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First, do no harm

Professor Nicholas Lintzeris and Professor John Saunders

Evolve Recommendations on Low-value Practices in Addiction Medicine

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John B Saunders MB BChir, MD, FRACP, FAChAM, FAFPHM, FRCP

John Saunders graduated from the University of Cambridge and undertook specialist medical training in internal medicine, gastroenterology and liver disease, and addiction medicine in the UK. After clinical and academic positions in Sydney (RPA Hospital and the University of Sydney) and Brisbane (Royal Brisbane Hospital and the University of Queensland), he continues at the National Centre for Youth Substance Use Research at UQ. He has extensive clinical experience in addictive disorders in hospital and community settings and is now in private consulting practice.

He has worked as an advisor to the World Health Organization since 1981 and has been a member of many expert panels and committees and advisory groups. He was responsible for developing the AUDIT questionnaire and has contributed to the substance use disorders section of ICD-10 and ICD-11. He is Founding and Emeritus Editor-in-Chief of the Drug and Alcohol Review (1984 to 2009). He was the inaugural Honorary Secretary of the Australasian Chapter of Addiction Medicine from 2002 to 2004, and from June 2020 is the Chair of the NSW/ACT Branch. He has been a member of many state and federal government committees, including the Australian National Council on Drugs (2001-2008). He has published six books, including “Addiction Medicine” published by Oxford University Press (Second Edition, updated, 2019). He has over 500 publications, including 370 in the peer-reviewed scientific literature, with cumulative citations > 40,000 and an h index > 70.

Declaration of Conflicts of Interest: none. I have never received any remuneration from the alcohol or tobacco industries and no fees from pharmaceutical companies as a speaker or in any other capacity in the past 5 years.

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Prof Nicholas Lintzeris BMedSci, MBBS, FAChAM, PhD

NL has worked in the AOD sector for over 30 years as an Addiction Medicine specialist and researcher. His current roles include

- Director of Drug and Alcohol Services at South East Sydney Local Health District
- President Chapter Addiction Medicine, RACP
- Conjoint Professor, Department Addiction Medicine, University of Sydney

AChAM Evolve Recommendation 1

DO NOT undertake elective withdrawal management in the absence of a post-withdrawal treatment plan agreed with the patient that addresses their substance use and related health issues

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Most (>70-80%) ‘stand-alone’ withdrawal episodes are associated with relapse to substance use within days to weeks.

Post-withdrawal outcomes (e.g. relapse rates, engagement in ongoing treatment) are improved when there is a structured post-withdrawal treatment plan in place.

Consider the risks of withdrawal management alone (particularly with injecting opioids). Repeated withdrawal episodes may increase harms.

Consider how to integrate ongoing psychosocial and pharmacological interventions for patients seeking withdrawal treatment.

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AChAM Evolve Recommendation 2

DO NOT prescribe pharmacotherapies as stand-alone treatment for Substance Use Disorders, but rather as part of a broader treatment plan that identifies goals of treatment, incorporates psychosocial interventions and identifies how outcomes will be monitored.

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DO NOT prescribe pharmacotherapies as stand-alone treatment for Substance Use Disorders, but rather as part of a broader treatment plan that identifies goals of treatment, incorporates psychosocial interventions and identifies how outcomes will be monitored.

“Use medications as part of a plan”

Many effective medications for addictive disorders exist, but the evidence base has been generated through trials involving some form of psychosocial intervention.

Psychosocial supports may be provided by the prescribing doctor, as part of MDTs, or by other service providers (e.g. counsellors)

AChAM Evolve Recommendation 3

DO NOT deprescribe or stop opioid treatment in a patient with concurrent chronic pain and opioid dependence without considering the impact on morbidity and mortality from discontinuation of opioid medications.

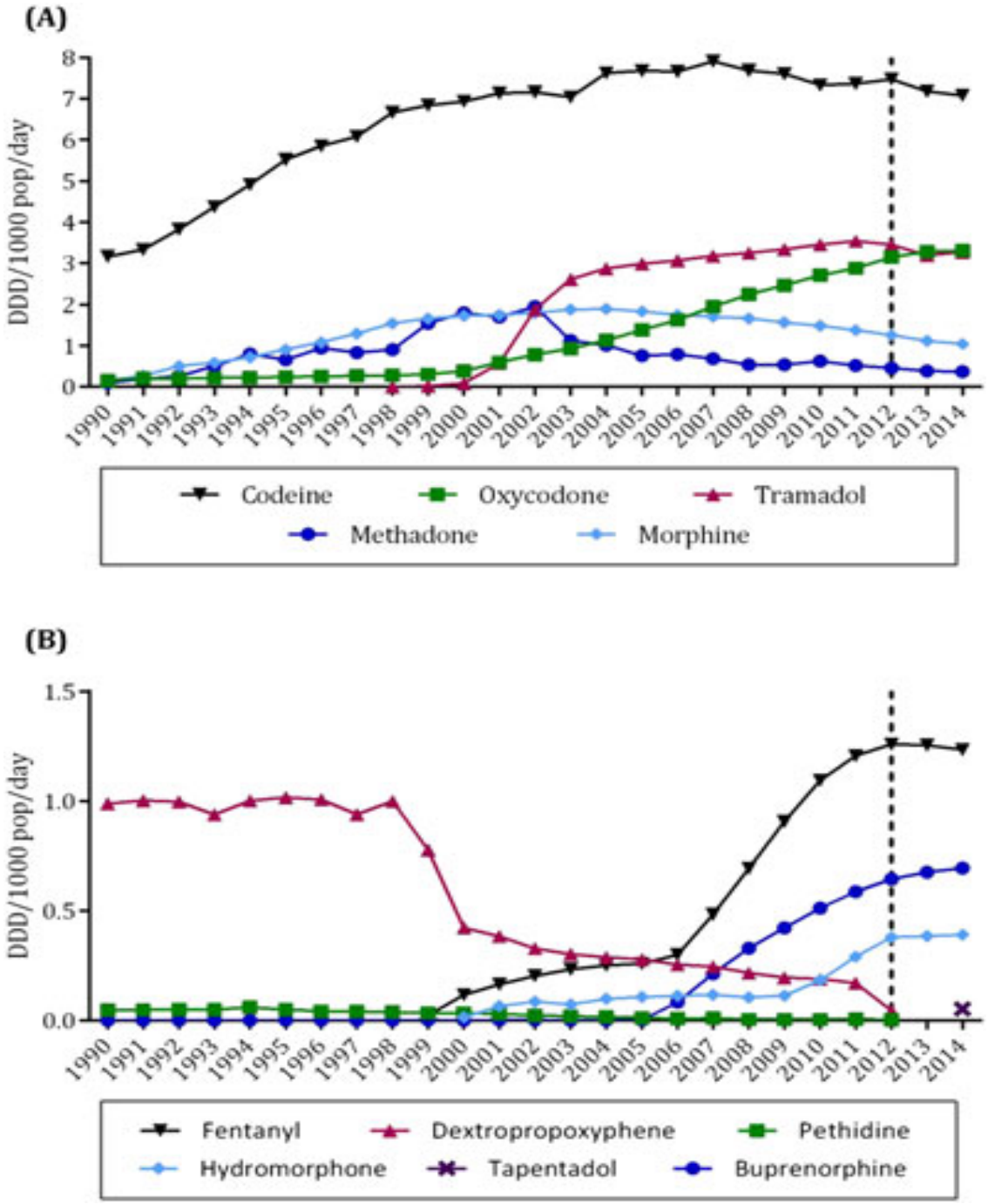
Where does the "deprescribing" movement originate from?

One motivator is the concern about over-prescribing of opioid drugs.

Epidemiological studies show that in Australia and many other Western countries (and particularly the US) there has been since 1990:

1. Four-fold increases in prescriptions for opioids dispensed and in pharmaceutical opioid production.
2. In Australia an increase in prescribed/OTC opioid-related hospitalizations from 605 to 1,464 cases annually from 1998 to 2009 (outnumbering hospitalizations due to heroin).
3. Deaths from prescribed opioids far outweigh those due to heroin: 2,145 from 2011 to 2015 from oxycodone, morphine, codeine, fentanyl, tramadol and pethidine compared with 985 deaths due to heroin.
4. Strong opioids account for 40% of total prescriptions.
5. Upswing temporally linked to TGA and PBS approvals for non-cancer pain.

Increase in prescribed opioid consumption in Australia, 1990-2014



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Opioids for cancer pain

1. For chronic and terminal cancer pain opioids are the most effective analgesics.
2. They relieve uniquely the affective component of pain.
3. Tolerance is expected but the dose should and can be increased correspondingly.
4. In patients with cancer pain, dependence (addiction) is unusual.

Opioids for non-cancer pain

1. For non-cancer pain, treatment with certain opioids (oxycodone, morphine and transdermal fentanyl) for three months confers some benefit in relief of pain and function. However, there is a risk of dependence developing after one month.
2. Weak evidence exists for benefit from morphine and transdermal fentanyl for up to 6 months.
3. Long-term opioid medication (defined as 6+ months) has little overall benefit, as judged by relief of pain and improvement of function, and adverse effects outweigh the benefits.

What are the features of opioid dependence?

Poll: Which of the following are the key features of opioid dependence:

- Use for > 6 months of > 50mg daily morphine equivalents.
- Impaired control of the amount, termination or duration of opioid use.
- Increasing priority given to opioid use over other activities (including health care).
- Concern of family members about prescriptions for opioids.
- Recent overdose involving opioid drugs.
- Increased tolerance and/or withdrawal features.

Does the patient have opioid dependence?

Check for the key features of opioid dependence:

1. **Impaired control** of opioid use.
2. **Increasing priority** given to opioid use over other activities including health care, and persistence of use despite harm or negative consequences.
3. **Physiological features** such as increased tolerance, withdrawal and use to prevent withdrawal.

Two or more of these three need to be present (ICD-11 criteria)

Check also for:

1. Pain which is out of proportion to the demonstrable pathology
2. Pain seemingly unresponsive to all other analgesics and modalities of treatment
3. Patient is “allergic” to non-opioid drugs
4. Patient requests opioid drug by name (or “near miss”)
5. Mobility when unobserved is greater than when observed (and may be normal)
6. Mobility and function are reported to be unimpaired by nursing and practice staff.

With a patient with chronic pain and opioid use, what is appropriate?

1. Continue the opioid and apply as appropriate for authorisation?
2. Advise and commence a tapering regime of the same opioid?
3. Embark on a withdrawal management approach?
4. Consider opioid agonist maintenance?

Some guidance

1. If pain < 6 months' duration, tapering/withdrawal of the opioid is often feasible, with no or reduced ongoing pain.
2. If the pain has persisted for 6 months to 2 years, withdrawal can be attempted and has a 40% chance of success (completion of withdrawal and pain manageable).
3. If pain has persisted beyond 2 years, the opioid dependence and associated behaviours are usually entrenched to a degree that withdrawal is difficult and relapse usual. Induction on to (long-acting) agonist maintenance in an approved program should be considered.

The evidence base for deprescribing (tapering/withdrawal) in chronic pain with long-term opioid dependence

- Systematic review of 12 randomized controlled trials (Mathieson et al., 2019)
- 10 patient-focused trails and 2 clinical-focused trials
- Patient interventions (e.g. a discontinuation protocol) showed no effect on opioid use, in terms of the daily dose or cessation of opioid use.
- One clinician-focused intervention showed a small reduction in the number of opioid prescriptions issued.
- The authors concluded that there is insufficient evidence to be able to recommend to clinicians any one particular method to deprescribe opioid analgesic medicines in patients with chronic non-cancer pain.

Induction on to agonist maintenance

1. The choice is essentially between methadone (syrup or solution) and buprenorphine (Subutex or Suboxone, and then potentially a depot preparation.
2. Seek advice on how to proceed.
3. Involve an addiction medicine specialist where possible.
4. My approach is to proceed over three successive days with the patient attending as a day patient.

AChAM Evolve Recommendation 4

WHILE managing patients with Substance Use Disorder, exercise caution in the use of treatment approaches that are not supported by current evidence or involve unlicensed therapeutic products.

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Many patients / carers seek “the magic bullet” that will cure ‘addiction’ and can be vulnerable to service providers offering the new “breakthrough treatment”

Principles of informed consent require clinicians to be transparent regarding available evidence, and when a treatment approach is still ‘experimental’

‘Experimental’ approaches should not be offered as first-line treatments, but only after conventional approaches have proven unsuccessful.

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AChAM Evolve Recommendation 5

USE a ‘universal precautions’ approach for all psychoactive medications that have known potential or liability for abuse, including opioids, benzodiazepines, antipsychotics, gabapentinoids, stimulants, baclofen, cannabinoids.

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Increasing use of psychoactive medications in recent decades

Whilst abuse & dependence to opioids and BZDs are well recognised, increasing evidence of misuse and harms linked to other psychoactive substances

‘Universal precautions’ framework developed to address growing problems with prescription opioids in North America

Gourlay DL, et al. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Pain Med. 2005; 6:107-12.

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AChAM Evolve Recommendation 5

Gabapentoids (pregabalin, gabapentin)

- Sedating effects when taken in large doses, or in combination with other sedatives. Contributing to falls, overdoses, ambulance call outs, deaths
- Discontinuation effects on attempted cessation
- Often no clear indication (history of epilepsy, neuropathic pain)

Murnion B, Conigrave KM. Pregabalin misuse: the next wave of prescription medication problems. Med J Aust. 2019;210:72-73

Schifano F. Misuse and abuse of pregabalin and gabapentin: cause for concern? CNS Drugs. 2014;28:491-6.

AChAM Evolve Recommendation 5

Quetiapine

- Sedating effects when taken in large doses, or in combination with other sedatives. Contributing to falls, overdoses, ambulance call outs, deaths
- Discontinuation effects on attempted cessation
- Often no clear indication (history of psychosis, bipolar)

Sutherland R, Jayathilake R, Peacock A, Dietze P, Bruno R, Reddel S, Gisev N. Trends and characteristics of extra-medical use of quetiapine among people who regularly inject drugs in Australia, 2011-2018. Drug Alcohol Depend. 2021;221:108636

Chiappini S, Schifano F. Is There a Potential of Misuse for Quetiapine?: Literature Review and Analysis of the EMEA Adverse Drug Reactions' Database. J Clin Psychopharmacol. 2018;38:72-79

AChAM Evolve Recommendation 5

‘Universal precautions’ framework for psychoactive medications

1. **Screen patients for risk**: identify patients at risk of non-medical use and/or at risk of developing ‘addictive’ patterns of medication use
2. **Identify clear treatment goals** with patient and consider role of medication and other treatment options, including likely harms and benefits of medication. Consider a trial of medication with clear measures of ‘success’.
3. **Structure treatment according to patient risk** including instalment dispensing; increasing medication adherence using urine drug screens and prescription monitoring; written treatment agreements; regular clinical reviews.
4. **Regularly monitor patient outcomes and medication-related issues** associated with aberrant behaviours and adverse events.

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The end

As part of a global movement, Evolve is a flagship initiative led by physicians, specialties and the Royal Australasian College of Physicians (RACP) to drive high-value, high-quality care in Australia and New Zealand.

Evolve aims to reduce low-value care by supporting physicians to:

- be leaders in changing clinical behaviour for better patient care
- make better decisions, and
- make better use of resources.

Find out more:

www.evolve.edu.au

Get in touch:

evolve@racp.edu.au

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