What does "Good" Treatment for Addictions Look Like?

Addictions Community-Based Services | April 26, 2017

Presenters

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Objectives

1. Enhance understanding of addictions and Addictions Community-Based Services
2. Consider current treatment foundations, approaches & outcomes

Are people accessing treatment, staying in treatment, benefiting from treatment

Getting to Know our Audience!

- What percentage of patients do you see that have a known Substance Use Disorder (SUD)?

A. 0% - 20%
B. 20% - 40%
C. 40% - 60%
D. 60% - 80%
E. 80% - 100%

Getting to Know our Audience!

- I am able to provide treatment to my patients with a Substance Use Disorder.

A. Strongly agree
B. Agree
C. Neutral
D. Disagree
E. Strongly Disagree

What is Addiction?

Chronic Health Condition

- Substance seeking & use that is compulsive, or difficult to control, despite harmful consequences.

Brain Impacts

- Repeated use can lead to brain changes that challenge an addicted person's self control & interfere with their ability to resist intense urges to use substances.

CBS - Who We Are

Trained healthcare professionals

19+ - problems alcohol, tobacco or drugs, and/or gambling

Family/Affected Others of above

Integration

CMH&A (7 sites)

2015

Work in Progress

Access

Central Intake 902-424-8866

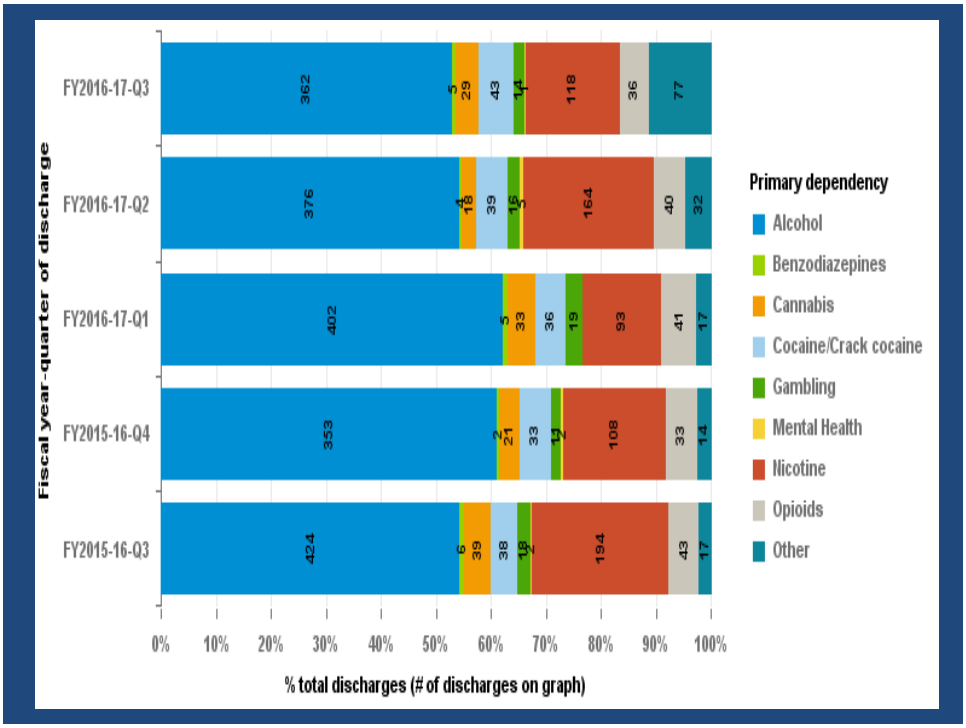
~ 3400 referrals/year

Access to ITS & OTP

Community

Outreach

Family Practice



Client Overview

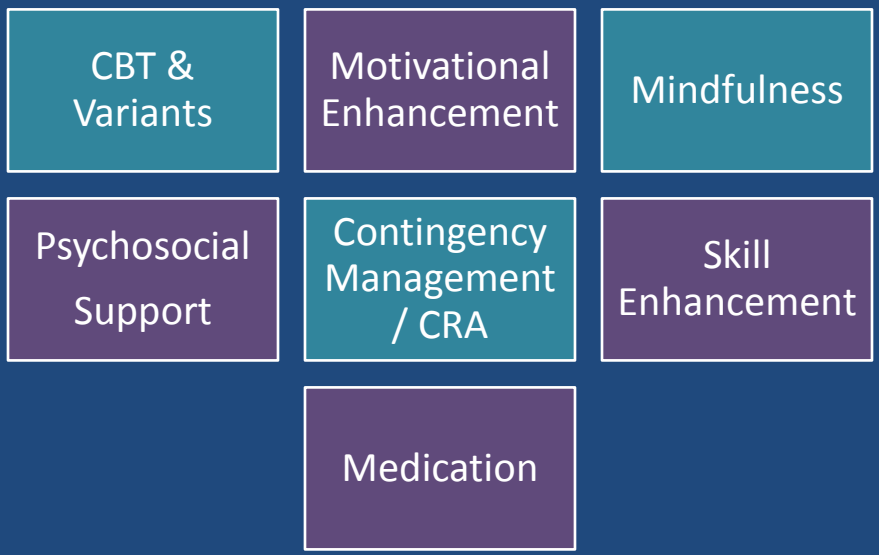
Gender	Female: 38.1%	Male: 61.8%	Transgender : 0.1%
Age (average)	Female: 43.95 yrs	Male: 42.29 yrs	
Education Level	Less than Gr 12: 18.39%	Gr 12: 24.08%	Greater than Gr. 12: 45.4% Unknown: 12.13%
Marital Status	Married/Common Law: 30.61%	Single: (NM) 47.99%	Other: 21.4%
Dependents	None: 50.38%	One: 15.81%	Two: 15.39% 3 +: 9.07%
Ethnicity	Canadian: 69.85%	African Canadian: 1.48%	Other: 28.62%
Occupation	General Labour: 18.88%	Professional/ Management: 18.65%	Service Industry: 12.56% Other: 49.92%
Income Source	Employment: 47.74%	Social Asst/EI: 18.92%	Pension: 12.64% None: 7.78% Other: 25.55%

Adrian

- – 38 year old male,
- poly substance abuse since teens.
  - Current presentation: between a pint & a quart alcohol/day, & snorting 1 gram of cocaine 3 – 4 times per week. No treatment history.
  - Family physician aware of some substance use concerns, however, not full extent
  - Friends & family have expressed concerns

Core Elements of Evidence Based Care

Treatment Evidence



Central Zone Addictions Program

- Individualized needs assessment
- Matching level of need to intensity of treatment
- Variety of options for skill development
  - Individual focused counseling for behavior change
  - Group therapy (SRP, MBRP, Seeking Safety)
  - 3 day workshops
  - Intensive 2 week programs
  - Specialty treatment (i.e. ITS, OTP, Women's Only)

Elements of "Good" Addictions Treatment

Skill Enhancement	• Coping • Self-care • Refusal
Behaviour change/Self-Management	• High risk situations • Relapse Prevention
Aftercare	• Primary Health Care • Community & Social Supports

Adrian's CBS Care

- Completed individual assessment
  - recommended to attend inpatient withdrawal management for 3 weeks.
- CBS clinician met with while inpatient to begin therapeutic rapport building.
- Adrian had a follow up visit with his clinician within 10 days of discharge.
- Adrian's treatment plan consisted of 1:1 focused counselling, SRP group, and a recommendation for family to attend AO program.

Treatment Considerations

- Continual appraisal of changing needs & level of services necessary
- Addiction as chronic illness - relapses are normal
- Inclusion & treatment for family / friends
- Supporting self efficacy & fluctuating motivation
- Role of anti-craving medication

Audience Question

- What percentage of patients with AUD have been prescribed evidence based anti craving medication in the past year?

A. 0% - 20%

B. 20% - 40%

C. 40% - 60%

D. 60% - 80%

E. 80% - 100%

Fact

- Evidence based, approved medications for Alcohol Dependence are prescribed for less than 9% of patients with Alcohol Use disorder in the US

(based on prescription monitoring).

Rational for Pharmacotherapy

- Pharmacotherapies can normalize neuroadaptive changes due to chronic drug or alcohol use.
- Enhance Abstinence and Prevent Relapse.
- Pharmacotherapies complement Psychosocial interventions.
- Can address aspects of Dependence (eg Craving) not well treated by Psychotherapy (MI and CBT)

Present State

"Do not routinely prescribe antidepressants as first-line treatment for depression co morbid with an active AUD without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms" ***(Choosing wisely guidelines)***

- A simplistic view that people can stop drinking easily?
- Physicians (Psychiatrists) are **not** treating SUD with proven anti-craving medication?

Landscape

- Alcohol use disorder (AUD) – lifetime prevalence 29.1% and clearly associated with Major depressive disorder (MDD) and all other mood disorders.
- 80% of patients with AUD do not seek help
- Patients with AUD are stigmatized by health professionals –> contributing to suboptimal care.

The Relationship between Alcohol and Mood

- The presence of either disorder (MDD, AUD) doubles the risk of the other disorder.
- Large European and North American studies suggest that…

AUD increases the risk of MDD > than MDD increases the risk of AUD

Questions?

- Does Psychiatric Treatment for MDD/Anxiety disorders improve outcome for these disorders ***in co-occurring SUD****?*
- Does Psychiatric Treatment for MDD/Anxiety disorders ***improve co-occurring SUD, specifically AUD outcomes?***
- Do specific pharmacological treatments of SUDs Alcohol->Naltrexone, Acamprosate; Opioids-> Methadone,Buprenorphine+Naloxone/Suboxone; improve outcomes ***for these disorders?***

Answers

- Psychiatric treatment for MDD/Anxiety in co-occuring SUD -> Moderately effective

1. Moderate but probably less effect than in MDD non AUD
2. Does reduce relapse in AUD

- Use of Anti-craving Medications helpful and warranted in severe SUD's

So why….???

- Are patients with MDD + AUD less likely to receive pharmacological treatments for MDD than patients with MDD without AUD?
- Despite evidence that antidepressants are effective treatments for MDD with co-occuring AUD
- And, "modestly" improve outcomes in AUD

The Evidence

- (Foulds et al. 2015) Meta –analysis: concluded Depression treatment in AUD has a 'large' early improvement in depressive symptoms;
- (Pettinati et al. 2010) Double –blind, placebo controlled trial combining sertraline and naltrexone for treating co-occuring depression and alcohol dependence. (*Am J Psych)* : combination of sertraline and naltrexone was superior to either alone for achieving abstinence, reduced heavy drinking, and improved mood.

Medications to consider

1. Disulfiram: (250-500mg/day deters alcohol use through inhibition of Aldehyde Dehydrogenase)
2. ***Naltrexone**
3. Acamprosate (Modulates Glutamate) dosing 2 tabs t.i.d. so compliance is important consideration.
4. ***Gabapentin**
5. Buprenorphine-Naloxone (Suboxone)

Naltrexone

- Decreases Cravings
- Opioid antagonist
- Binds to opioid receptors, thus blocking alcohol reward pathways
- Approved by FDA in 2004
- Not covered by Pharmacare in NS
- Daily dose 50- 100mg/day (25mg/day or alternate days in patients with significant liver dysfunction)

Gabapentin

- Normalizes the stress induced GABA activation in the Amygdala that is associated with alcohol dependence.
- At dose of 1800mg/day effective in treating alcohol dependence and relapse-related symptoms of….. Insomnia, dysphoria and craving.
- Not appreciably metabolized in the liver.
- Could be easily adopted as treatment option in Primary Care

Medications are Effective Treatments

- Which Patient?

Active Alcohol Dependence or Abstinent but Craving

- What Medication?

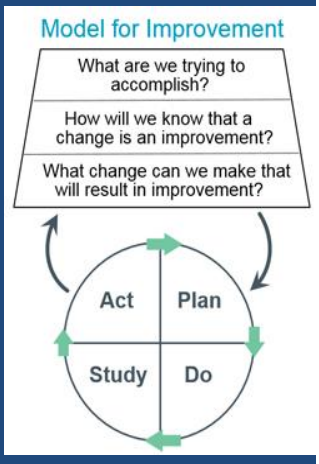
Consider compliance/adherence issues

- How long to treat?

Greatest risk of relapse is within first 90 days

Continuous Quality Improvement

- Enhance integration with MH
- Enhance communication with Family Practice
- Intensive Programs evaluation
- Evidence informed programming
- Planned & purposeful Outreach/ Health Promotion
- Flow efficiencies/ Transitions of Care



Sources

- Foulds et al. (2015). Depression outcome in alcohol dependent patients: an evaluation of the role of independent and substance-induced depression and other predictors. *J Affect Disord, 174*, 503-10.
- Mason et al. (2013). Gabapentin Treatment for Alcohol Dependence: A Randomized Clinical Trial. *JAMA Intern Med., 174(1*), 70-77.
- Pettinati et al. (2010). A Double-Blind, Placebo-Controlled Trial Combining Sertraline and Naltrexone for Treating Co-Occurring Depression and Alcohol Dependence. *Am J Psychiatry, 167*, 668–675.

Helpful links: Treatment guidelines

- http://www.asam.org/public-resources/treatment
- https://www.niaaa.nih.gov/guide
- https://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/PrescribingMeds.pdf
- http://store.samhsa.gov/shin/content/SMA15-4907/SMA15-4907.pdf

Questions