Polysubstance Use and MOUD

Monday, February 25th, 2019

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under contract number HHSH250201600015C. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Disclosures

The presenters have no financial conflicts of interest to disclose.

Objectives

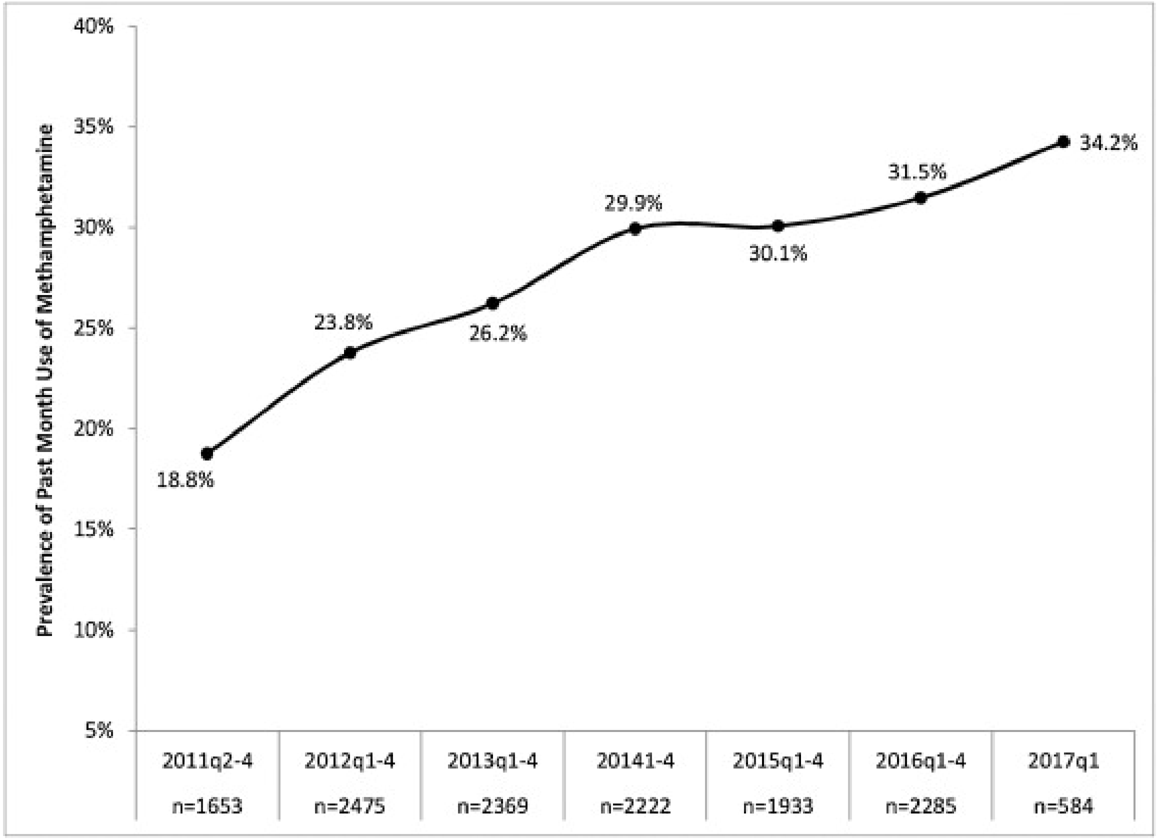
- Indicate three (3) ways that polysubstance use can negatively impact the treatment of patients with opioid use disorder.
- Identify two (2) challenges in the treatment of patients with co-occurring substance use.
- Specify three (3) treatment strategies to address co-occurring substance use in patients taking medication for opioid use disorder.
- Summarize two (2) lessons learned from case discussion.

Background

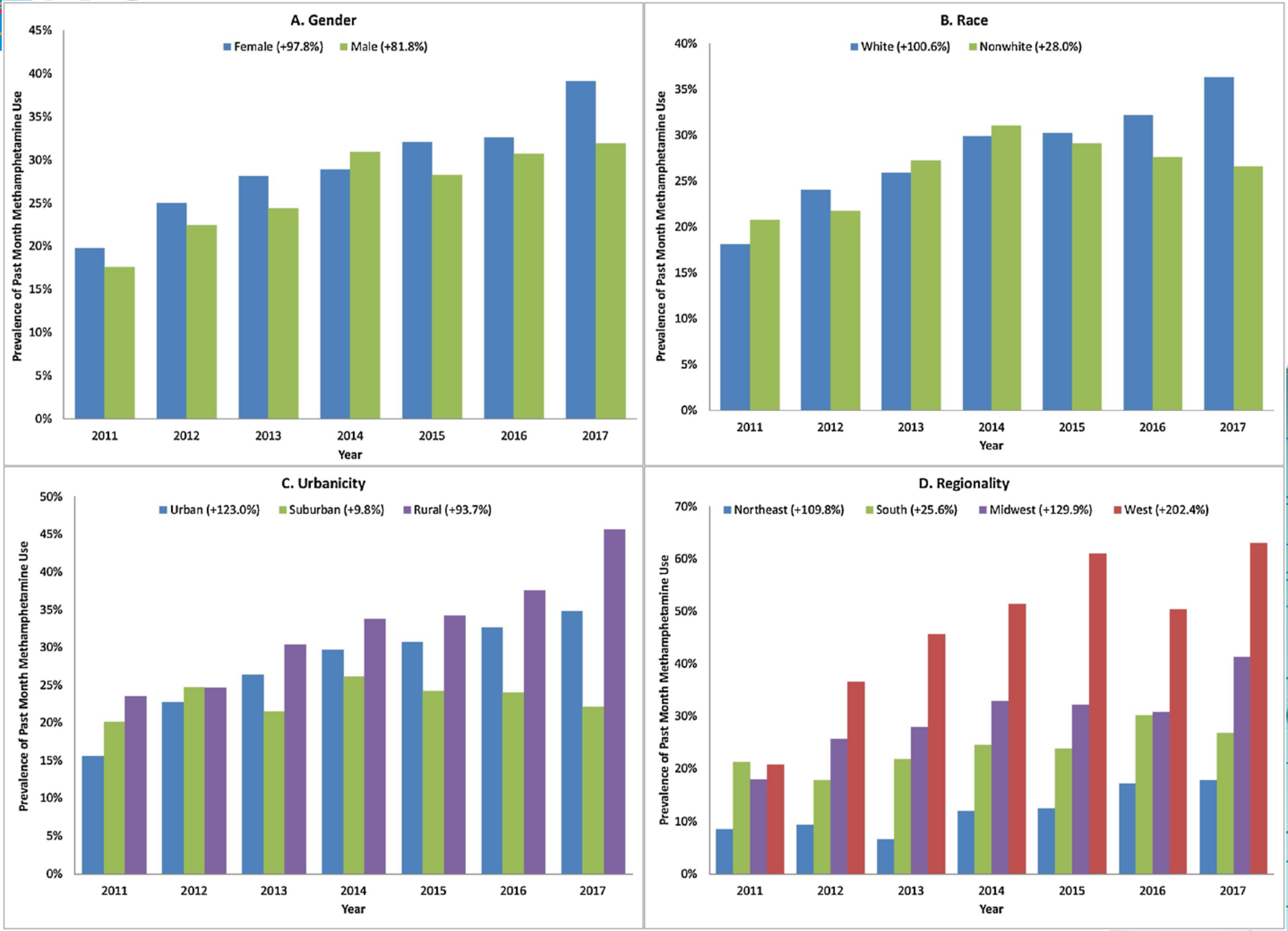
- Co-occurring substance use in patients on MOUD is very common
- Nearly one third of people in SUD treatment in 2013 reported treatment for alcohol and drugs
- OUD is typically most severe of comorbid conditions and should be priority of treatment

Stimulants

Methamphetamine use among patients with chronic opioid use is on the rise



Ellis, MS, Kasper, ZA, Cicero, TJ (2018). Twin epidemics: The surging rise of methamphetamine use in chronic opioid users. Drug and Alcohol Dependence, v193, 1 Dec 2018, 14-20.



A. Gender
Female (+97.8%)
Male (+81.8%)
B. Race
White (+100.6%)
Nonwhite (+28.0%)
C. Urbanicity
Urban (+123.0%)
Suburban (+9.8%)
Rural (+93.7%)
D. Regionality
Northeast (+109.8%)
South (+25.6%)
Midwest (+129.9%)
West (+202.4%)
Prevalence of Past Month Methamphetamine Use
Year
2011
2012
2013
2014
2015
2016
2017

Clinical Challenges with Stimulant Dependent Individuals

- Limited understanding of stimulant addiction
- Ambivalence about need to stop use
- Cognitive impairment and poor memory
- Short attention span
- Anhedonia
- Powerful pavlovian trigger-craving response
- Sleep disorders
- Poor retention in outpatient treatment
- Elevated rates of psychiatric co-morbidity

What **Does Not** Work

- Confrontation
- Insight-oriented psychotherapy
- Generic CBT
- Intensive group treatment
- Discharging people from treatment

What **Does** Work

- Motivational incentives/Contingency management
- Focused CBT
- Motivational Interviewing
- Medications – off-label effectiveness of buproprion, naltrexone, modafinil

Methamphetamine and Opioid Co-Ingestion – What are the Issues?

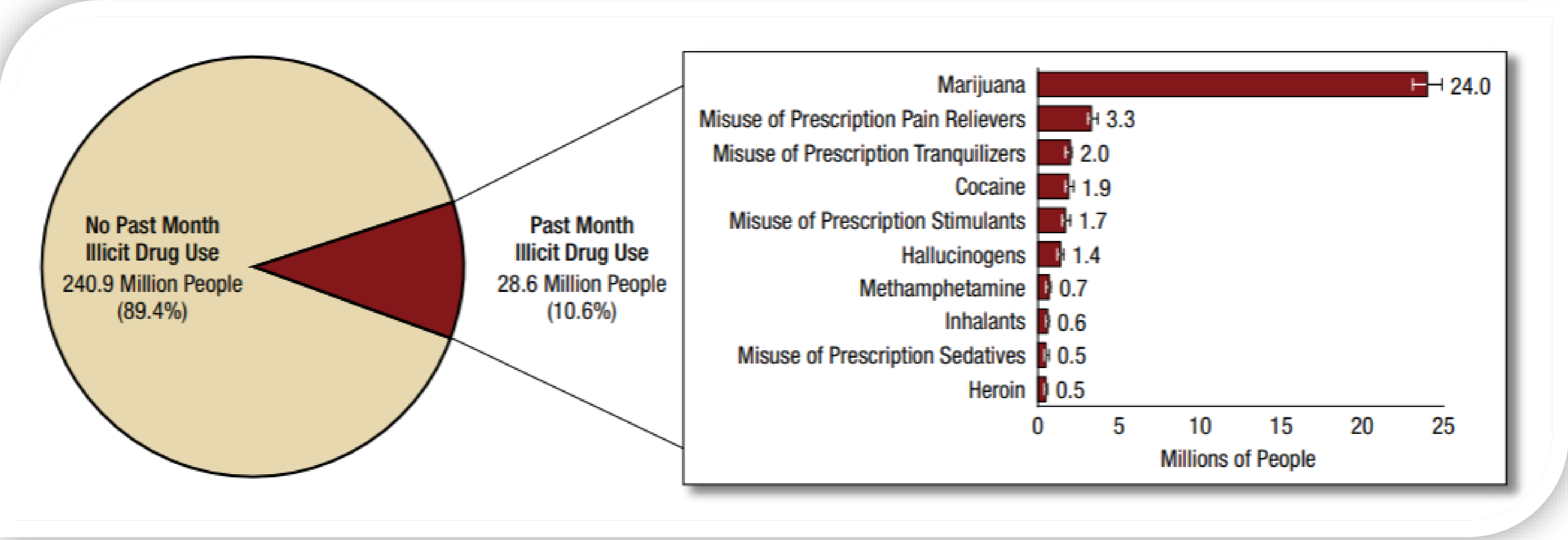
- A synergistic effect occurs when using meth and an opioid together (i.e., the result of using both is greater than the sum of each)
- The stimulant effect counterbalances the depressant effect, thus increasing overdose risk (respiratory depression AND cardiac arrest)
- The most potent effect seems to be in the first 90 minutes of co-injection

What are Some Treatment Implications for Methamphetamine and Opioid Co-Ingestion?

- Make sure you have sufficient naloxone kits available for overdoses
- Combine MOUD for opioids with contingency management (CM) for meth.
- Exercise may help to reduce methamphetamine use and reduce depression and anxiety symptoms in meth users
- Consider medications with off-label indications

Cannabis

Marijuana is the #1 Illicit Drug Used in the U.S. among People 12 and Older

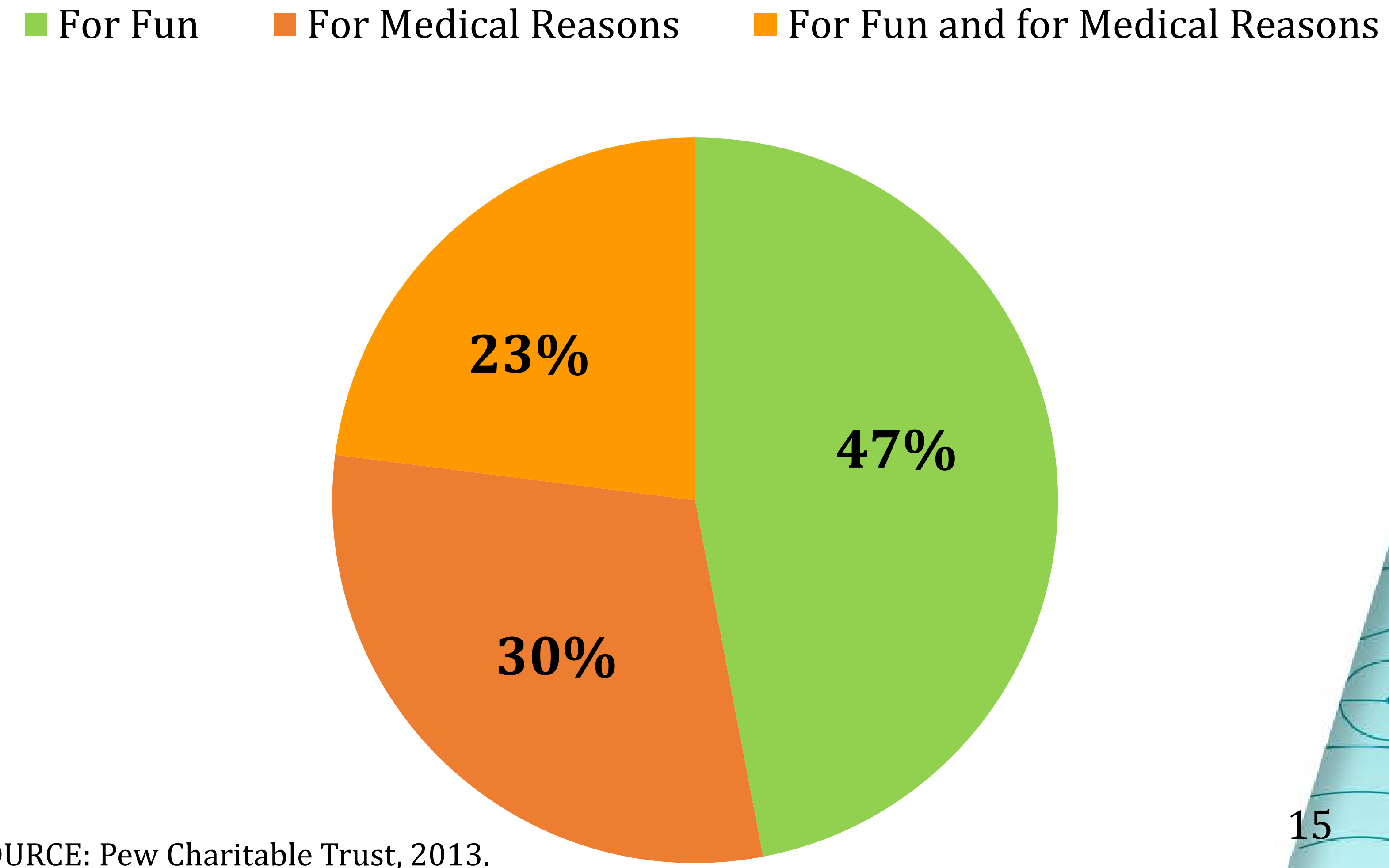


The number of past month marijuana users corresponds to 8.9% of the US population aged 12 and older

SOURCE: SAMHSA, NSDUH, 2016 findings.

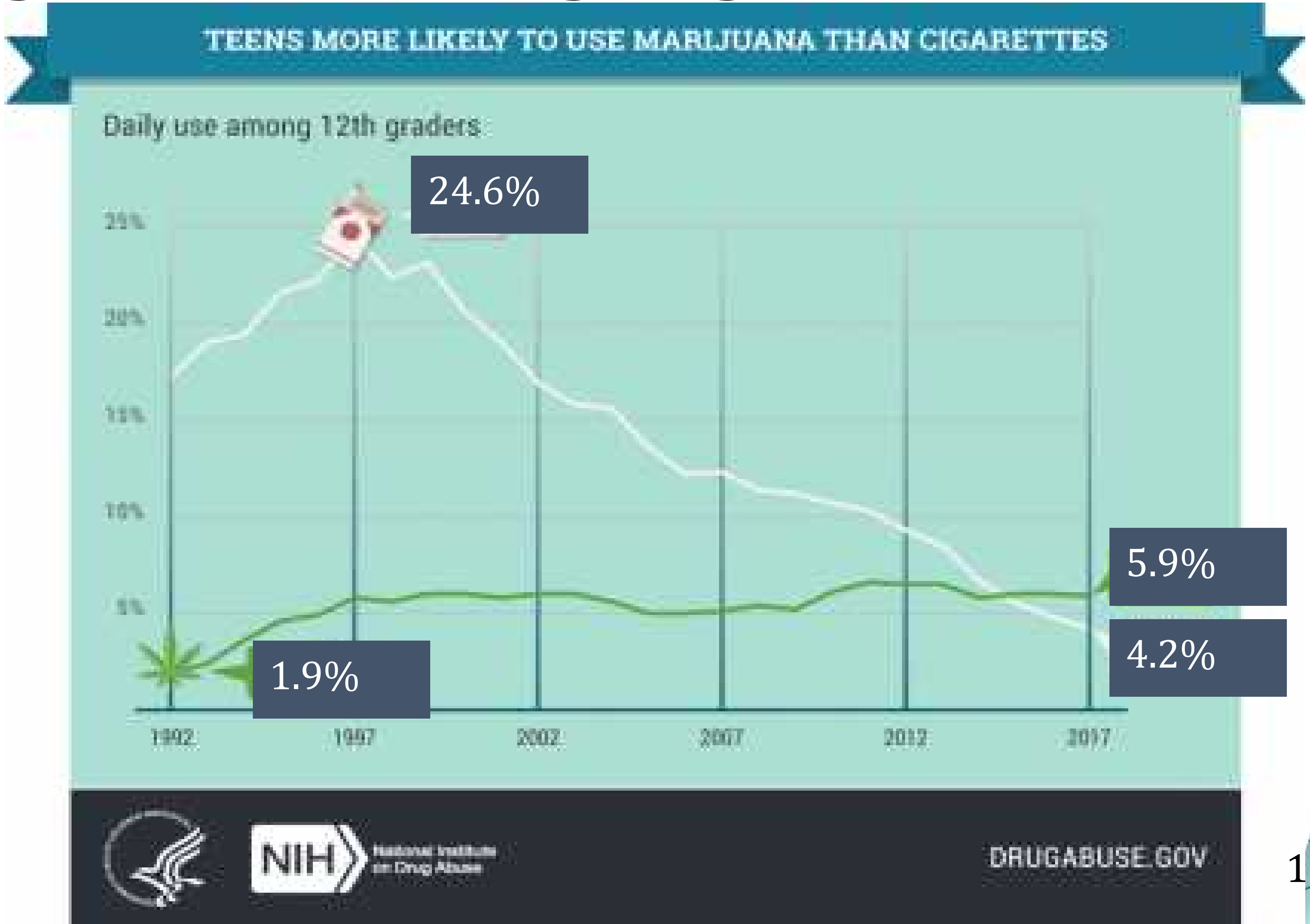
Why Do People Use Marijuana?

Among people who used marijuana in the past year:



SOURCE: Pew Charitable Trust, 2013.

Marijuana is Now More Common than Cigarettes among High School Seniors



Acute Effects of Cannabis in Intoxication Phase

- Cognition
  - Difficulty with complex tasks
  - Difficulty learning
- Executive Function
  - Impaired decision making
  - Increased risky behavior – STDs, HIV
- Mood
  - Anxiety – panic attacks
  - Psychosis - paranoia

Is Marijuana Use Associated with an Increased Risk of Opioid Misuse?

- Based on data from the National Epidemiologic Survey on Alcohol and Related Conditions
- Respondents who reported past-year marijuana use had 2.2 x higher odds than non-users of meeting diagnostic criteria for a prescription opioid use disorder by follow-up
- Also had 2.6 x greater odds of initiating prescription opioid misuse

Benzodiazepines and Other Sedatives

Including alcohol

Benzodiazepines/Sedatives

- High co-prescription rate
- Mixed findings in OD deaths, but since these and opioids are CNS depressants, there are additional safety concerns
- Not a reason to discontinue buprenorphine
- Consider slow taper of benzodiazepines as appropriate or treatment for benzodiazepine use disorder

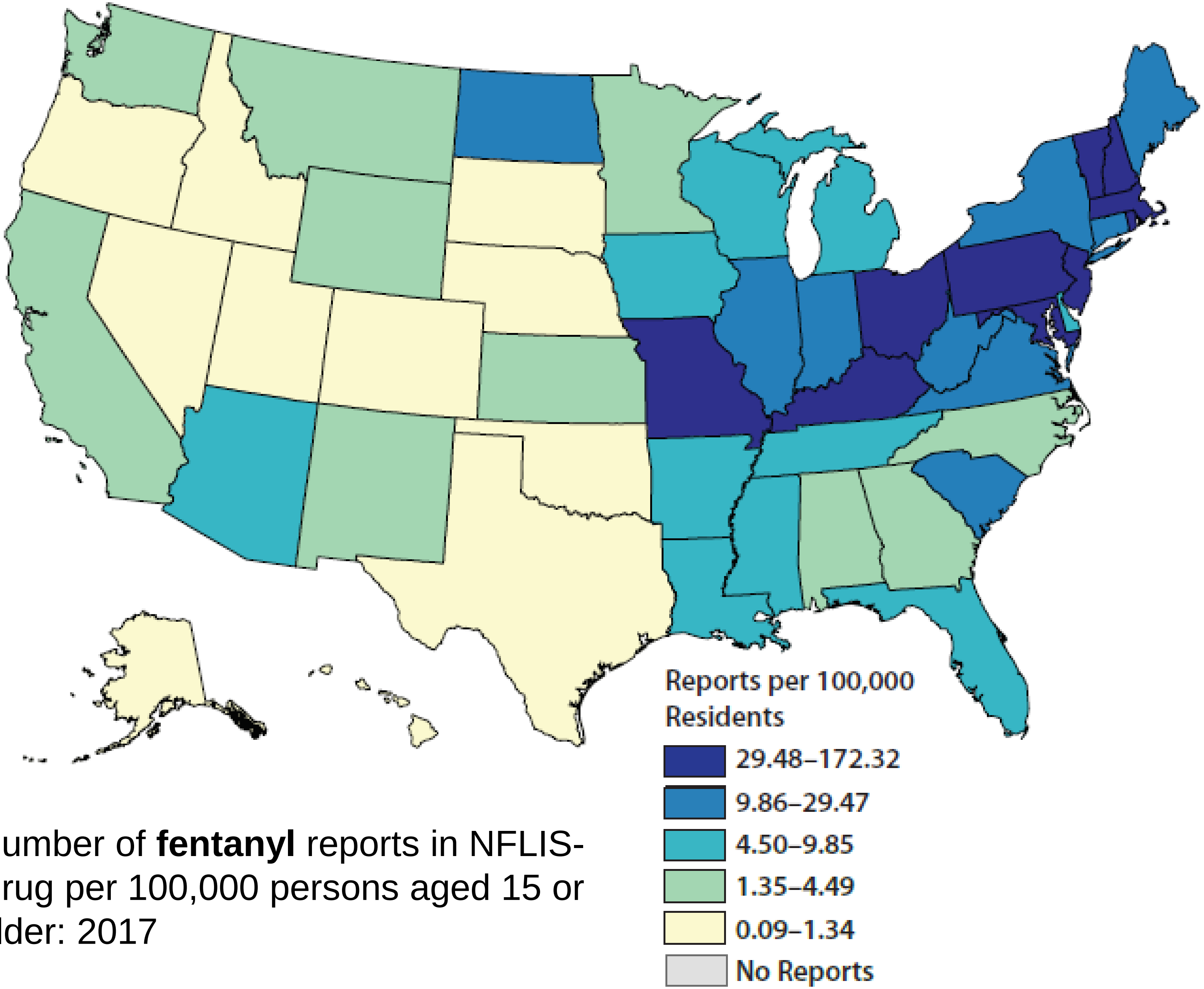
Alcohol

- NIDA CTN study found 38% prevalence of AUD among people seeking OUD treatment
- Other analyses found alcohol involvement in one fifth of opioid related deaths

Medications for Alcohol and Opioid Use Disorder

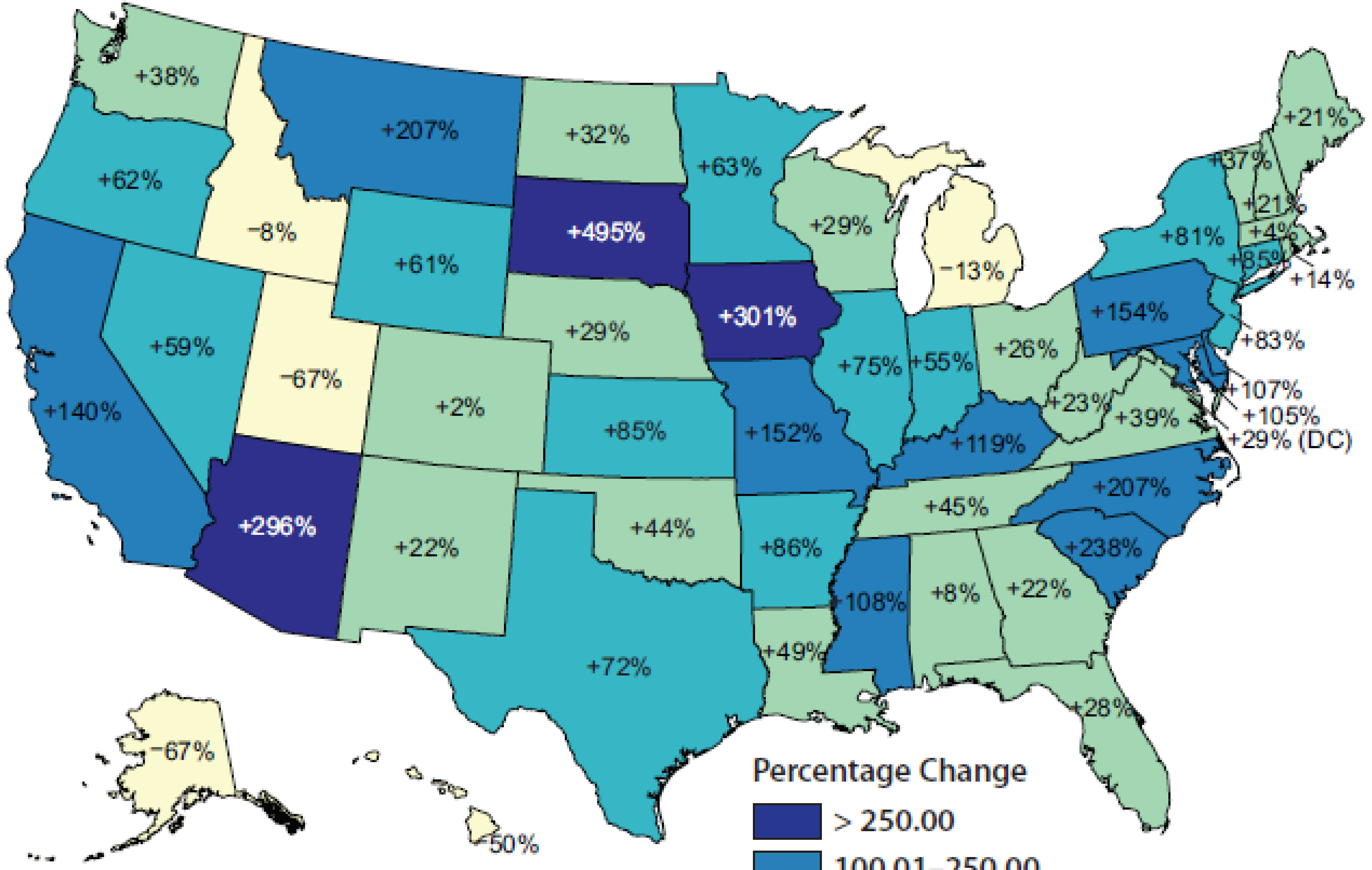
- Naltrexone IM (Vivitrol) may be best choice, as it is FDA approved for both conditions
- May require medically assisted withdrawal management (e.g., inpatient "detox"), as outpatient induction may not be appropriate

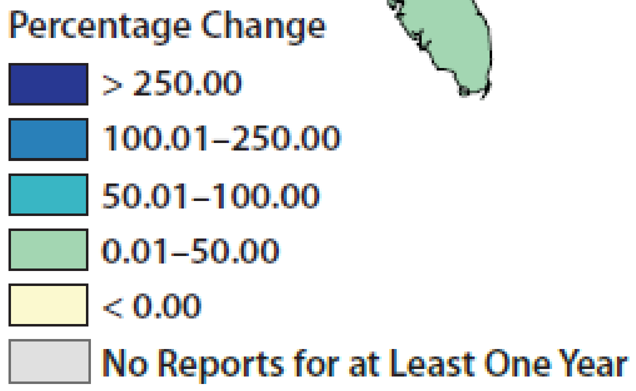
Fentanyl



Number of **fentanyl** reports in NFLIS-Drug per 100,000 persons aged 15 or older: 2017

Fentanyl





Percentage change in **fentanyl** reports in NFLIS-Drug in the United States by State: 2016–2017

Summary

- Nonopioid substance use is common in patients on MOUD
- Practice should focus on treating the nonopioid substance use
- MOUD treatment should be continued

Thank you for attending!

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