Best practices for RAAM clinics: An update

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META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION: PRIMARY CARE – HOSPITAL INTEGRATION

Disclosure

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- Presenter: **Meldon Kahan**
- Conflicts of interest: **None**

Development process

- Core writing team: Sarah Clarke, Mike Franklyn, Meldon Kahan, Tara Leary, Paola Nikodem
- Q&A format
- Questions based on suggestions from contributors and from META:PHI Google group discussions
- Answers supported by focused literature searches
- This year's presentation is an update of last year's presentation

ALCOHOL

Anti-craving medications (1)

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Naltrexone (LU 532):

- Naltrexone may be used in cirrhosis, even in liver failure
  - Monitor LFTs; d/c if they rise > 3 x above baseline
  - Risk of ongoing drinking far outweighs theoretical risk of further liver damage in cirrhotics
- 100 mg often more effective than 50 mg

Acamprosate (LU 531):

- Has been unavailable for months!
- Best for patients with severe AUD who experience withdrawal and are trying to abstain

Gabapentin

- Can be used to treat acute, mild withdrawal
- Also relieves subacute withdrawal and may relieve anxiety

Anti-craving medications (2)

Disulfiram

- Useful when dispensed by a spouse or pharmacist, and/or when the patient faces immediate, severe consequences if they continue drinking (e.g., loss of job, spouse, children)

Ondansetron

- Useful for early-onset alcoholics (< 25 years)
  - Usually have severe, destructive history of AUD
  - Related to deficiency of serotonin transport system
  - Don’t respond to SSRIs
  - Low doses of ondansetron effective, compounded
  - Not overly expensive

Anti-craving medications (3)

Varenicline

- Controlled trials suggest varenicline reduces drinking when given to smokers who also drink heavily

Thiamine

- High dose may be more effective than lower dose, though evidence is weak
- IM – better absorption
- 200 mg IM x 3-5 days, followed by 100 mg OD x 1 month

Medication combinations

- Controlled trials indicate combinations work better than single meds (e.g., naltrexone + gabapentin)

Baclofen

- High-dose baclofen not found to be effective in large RCT

AUD + anxiety/depression

- Three combinations have evidence of benefit for improving anxiety and drinking outcomes:

1. Naltrexone + sertraline
   - Improves both drinking outcomes and mood
   - Sertraline well-tolerated
2. Gabapentinoids (pregabalin, gabapentin)
   - Pregabalin works faster for anxiety (3-4 days) but gabapentin has greater evidence of benefit for AUD
3. Buspirone
   - Limited evidence of benefit

Concurrent AUD + OUD

- Probably first line is buprenorphine
- Some patients drink alcohol in part for relief of opioid withdrawal symptoms
- Relieving opioid withdrawal will reduce alcohol consumption
- Gabapentin is another option
  - But gabapentin increases risk of opioid overdose

Managed alcohol programs

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Indications:

- Drinks 10+ standard drinks per day
- Regularly drinks non-palatable alcohol (e.g., mouthwash, hand sanitizer, cooking wine)
- No response to an adequate trial of anti-alcohol medication
- Frequent emergency department visits
- Unable to participate or didn't respond to psychosocial AUD treatment
- Unstably housed or homeless

OPIOIDS

Choice of OAT

- Buprenorphine is first line
- Methadone is usually second line:
  - More potent, long and variable half-life, so greater risk of overdose than other potent opioids
  - But easier to start than buprenorphine (no risk of precipitated withdrawal)
- In most cases, patients should be started on buprenorphine but promptly switched to methadone if they continue to experience withdrawal symptoms, cravings and opioid use despite maximum buprenorphine dose (24-32 mg)
- Methadone may be first line patients who have previously done well on it or who don't want to try buprenorphine for fear of precipitated withdrawal

Avoiding precipitated withdrawal

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- Fear of precipitated withdrawal is a common reason for declining buprenorphine treatment
- Some methadone doctors prescribe methadone if the patient isn't able to make it to the office in withdrawal
- Two strategies for avoiding precipitated withdrawal:

1. Home induction
2. Micro-dosing

Home induction (1)

- Patients given ten or twelve 2 mg tabs and advised to start buprenorphine when they go into withdrawal
- 2-4 mg q 2H, maximum dose 12 mg on day 1
- Patients may be given the COWS to self-administer
- Give **careful instructions** on when and how to take the buprenorphine

Home induction (2)

- Pros:
  - Studies show that it is safe
  - Patients often find it easier to wait till they're in withdrawal at home rather than going to the office
- Cons:
  - Patients may start too early
  - Possibility of injection, diversion – but no evidence that this occurs, and patients are given only a few tablets

Microdosing (1)

- Bernese method – Vancouver protocol:
  - Buprenorphine 0.5 mg/day x 2 days
  - 0.5 mg bid x 2 days, 1 mg bid x 2 days, 1 mg AM, 0.5 mg HS x 2 days
  - Then 2 mg, 4 mg, 6 mg, 8 mg
  - Then 2 mg/day x 3 days, then 4 mg, then stop the opioid
- Transdermal buprenorphine patch can also be used
- Buprenorphine gradually displaces the opioid from the receptor, avoiding withdrawal
- Can extend the time course – e.g., 0.5 mg bid x 3-4 days
- Highest risk for precipitated withdrawal is when 8 mg dose is reached

Microdosing (2)

- Pros:
  - Patient doesn't have to go through withdrawal to start buprenorphine
- Cons:
  - Patient has to wait 7+ days before getting on a therapeutic dose
  - Have to cut tabs in quarters

Take-home buprenorphine (1)

- Take-home doses given according to prescriber's discretion
- Buprenorphine has very low risk of overdose compared to methadone so carries can be given more liberally
- In general, illicit opioid users should have daily observed dispensing with gradual introduction of carries when stable
  - They have a long-standing pattern of drug use involving diversion, snorting/injection, binge use
  - Daily observed dosing introduces safer pattern

Take-home buprenorphine (2)

Indications:

- Prescription opioid users who obtain meds only from their doctor, only use their tablets orally, & may not need daily observed dosing
- Sustained abstinence or non-problematic use of unauthorized drugs
- Stable housing, able to store meds safely
- Difficult to attend the pharmacy daily due to travel distance, family or work responsibilities
- Giving take-home doses can strengthen therapeutic bond – sign of trust

Buprenorphine + acute pain

- Acute pain: If non opioid treatments not effective, add short acting opioids for short period (usually not needed for > 1 week)
- Surgical pain: Not necessary to discontinue buprenorphine and can be destabilizing
- Add opioids if non-opioid meds ineffective

Buprenorphine + chronic pain

- Buprenorphine is a good choice for opioid failures, i.e., patients who continue to have severe pain and pain-related disability despite high opioid dose
- Canadian Guideline recommends opioid rotation in this case
- Buprenorphine a good agent for rotation:
  - Long duration of action so relieves withdrawal symptoms, which exacerbate pain
  - Safer than potent opioids

SROM

- For patients who have failed at or can't tolerate methadone and buprenorphine
- Less evidence on SROM, and is harder to monitor progress with UDS
- Extended release SROM is preferred agent – long duration of action
- Can be injected; illicit opioid users should have daily observed dosing
- Microgranules should be sprinkled on yogurt or in juice
- Initial dose 60-120 mg; maintenance dose 200-800 mg/day
- Titrate to relieve withdrawal symptoms, cravings and opioid use

UDS (1)

- UDS useful to monitor progress
- Patients may fail to disclose their substance use because of shame, or because they don't want take-home doses removed
- Test for norbuprenorphine, EDDP, oxycodone, morphine, benzoylecgnonine, benzodiazepines, fentanyl
- Newer analogues of fentanyl not detected on UDS strip and is often added to non-opioid drugs especially cocaine

UDS (2)

- Benzo detection times are highly variable
  - Clonazepam is hard to detect
  - Regular diazepam use can be detected for weeks
- EDDP is a metabolite of methadone – diverted methadone can be deadly
- Point of care testing can have false positives and negatives so order chromatography if surprising result, or if legal involvement (e.g., CAS)
- Use results for harm reduction (warn patients about risks of fentanyl) and counselling

UDS (3)

- Point of care testing should be done at every office visit
- Office visits (and therefore UDS) are done frequently at beginning of treatment, to titrate dose, etc.
- Testing between visits (e.g., weekly testing) is hard to enforce unless you withhold the script until testing done
  - There's no evidence to support this practice and it may be a factor in Ontario's high treatment drop out rate
- Do UDS even if patients acknowledges illicit drug use, to look for fentanyl

STIMULANTS

Pharmacotherapy (1)

- Cochrane review: Anticonvulsants are not effective in reducing cocaine use
- Naltrexone – weak evidence of effectiveness
- First choice for patients with concurrent alcohol and cocaine use disorder
- Buproprion has some evidence of effectiveness especially in cocaine users on OAT
- Can be a drug of abuse so should be dispensed with methadone

Pharmacotherapy (2)

- Several trials have shown that stimulants reduce stimulant use
- Trials were short term and outcomes were of questionable clinical significance
- Trials did not demonstrate sustained abstinence from cocaine or crystal meth, or improvements in mood, crime rates, employment, etc.
- Therefore, stimulant therapy not recommended given their risks (diversion, injection, cardiovascular complications, psychosis)

Pharmacotherapy (3)

- A trial of stimulants may be considered in patients who are engaged in psychosocial treatment and are highly motivated to quit but have strong cravings and periodic use
- Recommended agents are modafinil (used for narcolepsy) and lisdexamfetamine (long-acting stimulant)
- These agents are not more effective than other stimulants, but have less potential for abuse

Stimulants + ADHD

- ADHD appears to be a risk factor for stimulant use disorder
- Two small RCTs have shown that stimulants reduce stimulant use and improve ADHD symptoms
- Intervention meds: Mixed amphetamine salts 60, 80 mg; OROS methylphenidate up to 180 mg
- ADHD is a difficult diagnosis to make in adult stimulant users
- Use a formal validated tool
- Check patient's cardiovascular and psychiatric status
- If formal diagnosis made, use sustained release mixed amphetamine salts or methylphenidate
- **Therapeutic trial:** Discontinue if no clear and convincing evidence of decreased stimulant use, through UDS and self-report

Harm reduction

- Harm reduction kits: Pyrex system for crack smoking, lip balm, ascorbic acid – contact public health unit for supplies
- Do regular UDS for fentanyl
- If fentanyl positive, give take-home naloxone kit and warn patient re risks
- Consider naltrexone – may reduce cocaine use and has high affinity for receptor so may protect against fentanyl overdose
- Strong association between stimulant use and high risk sex
- Counsel patients on safe sex practices, and avoiding sexual triggers to use

Crystal meth–induced psychosis

- Controlled trials show that antipsychotics are effective at reducing psychotic symptoms and retaining patients in treatment, but not at reducing crystal meth use
- Trials found that olanzepine and risperidone were the most effective antipsychotics

Counselling for stimulant use

- Psychosocial counselling is the mainstay of treatment
- Cochrane review: All forms of counselling have been shown to be more effective than no counselling
- Most effective are contingency management with vouchers, and community reinforcement – a structured behavioural intervention

BENZODIAZEPINES

Tapering benzodiazepines (1)

- Many patients with a substance use disorder are on therapeutic doses of benzodiazepines
- Tapering is almost always indicated, although it may not be the top priority clinically
- Tapering may:
  - Improve mood, energy, sleep
  - Reduce risk of adverse drug interactions e.g., falls, sleep apnea from opioid/benzo or alcohol/benzo combinations

Tapering benzodiazepines (2)

- Taper with clonazepam, daily dispensed if the patient acquires benzos from multiple sources
- If on very high dose, convert to ½ - 2/3 the equivalent dose of clonazepam; adjust up or down according to symptoms
- Diazepam 5 mg = lorazepam 0.5 mg-1 mg = clonazepam 0.5-1 mg
- Scheduled dosing
- Flexible, slow reduction based on patient negotiation
- Emphasize that patients will feel better with tapering – more alert, energetic, better mood

Tapering benzodiazepines (3)

- May not be possible to taper to zero in every case, especially in patients with an underlying anxiety disorder who have been on benzos for many years
- When tapering, use other meds to treat active anxiety disorder
  - Meds with the strongest evidence of benefit are duloxetine, escitalopram, venlafaxine, pregabalin
  - Other agents have also been shown be effective: sertraline, mirtazapine, buspirone, fluoxetine
- See patient regularly, provide supportive counselling
- Formal group and individual psychotherapy can also be helpful, e.g., CBT

COUNSELLING

Strong therapeutic bond

- This is critical for effective counselling; has a major impact on treatment retention and outcome
- At least one member of a team should have an ongoing relationship with the patient – could be physician, nurse or case manager
- Not based on any one technique - bond is formed when therapist shows empathy, honesty, concern, and high regard for the patient
- Patient needs to feel that the therapist is on their side, that they can be trusted

Main messages (1)

- Substance use disorder is a chronic illness, not a weakness or a moral failing. Many people who use substances have shown great strength in their lives.
- There are effective treatments, involving medications and counselling. People can and do recover. Your life will get much better when you are in recovery.
- The **reward centre** in the brain releases **dopamine** when we engage in a survival activity such as eating. The memory and command parts of our brain causes us to regularly seek out food**.** Drinking and using drugs cause an **even bigger** release of dopamine, causing us to seek substances rather than food.

Main messages (2)

- **Influence of trauma:** People with a history of trauma or adverse childhood events have high levels of anxiety, depression, and suicidality. Using substances can help people to cope with these feelings and allow them to feel at ease and relaxed.
- **Paradox of drug use:** Sometimes the patient can't imagine life without the substance because they cause powerful but temporary relief of anxiety, and withdrawal markedly increases anxiety. But anxiety improves dramatically with abstinence.

Trauma-informed care

- Providers should recognize and explain the role of trauma in substance use disorders
- Emphasize the patient's resilience and successes despite the impact of trauma
- Encourage connect to trauma programs, e.g., Seeking Safety

Domestic violence

- Ask all patients about violence from partners/family members
- If physical violence present, discuss options:
  - Programs for victims of domestic violence
  - Shelter or WMS or stay with a friend – where the victim is safe from the abuser
- Encourage patient to contact police, and collect evidence
- Discuss concerns about police contact
- Emphasize that abstinence will make it easier to make the right decisions

WHAT'S NEXT?

What else is in the book?

- List of apps on self-management of substance use
- Description of motivational interviewing
- Harm reduction advice for alcohol and opioids
- Community resources

Next steps

- Currently under review
- Final version will be sent to Google group, posted on META:PHI website, and printed

THANK YOU!