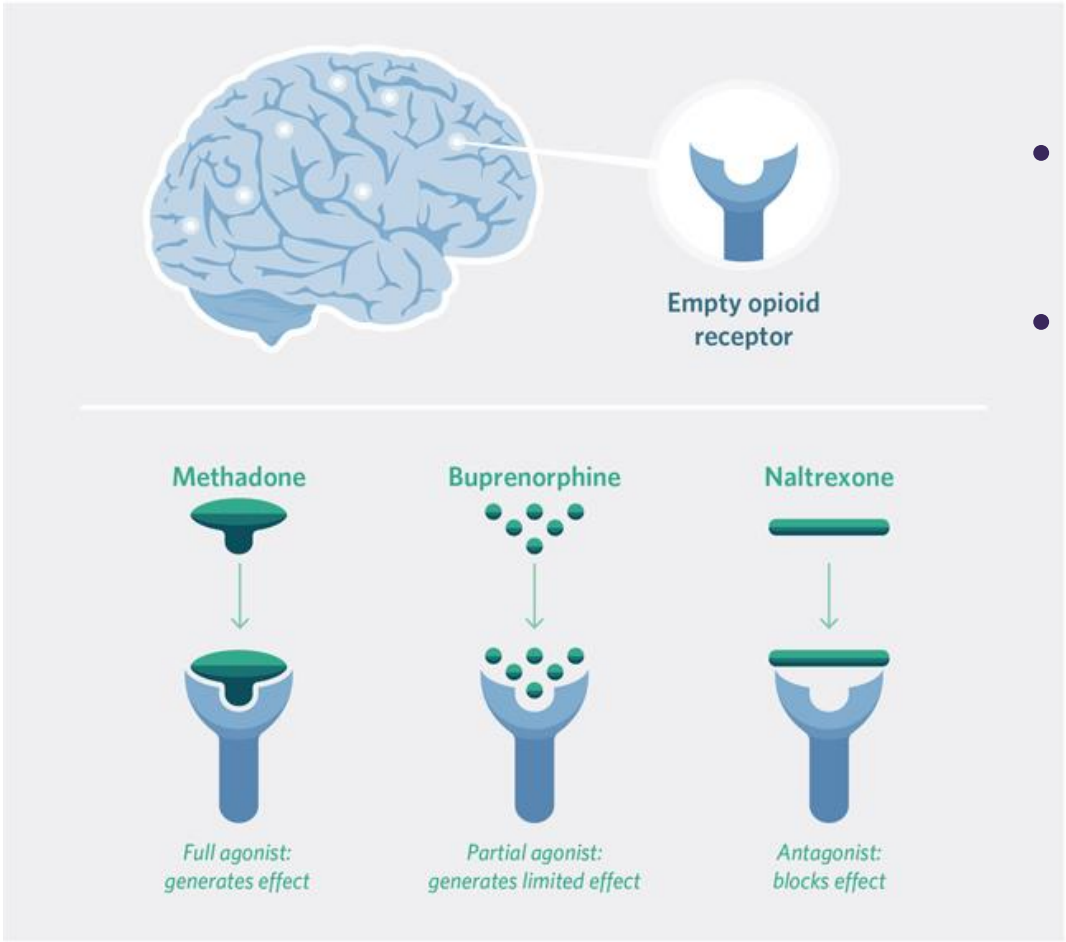
BASIC DEFINITIONS

Figure 1

How OUD Medications Work in the Brain



- **OUD**: Opioid use disorder
- **MOUD**: Medication for opioid use disorder
  - Opioid Agonists
    - **Methadone**
    - **Buprenorphine**
  - Naltrexone (opioid antagonist)

BASIC DEFINITIONS

- **PSA**: Polysubstance use
  - Cannabis, alcohol, stimulants, benzodiazepines

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GOAL 1: PREVALENCE AND IMPLICATIONS OF PSA IN MOUD

- Co-occurring PSA is very common in patients with OUD
  - Approximately 57% of US adults with OUD have an additional substance use disorder
- The prevalence of PSA in patients with OUD is increasing

GOAL 1: PREVALENCE AND IMPLICATIONS

Table 2. Average annual percentage change (AAPC) of opioid and stimulant diagnoses among Veterans, 2005–2019.

Diagnosis	N	AAPC	(95% CI)
Only opioid	141,940	6.9	(6.4, 7.5)
Only cocaine	99,297	-2.3	(−3.2, −1.4)
Only methamphetamine	25,732	15.3	(11.7, 19.0)
Opioid + cocaine (no others)	20,503	-3.2	(−4.6, −1.8)
Opioid + methamphetamine (no others)	5510	22.9	(18.3, 27.5)
Opioid + others (not including stimulants)	116,360	4.5	(2.9, 6.1)
Opioid + cocaine + others	82,732	-3.9	(−4.7, −3.0)
Opioid + methamphetamine + others	18,139	23.0	(17.7, 28.6)
Cocaine + others (not including opioid)	228,659	-4.3	(−5.4, -−3.3)
Methamphetamine+ others (not including opioid)	45,935	15.0	(11.5, 18.7)

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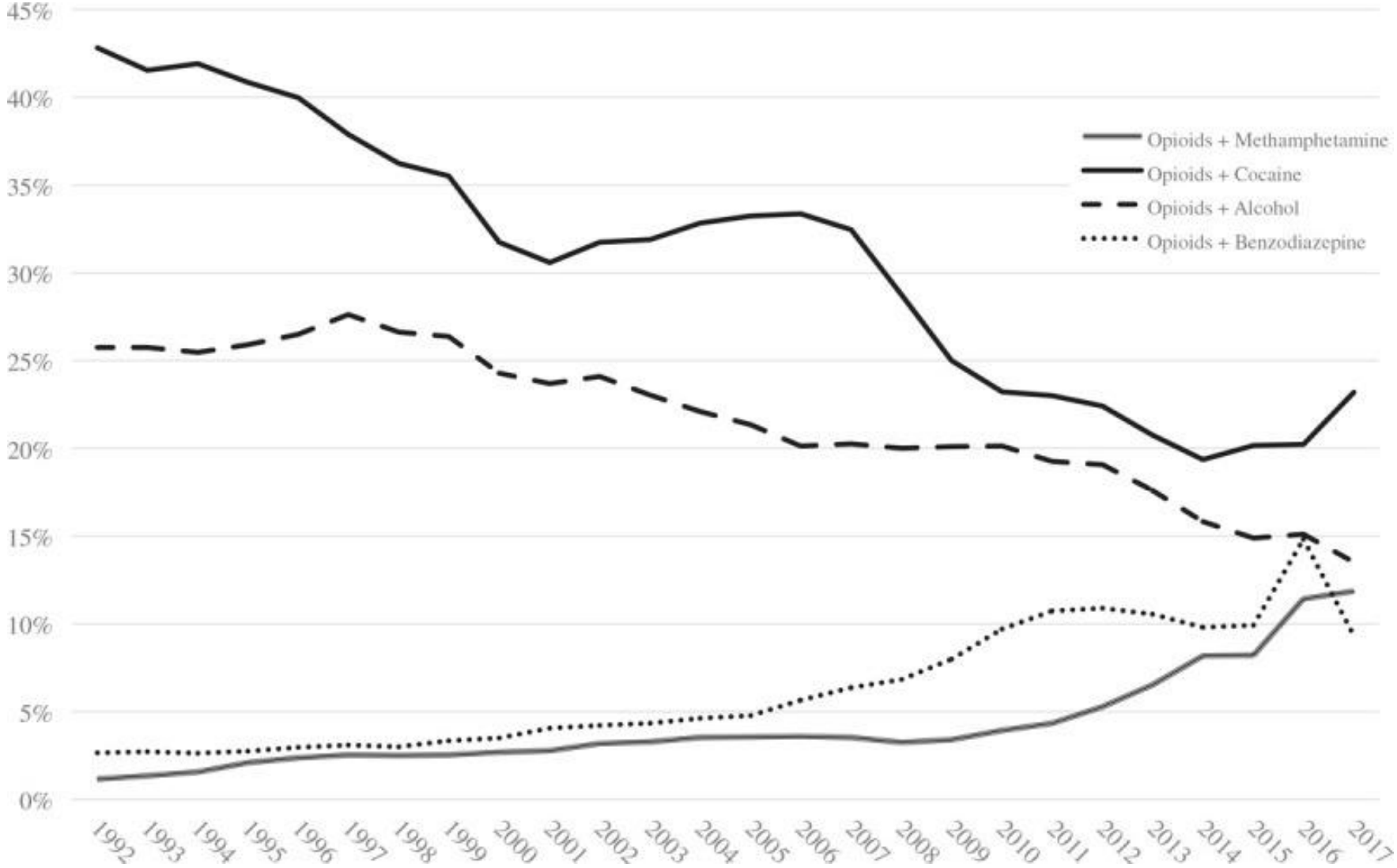
GOAL 1: PREVALENCE AND IMPLICATIONS



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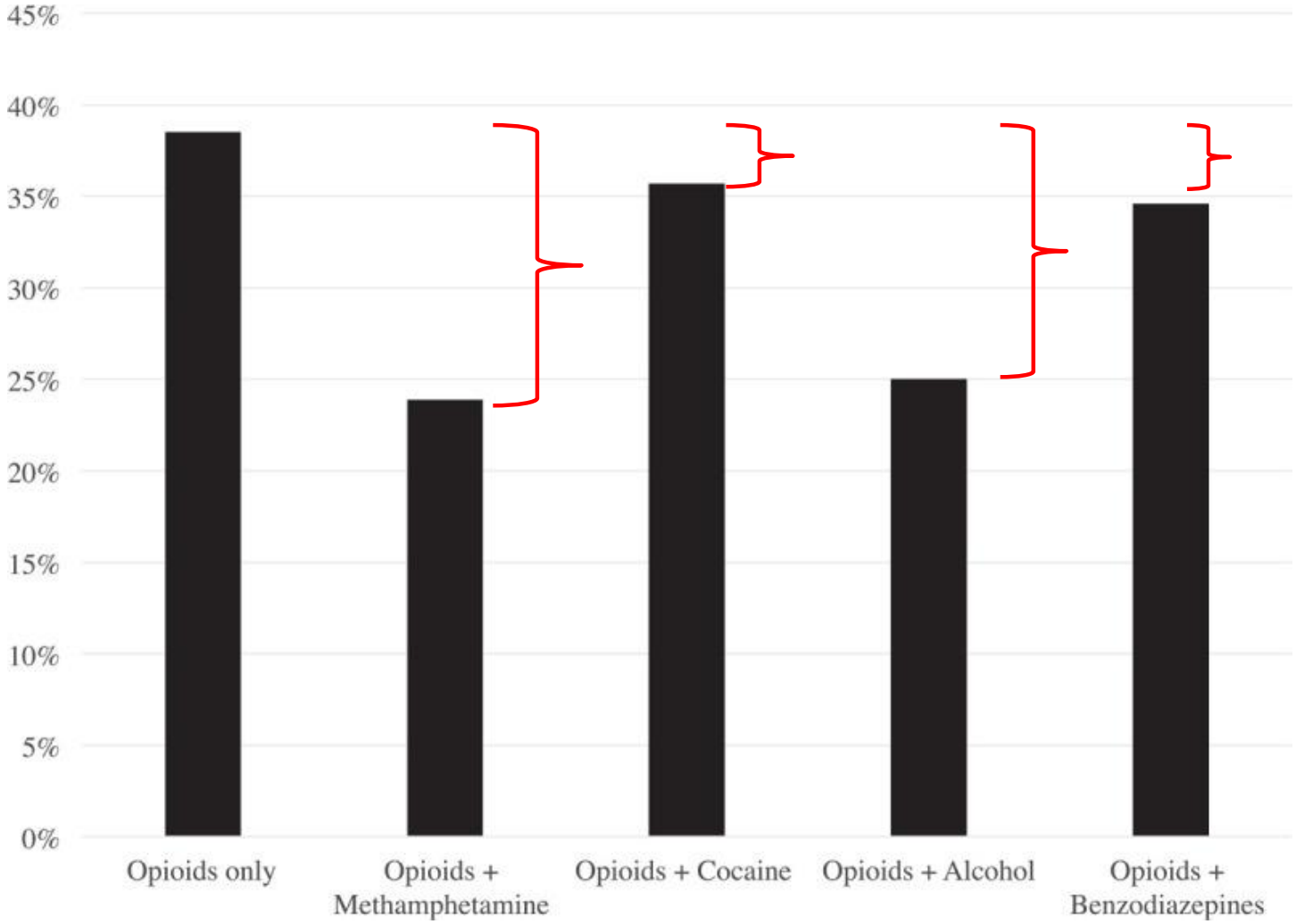
GOAL 1: PREVALENCE AND OUTCOMES

- Polysubstance use…
  - Reduces likelihood of starting and continuing MOUD
  - Lowers abstinence from opioids
  - Increases risk of HIV, Hep C, depression
  - Increases likelihood of criminal activity
  - Increases risk of overdose and death

GOAL 1: PREALENCE AND OUTCOMES

RECEIPT OF MOUD



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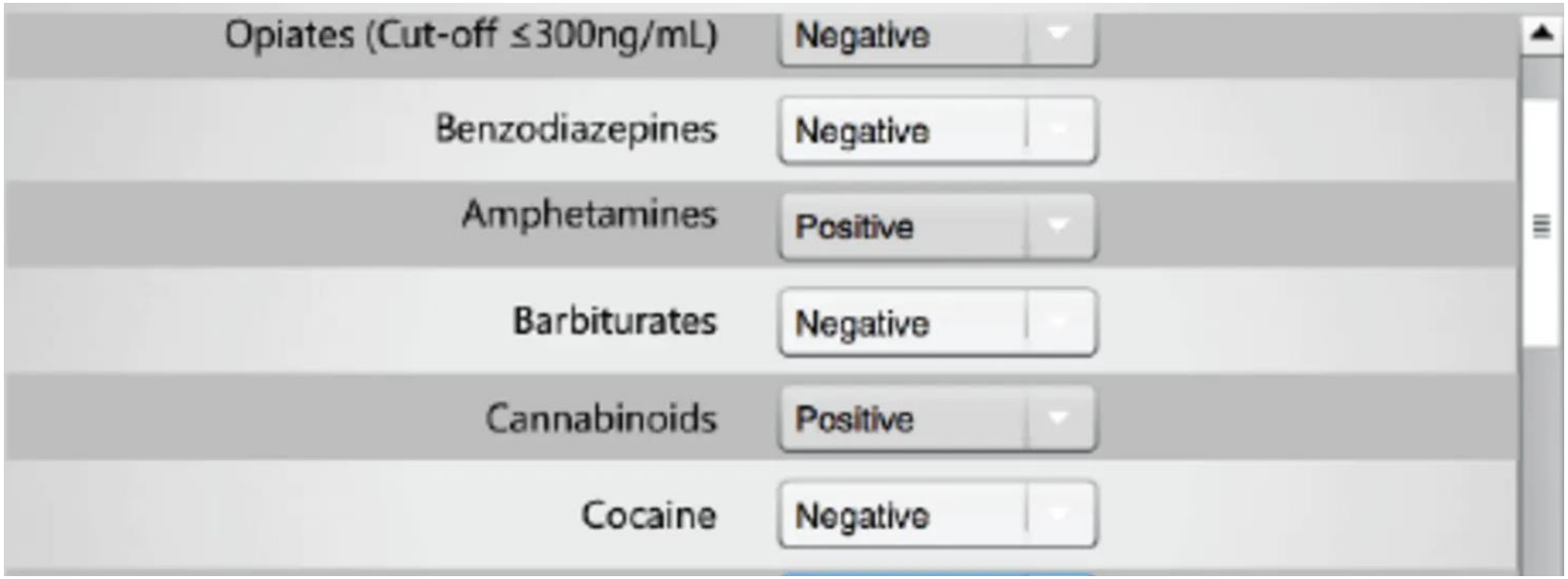
GOAL 2: SCREENING FOR PSA IN MOUD

- SAMHSA Guidelines
  - *"Testing for substances that can complicate [treatment with] OUD medication is essential"*
- When interpreting results consider window of detection, detection capabilities



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Drug	Time frame for positive urine assay with acute exposure* (time frame for chronic exposure in parentheses)
Amphetamine	▪ 1 to 2 days (2 to 4 days)
Benzodiazepines	▪ 1 to 5 days (most) ▪ 2 to 30 days for diazepam ▪ Chronic use does not significantly alter window of detection
Cocaine	▪ 2 days (7 days)
GHB	▪ <24 hours ▪ Chronic use does not significantly alter detection
Ketamine	▪ 1 to 3 days
LSD	▪ 1 to 3 days
Marijuana	▪ 1 to 3 days (>1 month)

- → Tests amphetamine molecule, may miss methamphetamine and MDMA

- →No single assay detects all BZDs. Some assays frequently miss commonly prescribed BZDs including lorazepam and alprazolam

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GOAL 2: SCREENING FOR PSA IN MOUD

- Testing frequency can be reduced as patients stabilize
- For patients on MOUD, random unannounced tests are preferred
- There is poor evidence that increased testing frequency (by itself) affects substance use

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CLINICAL CASE

- Mr. D is a 43 year old unmarried man with a 20 year history of severe opioid use disorder presenting to his PCP's office for treatment.
- His urine drug screen was positive for **lorazepam** and **heroin**.
- He is not open to naltrexone, but is curious about treatment options with opioid agonists.
- What do you do?

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CLINICAL CASE, CONTINUED

*43yo man with **OUD** and **BZD** use interested in MOUD with an opioid agonist*

- Require he stop BZD use before offering an agonist because of the overdose risk?
- Agree to suboxone, but limit dose to 4mg/day?
- Refer him to therapy without MOUD?
- Go back in time and stop yourself from ordering the correct urine drug screen for lorazepam?

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GOAL 3:
TREATMENT RECOMMENDATIONS

- General recommendations for polysubstance use in MOUD
- Specific recommendations for co-occurring benzodiazepine use

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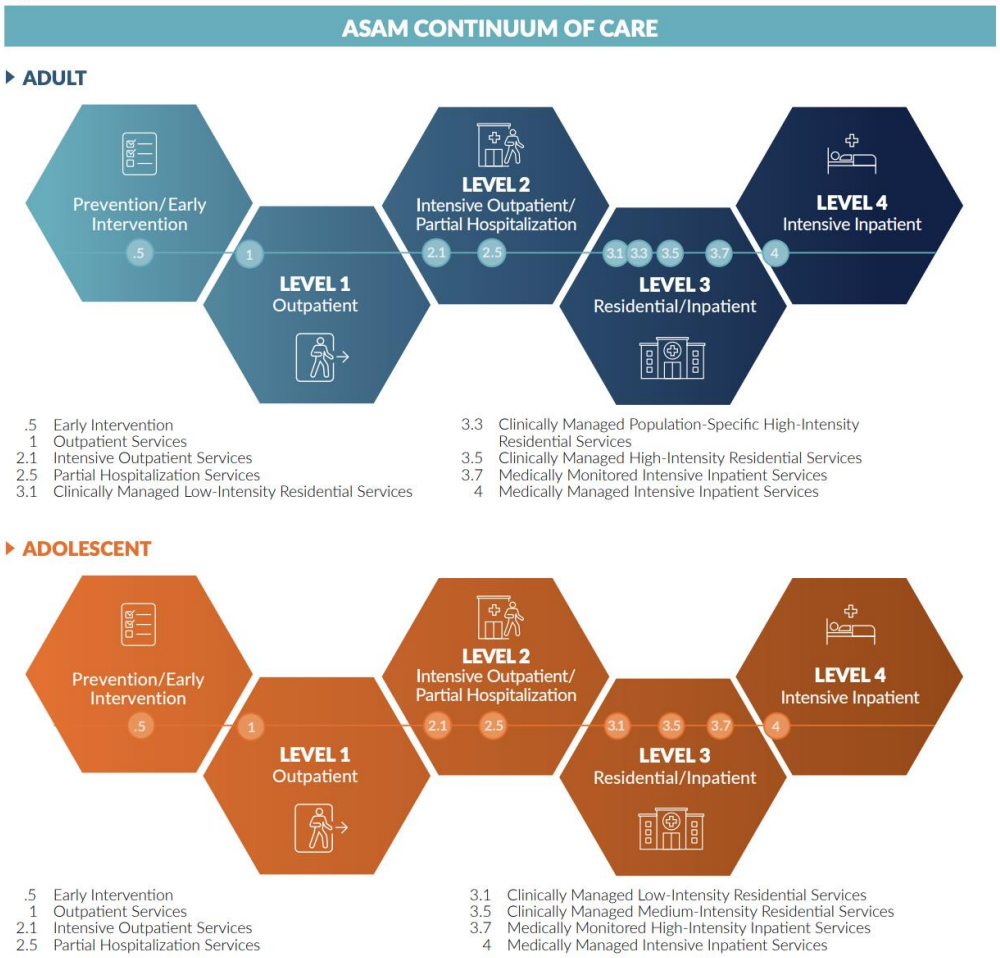
GOAL 3:
TREATMENT RECOMMENDATIONS

General Recommendations

- FDA 2017 Safety Bulletin:
  - **Do not withhold MOUD**
- Always assess (and reassess!) level of care
- Psychoeducation
- Use contingency management



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GOAL 3:
TREATMENT RECOMMENDATIONS

- Concurrent Benzodiazepine Use with MOUD:

No clear algorithm

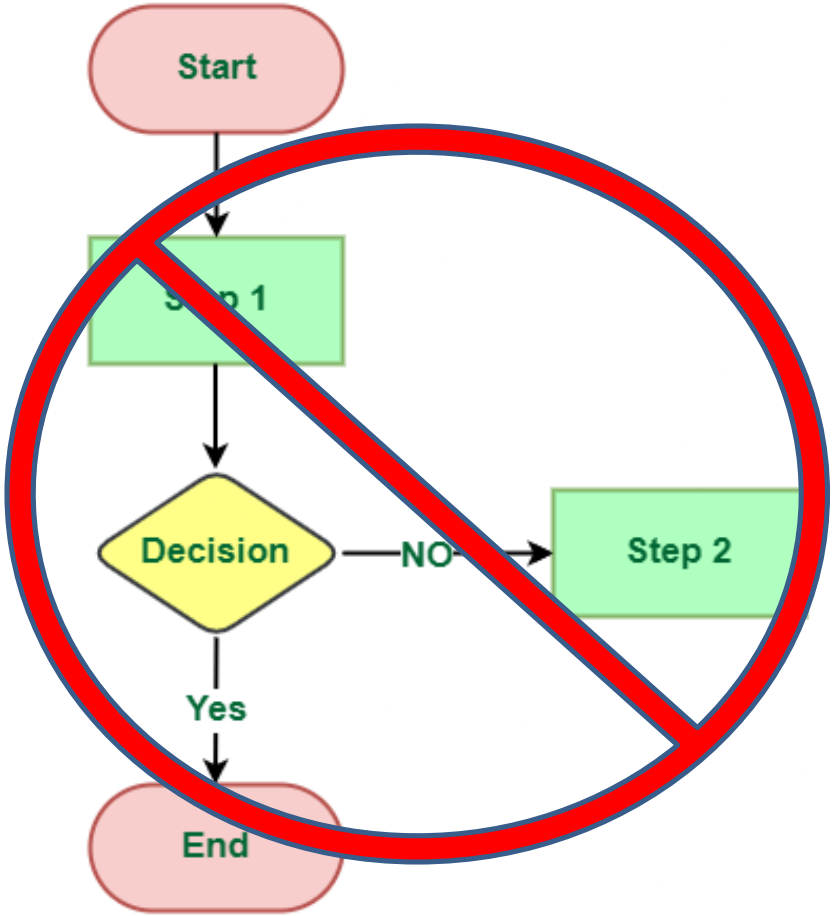

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EXHIBIT 3B.1. Strategies for Managing Benzodiazepine Use by Patients in OUD Treatment

- **Carefully assess th**
  use, including:
  - Intent of use.
  - Source (check th
    monitoring prog
  - Amount and rou
  - Binge use.
  - Prior overdoses.
  - Harms (e.g., car c
    trouble).
  - Co-use with othe
    increase risk for
    overdose.
  - Withdrawal histo
- **Also assess for:**
  - Psychiatric and
  - Motivation for ch
  - Psychosocial sup
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GOAL 3:
TREATMENT RECOMMENDATIONS

Concurrent Benzodiazepine Use with MOUD

- Carefully assess the risk level of the BZD use
- Do not withhold or rule out MOUD
  - Pre-determined dosage limits?
  - Hold dose if intoxicated
  - Short medication supply
- Develop treatment plan
  - Visit frequency
  - Drug testing

GOAL 3:
TREATMENT RECOMMENDATIONS

Concurrent Benzodiazepine Use with MOUD

- If physically dependent on the BZD
  - Outpatient taper
    - Consider consolidation to a long acting BZD
    - Follow guidelines for slow, gradual dose reduction over weeks or month
  - Inpatient medically supervised withdrawal
- Join us on April 27th for my second PACC Presentation:
  - "Strategies in Managing Illicit Benzodiazepine Use"

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SUMMARY

- PSA in MOUD is common and associated with poor outcomes
- Drug testing, and familiarity with the limitations of drug testing, is an essential part of treating patients with MOUD
- Polysubstance use – even with benzodiazepines - should not prevent patients from receiving MOUD if indicated.

ACKNOWLEDGEMENTS

- Special thank you to Dr. McCann and Dr. Buchholz!

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