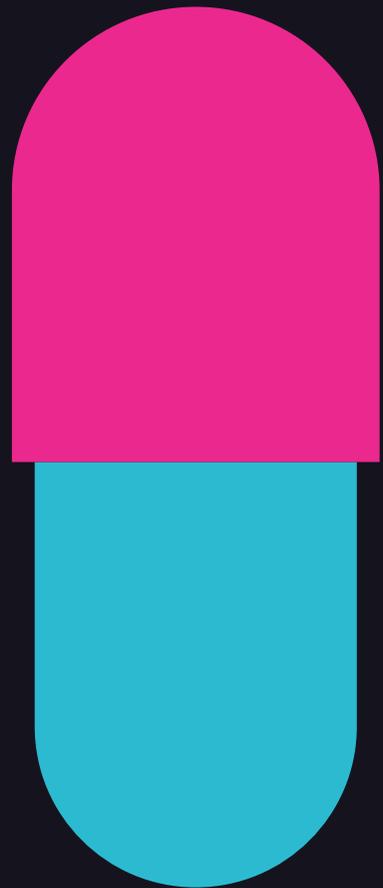


Polysubstance Use: Opioids and Stimulants

TOOLKIT



MICHIGAN OPIOID COLLABORATIVE

Background

In the United States, drug overdoses caused a record high [100,000 deaths](#) between April 2020 and April 2021. Overdoses involving co-use of opioids and stimulants (like cocaine and methamphetamine) are [increasing](#), and there are significant racial and regional [disparities](#) in mortality rates. Non-Hispanic Black Americans have experienced sharper increases in opioid/psychostimulant mortality than non-Hispanic White Americans.

Treatment of combined psychostimulant and opioid use is critical. Patients with opioid use disorder (OUD) and other co-occurring substance use disorders (SUDs) are [less likely](#) to be treated with methadone or buprenorphine and less likely to be retained in treatment.

The [Michigan Opioid Collaborative](#) has developed the following recommendations to respond to the increasing rate of deaths due to co-occurring opioid and stimulant use.

Treatment considerations

- Generally, do not discharge your patient for polysubstance use
 - Polysubstance is common, not rare: A [study](#) in 2017 found that most US veterans diagnosed with opioid use disorder also have at least one comorbid substance use disorder.
 - Patients may experience remission of OUD and continue to misuse stimulants or other substances.
 - [American Society of Addiction Medicine recommends continuing buprenorphine to treat OUD even with ongoing use of other substances.](#)
 - Consider referral to higher level of care when a patient consistently doesn't have buprenorphine in urine drug screens, is unable to follow-up/make appointments, or is unable to stabilize due to use of other substances.
 - Instead of discharging or referring your patient elsewhere, consider:
 - Increasing the frequency of visits to keep the patient engaged.
 - Questions such as: Is my patient willing to go to a higher level of care? Will barriers such as employment, transportation, or childcare impact their ability to attend another program or complete a residential program?
 - Encouraging other supports such as behavioral therapy or recovery-based groups.
 - Referring to a contingency management or SUD program while continuing medication management

- Treat co-occurring substance use disorders concurrently
 - Evidence supports other substance use decreases with treatment of OUD
 - [Buprenorphine treatment outcomes among opioid-dependent cocaine users and non-users](#)
 - [Association between methamphetamine use and retention among patients with opioid use disorders treated with buprenorphine](#)
 - Offer or refer patients to treatment for stimulant use disorder (e.g., behavioral treatments/psychotherapies including contingency management) while maintaining medication treatment for OUD.
 - Assess reasons for co-use, behaviors and patterns (e.g., is the patient using stimulants to counteract the effect of an opioid or vice versa? Provide education if needed – e.g., stimulant use does not protect against overdose but in fact increases risk.)
- Utilize a [harm reduction](#) approach to meet people “where they’re at.”
- Focus on treatment retention!
 - A [study](#) examining the impact of Adverse Childhood Experiences (ACES) on opioid use disorder treatment found that in a group receiving buprenorphine and counseling, each treatment visit decreased the odds of a return to illicit opioid use by 2%.
- Physical exercise may [decrease cravings](#) and [improve mood](#) during early abstinence from methamphetamine use.
- [Observational studies supporting the benefit of buprenorphine occurred in real world settings where polysubstance use is common.](#)
- [Contingency management](#) (CM) is an intervention in which individuals are reinforced or rewarded for evidence of positive behavioral change.
 - When people are rewarded for positive behavior, they are more likely to repeat that behavior in the future.
 - Has been shown to effectively treat substance use disorders, however there are often barriers such as lack of programs, funding and staff training in real world applications.
 - [Contingency Management/Motivational Incentives guide](#)

Clinical challenges

- [Patients with ADHD](#)
 - [Up to 24%](#) of patients with SUD have co-occurring ADHD.
 - Diagnostic challenge due to overlap of symptoms of ADHD, trauma, **and** untreated addiction.
 - Formal diagnosis requires neuropsychiatric testing, however in practice this can be a challenge due to access and insurance issues.
 - This study showed treatment of ADHD with stimulants [reduces relapse risk](#) in patients with ADHD and cocaine use disorder, even when the primary diagnosis is stimulant use disorder.
 - Consider long-acting stimulants when treating patients with SUD.
 - [Evidence supports using non-stimulant medications.](#)
- Patients with other psychiatric co-morbidities
 - [Lifetime prevalence of mental health disorders in people with SUD is >50%](#)
 - Screen for mental health conditions as part of intake
 - Treat all conditions concurrently
 - Screen for PTSD and if present, refer patient for treatment

Overdose prevention and harm reduction services

- Prescribe naloxone to your patients and remind them to avoid using alone.
- There have been multiple reports all over the U.S. of psychostimulants contaminated with fentanyl analogs, leading to overdose.
- Among overdose deaths between January-June of 2019, [37% of deaths](#) occurred with a bystander present.
- Educate your patients on where to find the closest [Syringe Service Program](#) (SSP) in Michigan
- Encourage use of fentanyl test strips, especially for non-opioid dependent people
- Screen your patients for [HIV](#) and [Hepatitis C](#)
- Discuss [PrEP](#)

Case example

- [Harm Reduction for Patients with Substance Use Disorders](#)