META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

NEWSLETTER

PERSPECTIVES

Being Trauma Informed is Not Enough

Josh Richardson RP RPN Psych Cert BA Hons
Psychotherapist and Practical Nurse Advisor, META:PHI Advisory Committee

There exists a popular thesis that all drug addiction stems from trauma. Whether inherited, vicarious, or first-hand, it reasons that trauma is the causal mechanism by which a drug user is changed into a drug abuser. Along with this popular thesis, however dubitable, we have seen an imperative emerge for clinicians to be 'trauma informed.' No matter what we may think of this phrase, it is apparent that people who use drugs and/or alcohol can and do suffer from the effects of trauma and other concurrent- mental health problems. Few would likely debate that proper assessment, diagnosis, and treatment should take place; fewer still would argue for their delay. And yet, this is what we risk doing if we don't offer patients access to evidence-based treatment for trauma-related disorders and other concurrent mental health conditions.

Systems as Extensions of Knowledge

Physicians, therapists, nurses, and psychologists assess, diagnose, and recommend treatment as appropriate, each according to their abilities and each according to the patients' needs. When these steps do not occur, mental health and substance use supports fail their patients. Preventing such failure requires patients having timely access to reliable clinical tools and practices, as well as sound clinical judgment. No one clinician or clinic has access to all the tools, or knowledge. So, systems of communication, referral, and professional practice function to meet these gaps in knowledge and expertise in order to benefit patients.

Co-operation Between Human & Natural Science

The human and natural sciences can differ greatly in their approaches to the same issue. This contrast is perhaps most stark when the physician or nurse practitioner

prescribes medication for the same ailment, for which the psychotherapist or psychologist resorts to conversation. This contrast affords an opportunity for co-operation between body and mind, prescriber and therapist, with the ultimate goal being for the patient to thrive. In order for this to happen, we must transition from information to knowledge, from analysis to synthesis, and connect those who suffer with the means for their recovery developed by both the human and natural sciences. This means providing patients with universal access to high quality evidence-based pharmacotherapeutic and psychotherapeutic supports for substance use and concurrent mental health problems. We must ensure medical and counselling services work in tandem to provide the best holistic and scientific treatments available so that our patients can flourish in mind, body and soul.

FACES OF THE FIELD

Robyn Nocilla BScN, MSc, NP-PHC
Grey-Bruce Health Services, Owen Sound

My day starts at 0800 when I check online for any new in-hospital consults, review new inpatient charts, and address any urgent issues. At the daily 8:30 am huddle, our team - Program Manager, RAAM SWs and RPN, WMS who are RPNs and non-regulated staff, and Community Assisted Treatment Services (CATS) - reviews each client. Admitting substance for withdrawal, current withdrawal scores, medications, primary care concerns, current length of stay, and further Tx planning are discussed with input from all staff encouraged. My role includes assessing those in acute withdrawals requiring medication and reviewing and adjusting tapering scripts. If patients require treatment of their withdrawals, I assess and prescribe standard loading of diazepam (based on their CIWA score) or offer OAT. Patients with history of seizures are sent to ER for assessment and medical stability and are then able to come back to WMS for further management. If patients have any complications, the ER and I liaise to determine further treatment.

I run the RAAM clinic Mon and Fri (physicians run it Tues-Thurs), which operates daily from 9 – 12 pm, and I work alongside a RAAM counsellor. Patients have the choice of virtual, phone or in-person bookings. In the afternoons I review new clients, and if no regulated staff are available, I complete COVID-19 rapid swabs on new admissions. This process has allowed the WMS to stay open in the midst of the pandemic. During the day I may be paged by ER or hospital clinicians for phone consultation and advice regarding withdrawal Tx. Otherwise, I work on education for staff on addiction and harm reduction within the organization, update policies/procedures, and review and update process/flow and RPN supervision for WMS.

The Addiction Treatment Services NP is a newer role for GBHS and has been very rewarding for me. The ability to use my full scope of practice in primary care, mental health and addiction is incredible! Knowing that we are not a medical detox facility, our biggest struggle continues to be creating a balanced and standard process in treatment for those who present to WMS in withdrawal. Every challenge becomes an opportunity to learn and grow and create further movement in an ever-changing addiction world.

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Join the META:PHI Google group:
E-mail laurie.smith@wchospital.ca to be added.

EVENTS

RAAM monthly videoconferences:

Prescribers	Dec 14	8 am
Nurses	Dec 8	9 am
Counsellors	Dec 10	9 am

META:PHI Webinar: January 12, 2022

Dr. Jonathan Bertram

Opioids, chronic pain and opioid use disorder: What can we learn from the POINT study?

PROGRAM INNOVATION

Medically Supported Alcohol Withdrawal Management: Where to Detox

Shawn Dookie NP-PHC RN (EC) BSc
Balmoral Withdrawal Management Centre, Thunder Bay

Just under 20% of Canadians will have an alcohol use disorder (AUD) within their lifetime, and of these, half will develop alcohol withdrawal syndrome (AWS). Luckily, the vast majority will recover with no medical intervention. The others need medically supported withdrawal management. An important first step in diagnosing AUD and AWS is knowledge of The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) criteria. Critical too, is knowing the pathophysiology of AWS, specifically its effect on the neurotransmitters of the autonomic nervous system. Withdrawal management resources range from community-based outpatient supports to residential withdrawal management settings, to inpatient acute withdrawal management, all with varying amounts of on-site medical and nursing support. At the 25-bed Balmoral Withdrawal Management Centre in Thunder Bay, we offer services to individuals with moderately severe AWS.

AWS can present with a variety of clinical manifestations – from mild symptoms of autonomic hyperactivity, gastrointestinal symptoms to full blown delirium. True delirium tremens (DTs) can occur in 5-10% of AWS cases and can be fatal if inadequately treated. Using an evidence-based and peer-reviewed tool like the Prediction of Alcohol Severity Score (PAWSS) helps determine who is at highest risk of moderate-to-severe AWS. This is extremely helpful in identifying mild withdrawal to minimize the unintended consequences of overtreating symptoms that would likely resolve without intervention. From a withdrawal management perspective, a PAWSS of 3 or less is considered low risk for severe AWS and clients can be treated in the community or even at home with support of a local RAAM clinic. PAWSS of 4 or more should be referred to a residential withdrawal management centre or inpatient setting, depending on the resources in your community.

The Balmoral Centre has on-site NP/MD coverage 7-days a week, 12-hours a day, and an on-call after-hours system. AWS is managed with a variety of medications that are tailored to the clients' situations and priorities. We prescribe benzodiazepines (diazepam or lorazepam) for folks with higher PAWSS or a seizure history and use a symptom-based approach to dosing based on Clinical Institute Withdrawal Assessment (CIWA-Alcohol) scores. When appropriate, we use alternative therapies for individuals with AWS with lower PAWSS. Antiepileptics (gabapentin, carbamazepine), or hydroxyzine are helpful with anxiety, restlessness and even tremors for some. For those with other symptoms of autonomic hyperactivity like sweating and tremors, we find clonidine is helpful in certain contexts, provided the client can adequately hydrate by mouth. AWS is a complex syndrome. Application of relevant clinical tools and the appropriate use of medications in the right environment can make the process a lot less daunting for providers and provide better outcomes for patients.

IN THE NEWS

Losing Access to Addiction Treatment (CBC Moncton)

Could Decriminalization Solve Canada's Opioid Crisis? (Global News)

Family Flying to Costa Rica for Drug-rehab Program (CBC News)

Digital Overdose Response System App (Calgary Herald)

U of T Students Develop Harm-reduction Toolkit (Dalla Lana School of Public Health)

Yukon Highest Opioid Deaths in Canada (CBC News)

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Interested in being featured in a future issue? E-mail laurie.smith@wchospital.ca