POLYSUBSTANCE USE IN THE TREATMENT OF OPIOID USE DISORDERS WITH BUPRENORPHINE

SESSION 3
OBJECTIVES

- Understand benefits and risks of treating OUD in context of polysubstance use
- Understand interventions available for alcohol, benzodiazepine, and stimulant use disorder
- Discuss programmatic approaches to ongoing polysubstance use
35 year old female on Bup-Nal 6-1.5mg qd for OUD-severe (heroin). She has been in treatment for three months and has been making her appointments. She is working occasionally, and is couch surfing.

At the time of enrollment she was taking illicit benzodiazepines and agreed to stop using them. However, she has continued to use them and every urine drug screen is positive. She reports having too much social anxiety without them. Also has irregular cannabis use.

What are your concerns and why?
POLYSUBSTANCE USE IS COMMON

Common in Opioid Use Disorder 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 IN PATIENTS BEING TREATED FOR OUD WITH BUPRENORPHINE?

- Associated with greater psychopathology
- Increased levels of risky behaviors
- Poor treatment engagement
- Death

WHICH OF THESE SUBSTANCES HAS BEEN ASSOCIATED WITH OVERDOSE DEATHS IN PATIENTS ON BUPRENORPHINE?

- Cannabis
- Cocaine
- Benzodiazepines
- Alcohol
- Methamphetamine
A HISTORY OF BUP-BENZO RELATED DEATHS

• 1998 French case series
  – Six overdose deaths related to bup + benzo’s
  – IV buprenorphine (Not Bup-Nal)

• Can occur at therapeutic doses of Buprenorphine in the following contexts:
  – Related supra-therapeutic doses of benzodiazepines
    • Removes ceiling effect
  – IV injection of benzos at therapeutic doses
  – Combined with sedatives

Reynaud M et al, 1998; Schuman-Olivier Z et al, 2013
Sample

– All Veterans (N=32,422) in 2007 with an Opioid Use Disorder (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>

Best practice: Avoid prescribing opioids and benzodiazepines to patients with Opioid Use Disorders

OPIOIDS: Z-DRUGS AND PREGABALIN

Sample

– Swedish nation-wide register-based open cohort from 2005-2012, N=4501

– OUD Dx and at least one Rx for methadone or buprenorphine

Results

– Overdose deaths
  • Z-drugs HR 1.98 (CI 1.38-2.84)
  • Pregabalin HR 3.22 (CI 2.13-4.86)

Best practice: Avoid prescribing z-drugs and pregabalin to patients with OUDs

Abrahamsson, T, et al 2017
Benzodiazepine use during buprenorphine treatment for opioid dependence: Clinical and safety outcomes

N=386, Primary Care-Nurse Care Manager Program, over 12 months

**Benzo Misuse vs No Benzo Misuse**

- No impact on treatment retention
- No impact on illicit opioid or cocaine use
- Prescribed benzos → more ED visits. (OR 3.75 this is high) due to accidental injury – worse in females
- No one died in treatment

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

Shuman-Olivier et al, 2013
The impact of benzodiazepine use in patients enrolled in opioid agonist therapy in Northern and rural Ontario

Reduced 1 year treatment retention

- Benzodiazepine users: 39.9%
- Non Benzodiazepine users: 44%

- When > 75% urine positives for benzodiazepines → 175% more likely to drop out
Implications

Concurrent CNS depressant use is not a contraindication to treating opioid use disorders with buprenorphine despite the increase risk of mortality.

Source: https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm
THE BENZODIAZEPINE BIND

• If patients are admin discharged or not enrolled for BZPs, then they will now likely be doing heroin + BZP

• Out of treatment ⇒ Not able to help
  – Increase risk for IV use, infections, OD, and death

• How do you identify it?
  – Ask about it at every visit
  – Monitor with Urine Drug Screens
ALCOHOL AND BUPRENORPHINE

- Has been associated with increased risk for death when combined with buprenorphine

- How do you identify it?
  - Use AUDIT or AUDIT-C to screen for risky use and use disorder at the beginning and yearly
  - Ask about use at every visit
  - Monitor with urine drug screens
STIMULANTS AND BUPRENORPHINE

• Notable in opioid treatment: cocaine
  – Higher opioid use at baseline
  – Higher relapse rates
  – Worse adherence to Buprenorphine

• How do you identify it?
  – Ask about it at every visit
  – Urine drug screens

• Methamphetamines
  – Buprenorphine can reduce methamphetamine cravings

CANNABIS AND OPIOID MAT

• Common: 39-66%
• Mixed impact, but...
  – Associated with non-medical opioid/heroin use
  – Increased risk of drop-out
• Not a benign substance
  – Psychiatric issues
  – Physical Issues
• How do you identify it?
  – Ask about it
  – Urine drug screen
  – Cannabis use disorder?
    • Use Cannabis Use Disorder Identification Test-Revised (CUDIT-R)

Wasserman et al, 1998; Balhara et al, 2014; Roux et al, 2011; Franklin A, et al, 201
NEXT STEPS
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. Works and has housing. No psychosocial support. Urine drug screens have remained positive for buprenorphine/norbuprenorphine, methamphetamines, and cannabis, only.
WHAT WOULD BE YOUR FIRST STEP?

• Administrative taper and discharge
• Reduce dose of Buprenorphine-Naloxone
• Continue Buprenorphine-Naloxone dose
CASE # 2: Methamphetamines

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What are some other approaches you would try?
GENERAL APPROACH TO POLYSUBSTANCE USE

• Increase frequency of visits
• Increase control of Buprenorphine dispensing
• Increase frequency of urine drug screens
• Consider prescribing of all controlled substances
• If continued use, consider higher level of care
  – Maximize psychosocial supports
• Others?
FIRST STEP: EVALUATION

• Why are they using it?
  – Opioid use disorder not adequately treated?
  – Another substance use disorder?
  – Psychiatric condition?
  – Stress management?
  – Others?
EVALUATION:
OPIOID USE DISORDER 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?**
  – Additional MAT?
  – Increase psychosocial support
1. Medication Assisted Treatment (MAT)

- Alcohol MAT options
  - Acamprosate, Disulfiram, Topiramate, Gabapentin
- Cocaine MAT options
  - None
- Methamphetamine
  - Bupropion, Mirtazapine
- Cannabis
  - Gabapentin (for withdrawal)
Is Substitution Treatment for Stimulant Use Disorders Effective?

– Cocaine: mixed results, poor retention
– Meth: no
2. Psychosocial Support
   – Critical for Alcohol Use Disorders
     • CBT
     • 12 step groups
   – Stimulant Use Disorders
     • Only consistently effective approach
     • CBT
     • Contingency Management

EVALUATION: PSYCHIATRIC DISORDER?

• Concerning signs?
  – Appearance
  – Mood
  – SI

Potential Treatment Adjustments?
  – Use screeners
  – Treat as indicated
(will discuss further during next session)
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
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What would be your next steps for treatment?
1. Cut bup dose in half to reduce toxicity
2. Treat underlying psych disorder
3. Residential Treatment
4. Taper
   1. Patient
   2. Clinic administered
What Are The Benefits To Keeping Patients in Treatment With Ongoing Polysubstance Use?

– Keeps people engaged with treatment providers
– Treatment with MAT reduces mortality
DISCUSSION

What Are The Harms Of Keeping Patients In Treatment With Ongoing Polysubstance Use?

– Are you just enabling patients?
– Other patients will find it disruptive
– Clinic hassle
– Risk of overdose
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?
Prompt

1. Write down any big ideas from this session.