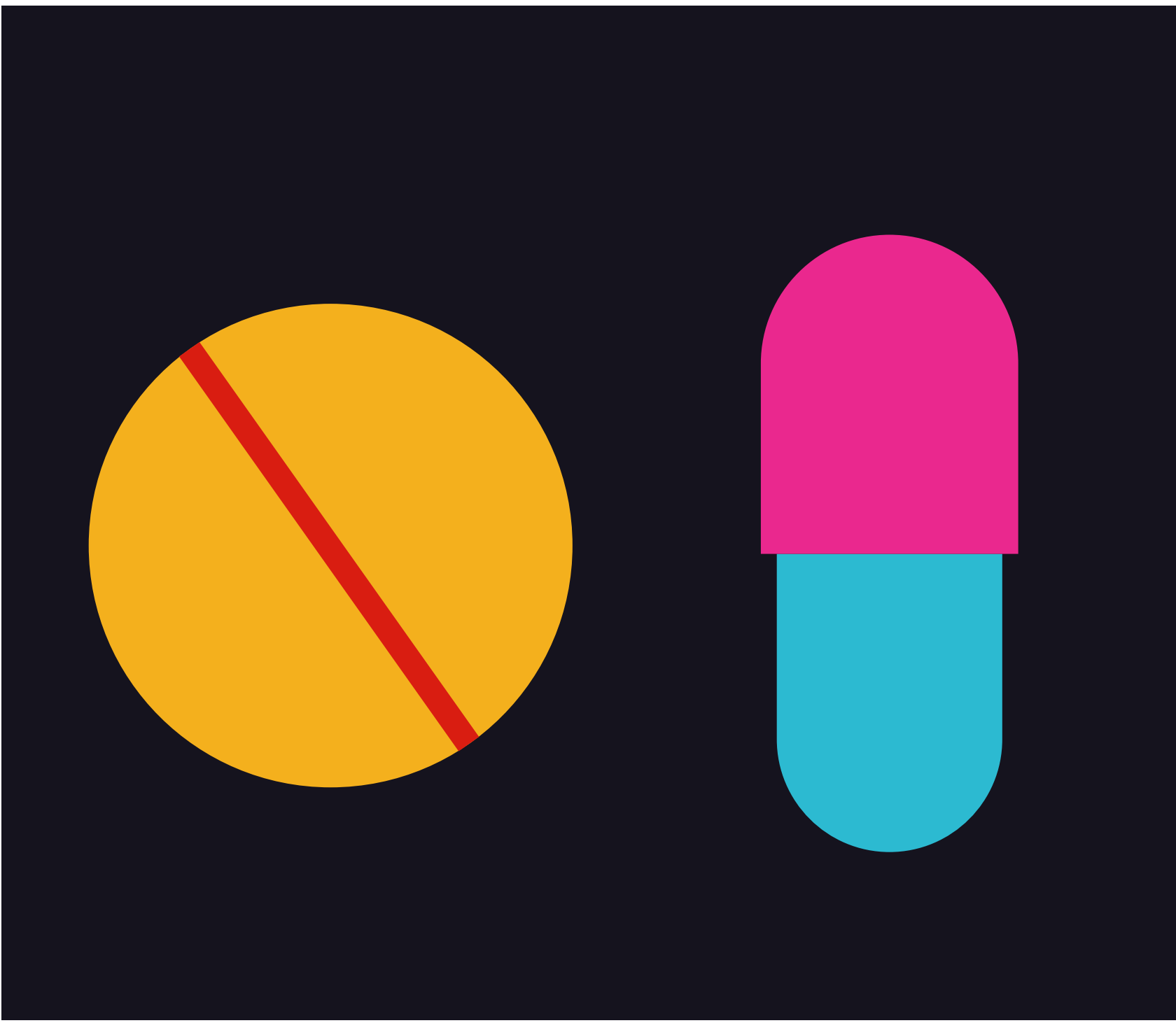
Polysubstance Use: Opioids and Stimulants

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 the return to substance use risks 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.
- 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