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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

METHAMPHETAMINE USE AND OUD TREATMENT

"What considerations should I make for patients in OUD treatment also using meth?"

NORAH ESSALI, MD

UW ADDICTION PSYCHIATRY FELLOW

SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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OBJECTIVES

1. Overview of methamphetamine and opioid co-use data
2. Explore potential reasons patients on OUD use meth
3. Discuss case of patient on MOUD with ongoing meth use

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Methamphetamine in Washington

Report to the Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services

June 2018

Susan A. Stoner, PhD, Jason R. Williams, PhD, Alison Newman, MPH, Nancy Sutherland, MLS, Caleb Banta-Green, MSW, MPH, PhD

ADAI | ALCOHOL & DRUG ABUSE INSTITUTE
UNIVERSITY of WASHINGTON

	Primary HEROIN n=664	**Primary METH** n=291
Used another drug in last 3 months	89%	48%
Other Drugs Used		
Heroin by itself	100%	36%
Methamphetamine	78%	100%
Heroin mixed with methamphetamine (goofball)	52%	24%
Powder cocaine by itself	16%	12%
Crack cocaine by itself	16%	8%
Cocaine mixed with heroin (speedball)	13%	5%
Prescription opioids	37%	20%
Benzodiazepines/downers	34%	16%
Fentanyl	13%	4%

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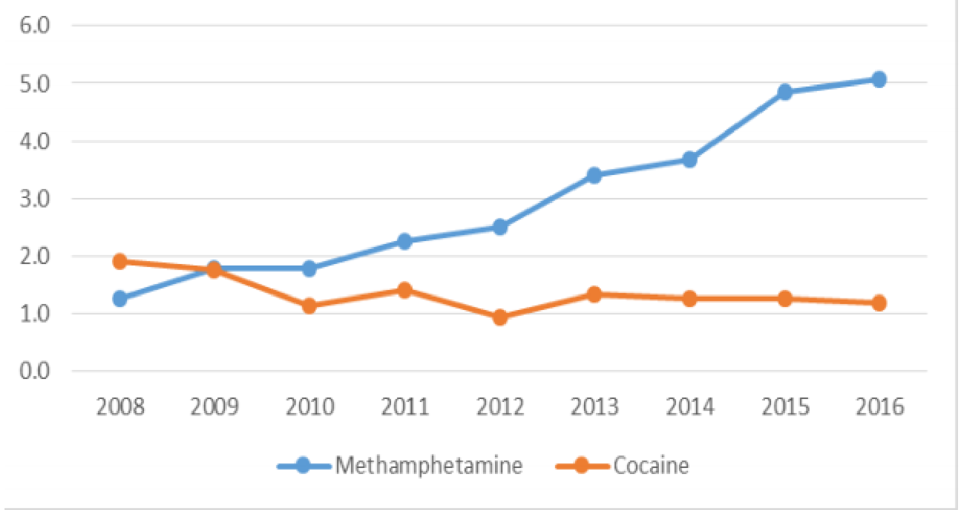

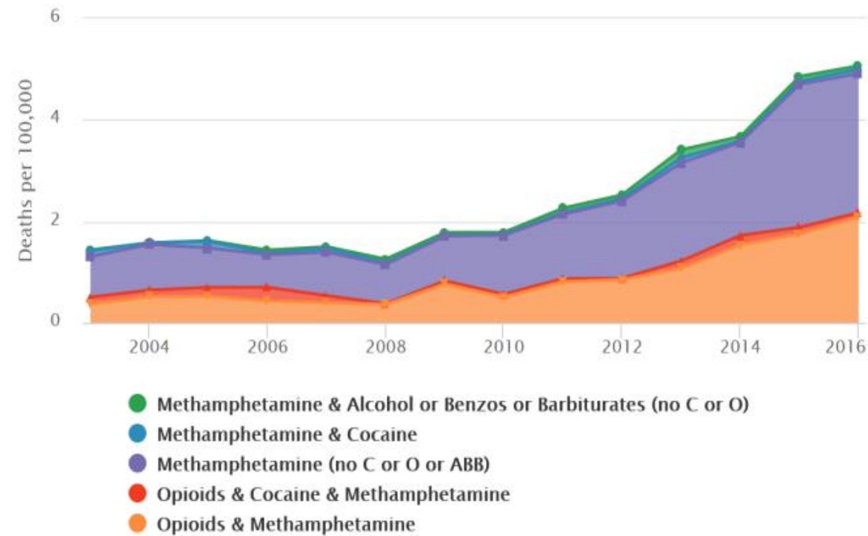

Sources: Washington State Department of Health (deaths), state Office of Financial Management (population)

Nearly half of meth overdose deaths involved an opioid

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Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants — 24 States and the District of Columbia, January–June 2019

Weekly / September 4, 2020 / 69(35);1189–1197

Julie O'Donnell, PhD[1]; R. Matt Gladden, PhD[1]; Christine L. Mattson, PhD[1]; Calli T. Hunter, MPH[1]; Nicole L. Davis, PhD[1] (View author affiliations)

- >50% of meth users use opioids
- **16,236** drug overdose deaths in 24 states and DC
- 5,301 (**32.6%**) involved opioids and stimulants (up from **12%** in 2017-2018)

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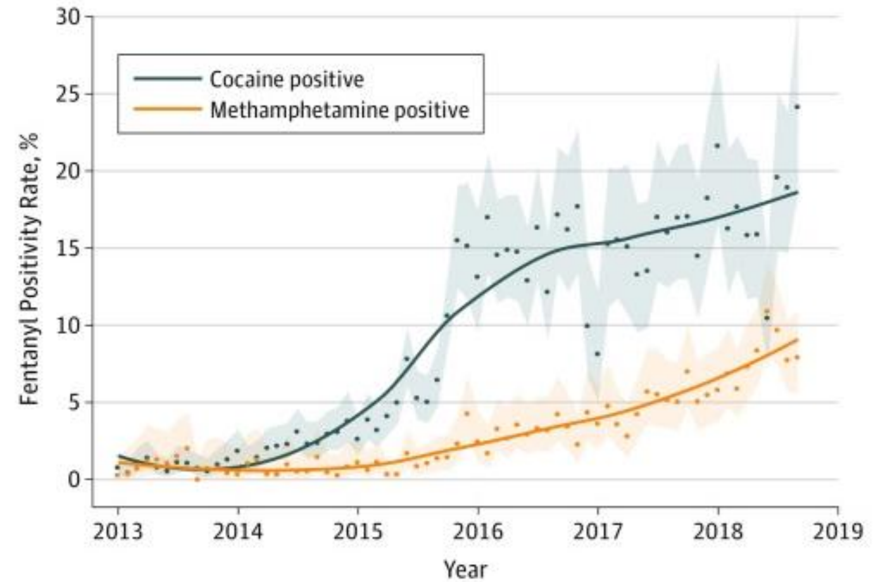
› JAMA Netw Open. 2019 Apr 5;2(4):e192851. doi: 10.1001/jamanetworkopen.2019.2851.

Rate of Fentanyl Positivity Among Urine Drug Test Results Positive for Cocaine or Methamphetamine

Leah LaRue [1], Robert K Twillman [2], Eric Dawson [1], Penn Whitley [1], Melissa A Frasco [1], Angela Huskey [1], Maria G Guevara [1]

Affiliations + expand

PMID: 31026029 PMCID: PMC6487565 DOI: 10.1001/jamanetworkopen.2019.2851



- 1 million UDT
- In methamphetamine positive specimens, fentanyl was found in **7.9%** of samples in 2018 (up from **0.9%** in 2013)

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› J Addict Med. 2020 Aug 27. doi: 10.1097/ADM.0000000000000726. Online ahead of print.

Associations Between Polysubstance Use Patterns and Receipt of Medications for Opioid Use Disorder Among Adults in Treatment for Opioid Use Disorder

Becky R Ford [1], Gavin Bart, Brian Grahan, Riley D Shearer, Tyler N A Winkelman

Affiliations + expand

PMID: 32868682 DOI: 10.1097/ADM.0000000000000726

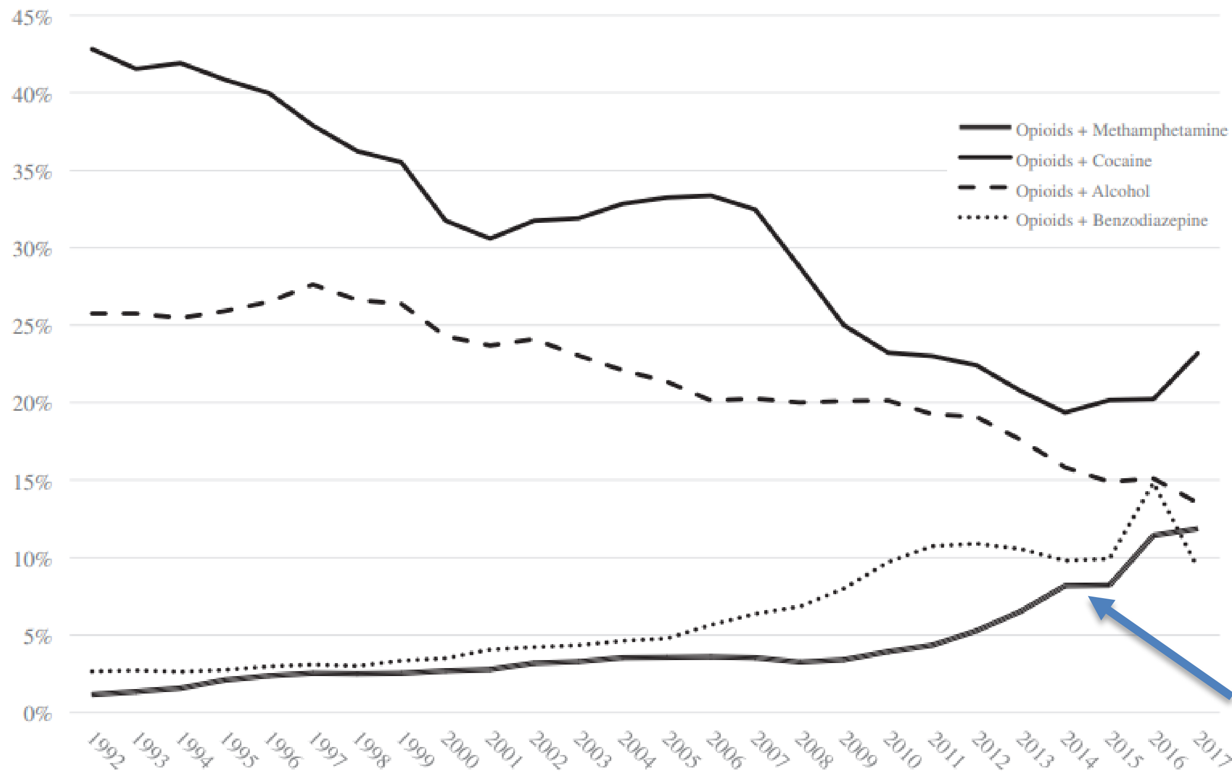

FIGURE 1. Adjusted rates of co-use of opioids with other substances (1992–2017).

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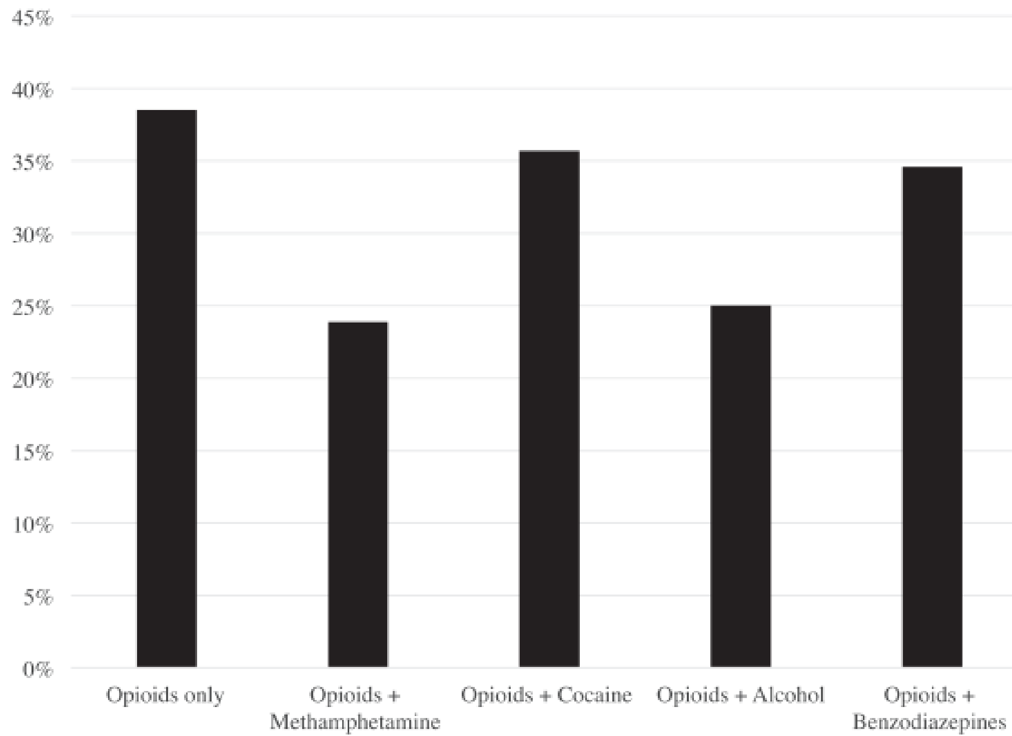

FIGURE 2. Adjusted rate of receipt of MOUD (2016–2017).

- Can be safely prescribed when co-use with stimulants/alcohol/benzodiazepines (risks v benefits)
- Co-users are at increased risk of fatal and non-fatal overdose
- MOUD may decrease use of other substances

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Harm Reduct J. 2020 Feb 27;17(1):14. doi: 10.1186/s12954-020-00360-9.

Motivations for crystal methamphetamine-opioid co-injection/co-use amongst community-recruited people who inject drugs: a qualitative study

Anna Palmer [1], Nick Scott [2] [3], Paul Dietze [2] [3], Peter Higgs [2] [4]

Affiliations + expand

PMID: 32106854 PMCID: PMC7047412 DOI: 10.1186/s12954-020-00360-9

- 16 participants – all opioid dependent/on MOUD
- Motivations:
  - Heroin to come down from meth
  - Cocktailing/Goofballing - Crystal meth prolongs heroin intoxication, improves heroin sensation, and forestalls opioid withdrawal. Cost-effective.
  - In OTP – psychological desire for intoxication (anxiety/depression when sober)

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CASE - S 37 YEAR-OLD FEMALE

Substance Use History:

Cocaine - started using at age 15. Interrupted during military, then used regularly until It became harder to find, slowly replaced with Meth and completely stopped in 2018.

Methamphetamine - Started at age 17. Stopped using completely while in the military. Resumed intermittently after discharge and returned to regular use around 2018. Smokes/snorts about 0.5 g to 1 gram over 3-4 day binges. Longest sobriety period ~ 1 year (Naltrexone + CM).

Heroin - started using in 2018 to come down from Meth then became daily smoker of 0.5 gram +/- ingesting available oxycodone/Percocet when found. Stopped in 2019 once started on Suboxone.

Psychiatric History:

Inpatient: x2 for SA, x2 for manic episodes (last in 2019)

Outpatient: Dx ADHD at age 11. Dx Bipolar age 22 in military(sc). Long list of med trials. Currently in VA ATC after starting suboxone in last inpt admission 2019.

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Medication Trials

Mood stabilizers
- Lithium since 2008
- Depakote 2005-2006, 2010-2014, Dec 2019 up to 750mg (felt overmedicated), worried about hair loss

-Lamotrigine 100mg (2008, 2017)
-Topiramate 2015 (foggy)

Antipsychotics
- quetiapine up to 400mg (2011-2018)
- aripiprazole 20mg (2006-2009) 10mg (2018-2019)
- risperidone po and dec (2006, 2011-2015)
- paliperidone dec (2015-2017)
- olanzapine 2019-2020 (over-sedated)
- ziprasidone 2008
- Haldol 5mg 2014
- fluphenazine dec 2012-2013

Antidepressants:
- bupropion (2006-2008, 2016-2017)
- fluoxetine up to 60mg (2010-2013)
- citalopram 2007, 2009

Stimulants - Adderall 2010 (helpful), methylphenidate 2009

Other - prazosin, propranolol, hydroxyzine, clonazepam, zolpidem, naltrexone IM, gabapentin

Social History

Parents divorced when vet was 6 y/o.
Chaotic childhood. Raped at age 15. Dropped out of school in 10th gr.
Joined military at 18 and served in Korea. MST.
Divorced x 2
Legal charges due to violence when manic
Unemployed

Family History

Mother – bipolar, cocaine dependence, and would take Adderall rx'd for the vet when she was 11y/o
Brother – SUD

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Diagnoses:
OUD (on buprenorphine/naloxone)
Meth use (ongoing)
Bipolar Disorder
PTSD (childhood and MST)
R/O ADHD.

Current Medications:
Buprenorphine/Naloxone 16/4mg po qday
Lithium 1200mg po qhs – 0.36
Olanzapine 2.5mg – 5mg po qhs
Nuvaring (OCP)

Asking for help with:
Ongoing meth use.
Unstable mood – pressured speech, depression, irritability, poor concentration, fatigue.

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WHAT WOULD YOU DO?

A. Stop prescribing buprenorphine given illicit substance use
B. Start Buproprion/Mirtazapine/Topiramate/Naltrexone for meth use
C. Give up- it's the pandemic, Contingency Management programs are unavailable/closed.
D. Taper buprenorphine and switch to Naltrexone IM given past success
E. Encourage 12 step group online attendance
F. Increase Lithium or Olanzapine for mood

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WHAT HAPPENED..

- Opted for patient's choice and past experience with Naltrexone IM
- Started patient led taper of Buprenorphine – 1mg currently
- Started attending support groups 5 times a week, has sponsor
- Meeting with counselor once a week – support and problem solving
- Attending OBB clinic once a week – accountability (UDS) and support
- Improved adherence to Bipolar medications and optimized Lithium dose
- Deleted all contacts (friends who use and dealers)

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OUTCOME…SO FAR..

- 120 days with one 3 days relapse on meth (thanks, Facebook) and twice use of cannabis
- Abstinent from opioid use
- Mood more stable
- Plan for Naltrexone IM 7 days after last Buprenorphine use and continued close follow up

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WHAT CONSIDERATIONS SHOULD I MAKE FOR PATIENTS IN OUD TREATMENT ALSO USING METH?

"Snorting Party Kit" distributed by the People's Harm Reducation Alliance and Stay Safe Seattle.
Source: http://www.peoplesharmreductionalliance.org

- ❖ Improve access to and continue OUD treatment
- ❖ Educate on increased risk of overdose (respiratory depression when stimulant effect declines)
- ❖ Prescribe Naloxone- Meth contamination with Fentanyl
- ❖ Assess functional purpose of meth use for patient.
  - ❖ MH concerns? Sedation? Withdrawal? Homelessness?
- ❖ Screen for STIs (increased risky sexual behavior)
- ❖ Harm reduction is an important alternative to those unable/uninterested in abstinence.

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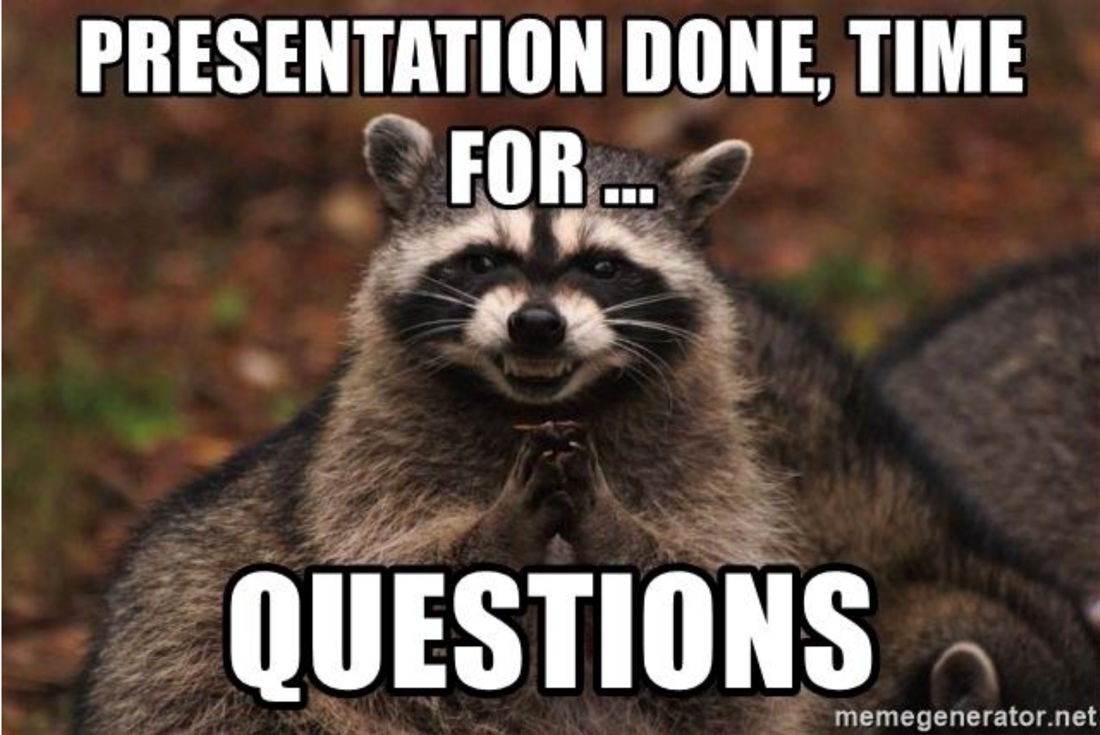

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