Best Practices for RAAM Clinics

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WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Faculty disclosure

- **Faculty:**
  Dr. Meldon Kahan, Associate Professor, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto
- **Relationships with commercial interests:**
  None

Learning objectives

- **Outline best practices for RAAM clinicians in**:
  - Managing alcohol withdrawal in the RAAM clinic
  - Prescribing anti-craving medications
  - Buprenorphine in the ED and WMS
  - Buprenorphine induction (home vs office; micro-dosing)
  - Managing substance use and anxiety

Background

A force for system change (1)

- The current health care system is failing addicted patients
- Low-cost, safe, and very effective treatments for alcohol, opioid, and other substance use disorders are available
- Yet addicted patients rarely receive these treatments
- The addiction treatment system is also failing patients:
  - Psychosocial treatment programs usually do not offer medication-assisted treatment and are often difficult to access
  - High-volume methadone clinics don't manage concurrent substance use or mental disorders, and don't transfer patients back to primary care

A force for system change (2)

- The RAAM clinic model is a **powerful force for system change**
- RAAM clinics provide immediate, on-site, low-barrier access to comprehensive and highly effective treatment
- RAAM clinics have the potential to:
  - Reduce morbidity and mortality and improve quality of life for thousands of Ontarians with substance use disorder
  - Change practice in the wider health care system – EDs, other hospital units, primary care, and the addiction treatment system

Why best practices are needed

- Many RAAM clinicians are new to this type of practice
- Limited availability of high-quality clinical information and guidance
- Most resources are aimed at primary care, not addiction clinicians
- RAAM patients have complex and urgent problems

How best practices can help

- Provide clinical information and direction in the face of uncertainty and complexity
- Keep RAAM clinicians up to date on new developments in addiction medicine
- Enhance clinicians' confidence and clinical skills

Process for developing best practice recommendations

- Core writing team (in alphabetical order):
  - Sarah Clarke, PhD (META:PHI)
  - Paola Folino, RN BScN MPH-NS (Health Sciences North)
  - Mike Franklyn, MD CCFP (Health Sciences North)
  - Meldon Kahan, MD CCFP FRCPC (Women's College Hospital, META:PHI)
- Sources:
  - Focused literature searches
  - Physician clinical experience
- Draft to be circulated to larger group of RAAM clinicians (November 2018)
- This presentation is a preview of our best practice recommendations on selected topics

Management of Alcohol Withdrawal

RAAM management of withdrawal

- **ED** management often suboptimal
  - Dosing not aggressive enough
  - Patients discharged before withdrawal is resolved
  - No treatment offered for underlying AUD
- **WMS facilities** not equipped to treat withdrawal or AUD pharmacologically
- **RAAM clinics** can treat alcohol withdrawal electively as a therapeutic intervention:
  - Heavy drinkers often experience daily withdrawal symptoms and drink to avoid these symptoms
  - Elective treatment of withdrawal will increase the effectiveness of anti-craving meds and counselling

Indications

- Reports withdrawal symptoms in AM or early afternoon: tremor, anxiety, quickly relieved by alcohol
- Not on methadone or high doses of opioids
- No cirrhosis/liver disease or respiratory disease
- Endorses abstinence as a goal but has been unable to abstain without medical assistance

Protocol

- Advise patient to have last drink the night before
- Use symptom-triggered benzodiazepine protocol using CIWA-Ar or SHOT
  - Diazepam for healthy younger patients
  - Lorazepam for patients who are older, on opioids or other sedating drugs, have respiratory disease or liver dysfunction
- Discharge when withdrawal has resolved
- If still in mild withdrawal when RAAM clinic closes, transfer to WMS – they can give scheduled benzodiazepine treatment with MD/NP order (e.g., diazepam 10 mg q 4H x 1 day)

Transfer to emergency

- Be ready to transfer patient to ED if…
  - Withdrawal not resolving
  - Vomiting, profuse sweating, tachycardia
    - May need fluid/electrolyte replacement or cardiac monitoring
  - Sedated
    - May need monitoring of O2 sats
    - Could indicate benzodiazepine toxicity, or hepatic encephalopathy (if underlying cirrhosis), or opioid toxicity (if on opioids)
  - Confused, agitated
    - Onset of DTs

On discharge

- Emphasize that patient no longer needs to drink alcohol for withdrawal relief, and can now maintain abstinence
- Prescribe anti-craving medication (e.g., naltrexone, acamprosate, etc.)
- Arrange follow-up and counselling

Gabapentin for withdrawal

- Consider **gabapentin** as an alternative for patients with no history of seizure or other serious complications of withdrawal
- A few controlled trials have shown that it is effective for mild/moderate withdrawal
- Advantages over benzodiazepines:
  - Patients are more likely to abstain after withdrawal resolves
  - Gabapentin relieves subacute withdrawal symptoms and cravings
- However, not everyone responds to gabapentin; clinician should switch to benzodiazepine protocol if non-response

Gabapentin protocol

- 600 mg gabapentin q 2H, to maximum of 3600 mg/day, according to CIWA or SHOT
- Switch to (or add) benzodiazepines at any time if patient getting worse despite gabapentin
- Lower dose over next couple of days if patient reports sedation, etc.
- Optimal therapeutic dose for cravings is **1800 mg** (600 mg tid) or more

Alcohol anti-craving medications

Anti-craving meds are effective

- Anti-craving medications for alcohol are not as dramatically effective as OAT is for opioids, but they **still have proven benefit**
  - Especially effective when combined with psychotherapy
- Should be **routinely offered** on the first visit
- Some evidence that combined pharmacotherapy may be more effective than a single agent (e.g., naltrexone + gabapentin)

Medications (1)

- **Naltrexone (LU 532)**
  - First-line medication
  - Blunts reinforcing effects of alcohol, reducing cravings
  - Can help full spectrum of AUD
  - Often 100 mg more effective than 50 mg
  - No need to be abstinent before initiation
- **Acamprosate (LU 531)**
  - First-line medication
  - Relieves subacute withdrawal symptoms
  - Should be abstinent for a few days before starting
  - Best for patients with more severe AUD who experience withdrawal and are trying to abstain

Medication (2)

- **Gabapentin**
  - Can be used to treat acute, mild withdrawal
  - Also relieves subacute withdrawal and may relieve anxiety
- **Disulfiram**
  - Deters drinking by causing toxic reaction when alcohol is consumed
  - 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, custody of children)

Using buprenorphine

Immediate access

- Controlled trials have shown that patients who receive buprenorphine in the ED are more likely to attend follow-up treatment than if they receive only counselling and referral
- Buprenorphine should be dispensed on-site to patients in withdrawal in the ED, other hospital units, and RAAM clinics
  - RAAM clinicians should provide education and training to providers in other settings on induction
- Set up care pathways to facilitate access to buprenorphine to clients in withdrawal management services, supervised injection sites, and other community settings
  - Clients may not be willing or able to attend a medical setting but may still benefit from buprenorphine as a harm reduction tool

Avoiding precipitated withdrawal

- 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
- Address the fear of precipitated withdrawal with all patients
- If patient is reluctant to try office induction or misses a scheduled induction, considering offering one of two strategies as an alternative:
  1. Home induction
  2. Microdosing

Home induction protocol

- Give six to ten 2 mg tabs and advise to take first dose when they go into withdrawal
- 2–4 mg q 2H, maximum dose 8-12 mg on day 1
- Provide **careful instructions** on how and when to take the tabs
- Consider giving a copy of the COWS for self-administration

Home induction pros and cons

Advantages	Disadvantages
• Studies show that it is safe • Patients may find it easier to wait at home until they are in withdrawal than come to the clinic in withdrawal	• Patients may start too early, causing precipitated withdrawal • Possibility of injection, diversion

Microdosing protocol

- Bernese method: Buprenorphine is taken concurrently with patient's usual opioid, eg
  - Bup 0.5 mg/day (1/4 of a 2 mg tab) x 3 days, then 2 mg/day x 3 days, then 4 mg, then switch to usual protocol
- Buprenorphine gradually displaces the opioid from the receptor, avoiding withdrawal

Microdosing pros and cons

Advantages	Disadvantages
• Patient doesn't have to go through withdrawal to start buprenorphine	• Patient has to wait 7+ days before getting on a therapeutic dose • Have to cut tabs in quarters (easier with a pill cutter)

Comorbid anxiety

A common symptom

- Many patients with SUDs present with severe anxiety
- Anxiety may be due to…
  - Imminent loss of job, relationship, or other catastrophe
  - Underlying anxiety disorder (e.g., PTSD, GAD, etc.)
  - Substance-induced anxiety
  - Withdrawal symptoms

Managing anxiety (1)

- Explain to patient that, while substances are initially very effective at relieving anxiety, ultimately they have a profoundly negative impact on mood:
  - Develop tolerance
  - Experience withdrawal symptoms
  - Poor job performance, interpersonal conflict
  - Sedation, fatigue, depression caused by high doses of alcohol, opioids
- Explain that mood often improves quickly and dramatically with reduced substance use

Managing anxiety (2)

- Many patients (especially women) experience tremendous guilt and shame over their substance use
- Present the disease model of SUD
  - Explain that SUD is not their “fault”, but due to childhood trauma, genetics, difficult social circumstances, etc.
  - SUD doesn’t make you a bad, weak, or stupid person
  - This message has extra import coming from a **physician**; reinforces SUD as a **medical condition**

Managing anxiety (3)

- Arrange frequent follow-up
- Connect patient to AA, community services
- Assist with practical issues
  - E.g., OW or short-term disability – time off work can help patient focus on recovery
- Encourage patient to…
  - Reconnect with family and friends
  - Stick with it – slips and relapses are very common in early recovery
- Acknowledge and reinforce progress even if it's partial and/or temporary

Pharmacotherapy

- Treating withdrawal and prescribing anti-craving medications may relieve anxiety
- SSRIs are usually the treatment of choice
- Pregabalin can be prescribed concurrently – fast onset of action (3-4 days)
- Trazodone for sleep, or prazosin if PTSD nightmares
- Avoid benzodiazepines if possible (except for treating alcohol withdrawal)

More information

Availability

- Full document will be available on the META:PHI website, under Provider Tools, in November

  http://metaphi.ca/provider-tools.html

- We welcome your feedback on the first edition!

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Thank you!