META:PHI NEWSLETTER
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION — PARTNERS IN HEALTH INTEGRATION
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PROGRAM INNOVATION

Modernizing the Treatment of Alcohol Withdrawal Syndrome in the Emergency Department

Brady Bouchard MBBS MPH CCFP(EM) CCSAM
Provincial Emergency Medicine Addiction and Vulnerable Populations Lead,
Battlefords Union Hospital / RAAM Clinic, North Battleford, Saskatchewan

As noted recently by Giesbrecht, alcohol is responsible for a larger health system burden and overall cost to society than any other substance. Alcohol withdrawal syndrome (AWS) is itself a significant proportion of substance use disorder presentations to Canadian emergency departments (EDs), and yet there remains a wide gap between the care we provide to this patient population and what the evidence suggests we should be doing.

In Saskatchewan, we have a unified provincial health authority that has allowed us the opportunity to modernize our care in an evidence-based fashion. Prior to this, there was a fair degree of variation in treatment approaches in the province, with some former health regions having no structured approach at all. Our new provincial order set, launched in October 2023, has 3 substantial changes.

First, we have provided two separate medication "pathways" (benzodiazepine (BZD) or phenobarbital (PB) monotherapy) to be used at clinician preference. Second, we have moved away from the ubiquitous CIWA-Ar scale to the Brief Alcohol Withdrawal Scale (BAWS) for monitoring and treatment decisions. And finally, we have included pre-printed prescriptions for medications for alcohol use disorder (MAUD) to hopefully increase their use on an outpatient basis.

Our inclusion of a PB monotherapy approach is based on growing evidence of safety and efficacy, as well as local published experience. Our order set utilizes an initial 10mg/kg IBW IV load, followed by smaller titration doses. Our 2022 retrospective review performed at one regional ED showed a substantial reduction in hospital admission rates with a PB monotherapy approach compared to BZDs (Pistore 2022). We have grant funding for a pilot randomized controlled trial (RCT) to prospectively compare these approaches.

The CIWA-Ar scale, while ubiquitous, is long, imprecise (with wide, underspecified ranges) and includes several subjective criteria, leading to poor inter-rater reliability. Because of these known issues, several modern replacements have been developed. We selected the BAWS: developed at Johns Hopkins, it is in ongoing clinical use at both their hospitals and has published internal and external validations. It removes much of the subjectivity and focuses on objectively measuring the main signs and symptoms involved in presentations of alcohol withdrawal.

Finally, Spithoff demonstrated that only a tiny fraction of patients with AUD are being offered evidence-based anti-craving medications (or medications for alcohol use disorder, MAUD) in the ED. We need to do better here, certainly. We have included in our order set pre-printed prescriptions for the two most common MAUDs (naltrexone and acamprosate), with standardized dosing and duration to hopefully increase the amount of prescribing that occurs from the ED.

It can be difficult to get buy-in for clinical practice changes for substance use amongst many competing priorities in resource-strapped EDs. It was important to us that we utilize nudge theory and nudge strategies to encourage change without mandating it, hence making as much of the order set optional as possible. Early feedback is encouraging, and we are happy to share our experience with others.

FACES FROM THE FIELD

Kyra Sedor BSc
META:PHI Community Consultant
Person with Lived Experience

A doctor once told me you have to "sit with the suck", the only way out is through.

I hated hearing, "When's the last time you used?" and "Why can't you just stop?" I thought, if you only knew what I go through. People fail to understand how utterly consuming and intense the inner thoughts and emotions were - all day, every day. *I feel like garbage, I look like garbage. What am I going to do today? I'm not going to use. Today is the day! Maybe today I'll get help. But I'm going to feel so bad, how am I going to get any money, do I have anything I can sell, anyone to borrow from? It's 8 am, should I go to the clinic, I gotta go see if I can find a smoke, I can quit on my own, I wish I had a coffee, I'm a loser.*

I cried. And cried, and paced, and loathed myself. The brain rewires all logic and reason, and tricks you into justifying, excusing and rationalizing everything: *I can moderate myself, this will be the last time. I'll feel better, I'll stop crying, I'll only do this once. I'll be able to eat, I'll call someone, just a little bit, no one will know. If I have to pay for medication, I might as well pay for the real stuff. I need it just to get going, then I'll stop. The streets aren't so bad.* The guilt and self-recrimination were horrendous; wanting to get clean but making the wrong choices.

I didn't have the means or clarity to control my emotions, learn from my mistakes, or even see the relationship between the two. This cause and effect cycle, negative feedback loop, needs to be controlled and monitored. The same way insulin regulates sugar, I needed help learning how to regulate my emotional ups and downs. Learning to recognize where you're going before you get there has been the key to my success. Even now, if I'm too happy or too sad, I need to do something physical or consciously change my thoughts.

The road to sobriety, I found, was like an open pit mine, except you're starting at the bottom and you're ever so slowly climbing out, each level a new coping mechanism. After a few days I was able to live in the moment for short periods of time – to watch a movie, have a meal – even 45 minutes without that inner fight was a huge blessing. One day at a time. (No reason to think ahead because if you cannot get sober there is no future.) You really have to want to stop, and not think about using, in order to stop using – this is the hard truth. It takes unexplainably tremendous effort to turn these thoughts away.

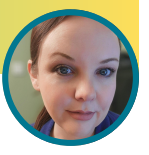
Even today I struggle finding a comparison matching the ferocity – like the 30 seconds after you crash your car before you realize you're okay – and especially the duration, of these emotions. Imagine you're a parent and the school calls: your child is hurt and in hospital. That's all you know. You need to be there, your mind is going every which way trying to figure out what happened. You're frantic; left, right, which way is shorter, you're getting every red light. That frustration, panic, anger is akin to how I felt about myself. The instinctual need to get to your child is the craving. Being a mother now, it hurts me to even compare the two, but that's what I experienced: needing to be somewhere with all my heart but unable to get there.

If you know someone struggling, there are so many other ways you can ask how they are doing rather than asking the last time they used.

In the Media

Closing Practice After 20 Years - Toronto Life

PERSPECTIVES



Implementing Contingency Management for Stimulant Use Disorder

Stephanie Rochon RPhT
Coordinator of the Brant Haldimand Norfolk RAAM Clinic
Brant Community Healthcare Systems, Brantford, Simcoe, and Dunnville, ON

At the Brant Haldimand Norfolk RAAM clinic, our mission is to provide comprehensive care to individuals with concurrent disorders. Staffed by a multidisciplinary team including physicians, nurse practitioners, concurrent disorder clinicians, counsellors, case managers, patient navigators, laboratory technicians, and social workers, our clinic manages a high volume of patients facing complex challenges.

Coming to us from various sources, including the emergency department, inpatient mental health units, and partner agencies, patients present with severe substance use and mental health disorders. A significant portion of these individuals struggle with concurrent severe stimulant (methamphetamine or cocaine) and opioid use, compounded by symptoms of severe mental illnesses such as PTSD, borderline personality disorder, or substance-induced or primary psychotic disorders. Unfortunately, accessing treatment and support can be challenging for these complex cases.

In response to this need, in 2020 we implemented a Contingency Management (CM) program, utilizing the protocols outlined in the manuals authored by Dr. Nancy Petry. CM offers a therapeutic intervention that rewards individuals for making positive changes and supports them in maintaining those changes.

At our RAAM clinic, CM is integrated as a core component of our treatment planning for individuals seeking to stop using stimulants. This program focuses on measurable target behaviors, that is, drug abstinence confirmed by point-of-care urine drug testing strips. We establish a structured framework for achieving and maintaining recovery by setting clear objectives and consistently monitoring progress. Concrete reinforcements, such as vouchers and prizes, contingent upon meeting these objectives, serve as powerful motivators, enhancing appointment and treatment adherence and outcomes.

Our implementation strategy aims to seamlessly integrate CM into existing clinic processes, minimizing additional burdens on staff and maximizing treatment effectiveness. Automated reminders ensure clients remember to attend during clinic hours, with flexible scheduling (including walk-ins) during operational hours to accommodate diverse needs.

As part of our protocol, patients are guided through the CM process, from signing a treatment agreement and understanding the risks, rules, and benefits, to receiving a tour of the clinic, explanation of urine sampling procedures, and viewing the prize cabinet and examples of vouchers. A twice-weekly sampling schedule, coupled with calendar tracking and support from counsellors or case managers, reinforces commitment and accountability.

At the first visit, patients are primed by receiving rewards regardless of their sample results. This helps establish positive momentum and reinforces the value of their participation. With an average cost of $265 per person for a 12-week program, supplemented by generous donations, CM proves to be a cost-effective treatment that can improve adherence to appointments with providers, counsellors, and case managers to support clients in achieving their treatment goals and improve quality of life.

Our experience highlights the transformative potential of CM in treating stimulant use disorder at RAAM Clinics. By integrating interventions such as contingency management and anti-craving medication, we aim to address the limited availability of stimulant treatment in communities, encouraging expansion of services.

For more information on CM, refer to Dr. Nancy Petri's book, 'Contingency Management for Substance Abuse Treatment: A Guide to Implementing This Evidence-Based Practice'

THOUGHTS FROM A SEMI-RETIRED ADDICTION DOCTOR

The Crisis in Primary Care: How Should the Addiction Field Respond?

Meldon Kahan MD CCFP FRCPC
Medical Director, META:PHI

Primary care is in trouble. Family physicians are retiring early or switching to a focused practice. The Ontario Medical Association estimates that 2.3 million people are without a family doctor, and this number is expanding quickly. Nurse practitioners are providing valuable primary care services, but there are not nearly enough NPs to meet the need.

Family physicians are leaving because they are overwhelmed with complex patients, administrative burden, rising costs, and lack of support from the general health care system. In a way, family physicians are experiencing ongoing "moral injury": they are finding it increasingly difficult to provide the care that they know patients need, and this leaves them feeling guilty, angry, and betrayed by a non-responsive system. This has repercussions for patients with substance use disorders. It would be best if stable patients received opioid agonist treatment in a primary care setting. Those patients who do, do just as well as those receiving OAT in specialized settings (Krownyk 2019). And patients receiving care in a specialized OAT clinic are less likely to receive primary care; one study found that patients who are on opioid agonist therapy have substantially lower rates of screening and chronic disease management than matched controls (Spitoff 2019).

Yet, many patients with substance use disorders don't have family doctors, and already overburdened family physicians are reluctant to take on more clinical tasks, such as prescribing OAT. Probably the best approach is to build collaborative or shared care services. These services are most likely to be accepted by family physicians because they make management of their own patients with SUD easier and more satisfying. RAAM clinicians can provide primary care providers with valuable advice and support in in managing common substance-related issues in primary care - alcohol use disorder, opioids for chronic pain, benzodiazepines for anxiety, cannabis smoking in youth. Consider a primary care provider with a legacy patient on high doses of opioids for chronic pain: the RAAM clinician could help diagnose or rule out a prescription opioid use disorder; support the primary care provider in initiating buprenorphine treatment if indicated; or make recommendations on tapering or switching to a different opioid.

Formal shared care programs require funding. But informal partnerships between RAAM clinics and neighbouring primary care clinics are a good start. RAAM clinicians can support their primary care colleagues by making themselves available for phone calls and urgent consultations. Sometimes a simple phone call is all the primary care provider needs.

It would be helpful to hear of RAAM clinicians' successes (and difficulties) in connecting with and supporting primary care.

Please post on the META:PHI listserv. There is a great deal of innovations and new connections happening in the field right now so please share!

EVENTS

2024 Webinar Series - Session #4

Neuro-Nexus: Neurodivergence and Substance Use Care
Megan O'Brien
Wed May 15, 7-8:30 pm Register **HERE**

RAAM Monthly Videoconference Dialogue Series

Primary Care Overload and Advocacy for RN Prescribing
Wed May 1, 12-12:45pm

Addiction NP Videoconference Discussion

Wed May 29, 12-1 pm
To join any of these events contact laurie.smith@wchospital.ca