Low-threshold, Complex Outpatient Withdrawal Management in Resource Limited Communities

Sarah Spencer DO, FASAM Ninilchik Tribal Community Clinic

Workshop Session, ASAM 2024 Annual Conference, Dallas, TX April 2024

Financial Disclosures

I have no financial conflicts of interest to disclose

I am currently employed by the Ninilchik Tribal Council

I work as a treatment consultant for the Opioid Response Network, the Alaska Native Tribal Health Consortium, as well as for other non-profit agencies.

Learning Objectives

- Explore challenges in providing stabilizing care to individuals with complicated use disorders in communities with limited resources.
- Work as a team to problem-solve cases for patients from vulnerable populations who are using multiple substances, whose goals may not be abstinence-based
- Compile information from evidenced-based resources as well as clinical experience and local knowledge to create patient-centered, harm-reduction focused care plans.

Off Label Disclosure

This workshop discusses many off label medication uses.
Not all patients fit neatly in a box;
That's why medicine is an art.

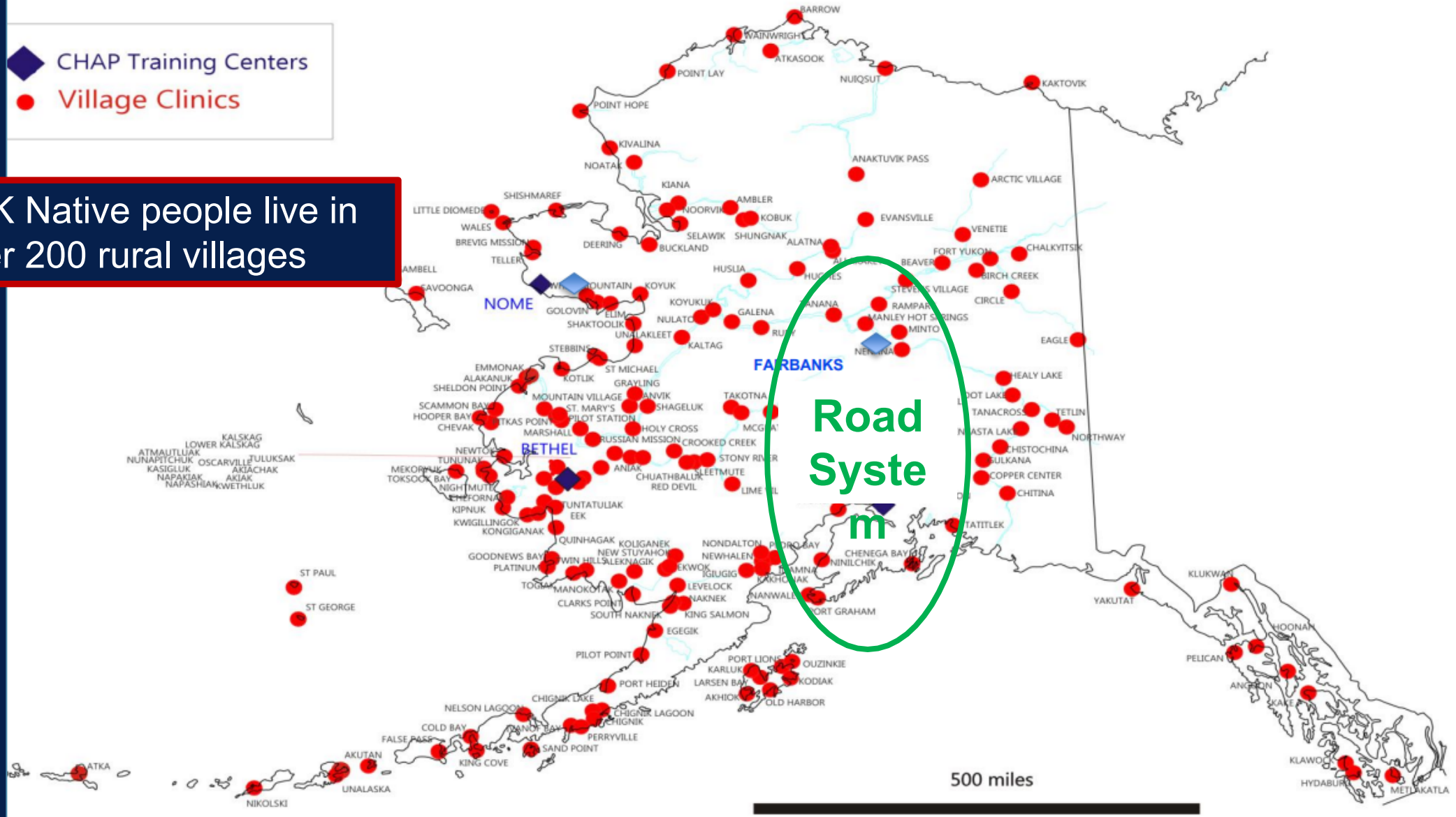
We will discuss utilizing evidence-based practices along with local resources to address complex cases when "standard of care" treatment is not accessible. Some off label uses discussed include:

- Managed alcohol use and outpatient alcohol withdrawal management
- Rapid outpatient benzodiazepine tapers
- Rapid initiation of long-acting injectable buprenorphine
- Alternative buprenorphine dosing strategies

Access to Care in Rural Alaska

Community Health Aide/Practitioner Village Clinics

90K AK Native people live in over 200 rural villages



Alaska Native Tribal Health Consortium
rhall@anthc.org
2014

Barriers to Treatment Access in Rural AK

- Travel costs (over $1,000 per trip to ANC) and time
- No local pharmacies, weather holds/ Rx delayed in the mail
- No local licensed medical/BH providers (only CHAPs/BHAs)
- No local OTP or inpatient withdrawal management
- Lack of anonymity, STIGMA

Community Resources in Rural Alaska

Community Health Aides and Community Health Practitioners (CHA/Ps)

- Local people
- Initially described as “the eyes, ears and hands of the physician”
- Approximately 180 villages utilize CHA/Ps
- Conduct more than ½ of all yearly patient encounters in the State of Alaska
- Includes emergency, acute, chronic, and preventive health components
- Training is “skills” based
- Does not include differential diagnosis
- Under medical supervision of a licensed physician

Community Health Aides and Community Health Practitioners (CHA/Ps)

Clinical skills include:

- Taking a history
- Performing a physical exam
- Performing lab skills
- Use of the Community Health Aide Manual (CHAM) to make Assessments
- Report
- Following plans per the CHAM
- Giving patient education
- Administering medicines
- Performing certain treatment procedures
- Documenting patient encounters

CHAPs and BHAs can do home visits

Growing Our Own:

A Grassroots Approach to Increasing Behavioral Health Access for American Indian and Alaska Native People

BHA
Behavioral
Health Aide

https://www.anthc.org/behavioral-health-aide-program/

BHAs are an integral part of our substance abuse programs. They are assist in facilitating sessions for our Intensive Outpatient Substance Abuse program that is delivered via televideo to the villages and, recently, they volunteered to fill-in at our recovery camp program, which is currently experiencing a staffing shortage.

Substance abuse assessment & treatment

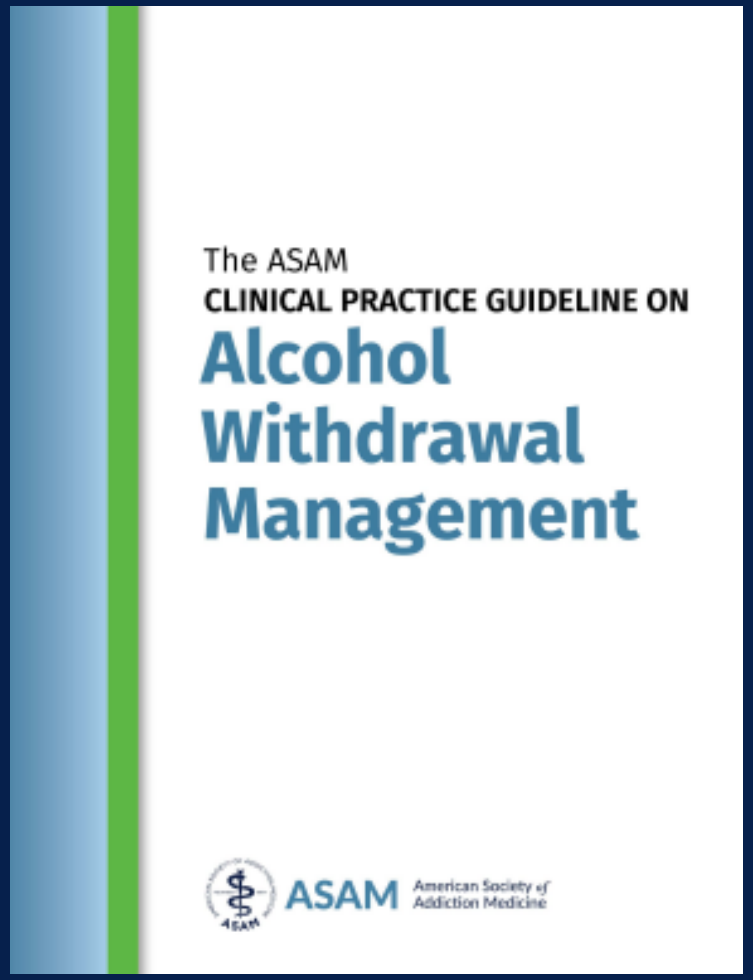
ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

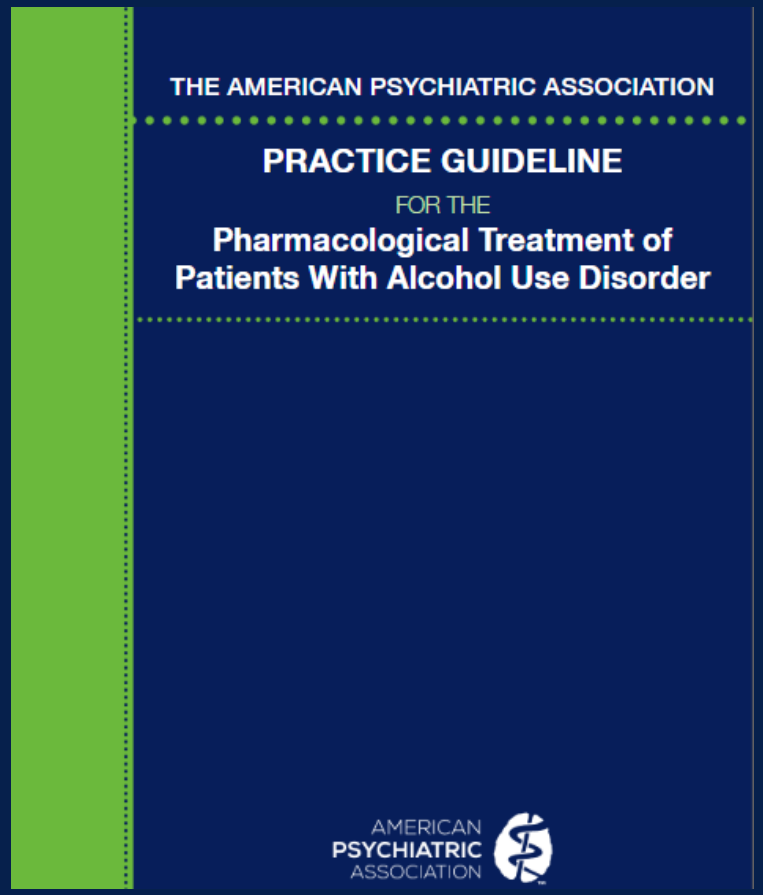
Peer Support/Behavioral Health Aide Roles

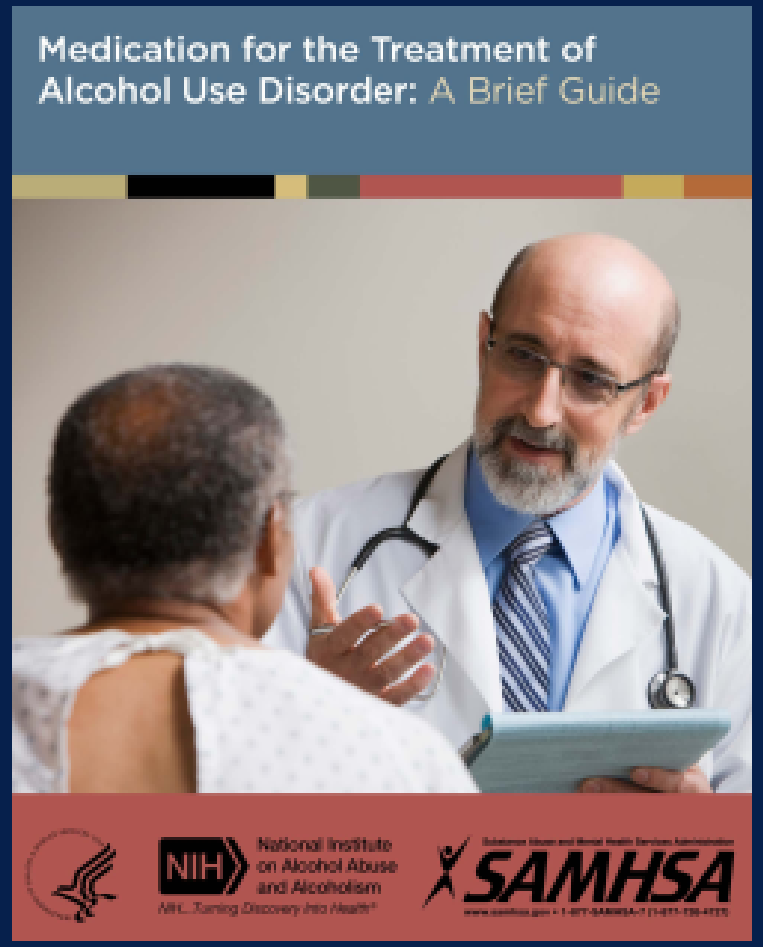
- Available by cell phone (patients can call/text)
- Connect with patients at medical appointments to check in with them
- Support groups (Virtual)
- Recreational opportunities (crafting/drumming groups, beach cleanups, fish camp)
- Connect patients to resources (doing the research, providing and helping fill out paperwork- housing, employment, treatment)
- Providing transportation (to medical/behavioral health appointments, mutual support meetings, court, residential treatment)
- Volunteer and connect with participants at our local syringe access program
- Warm handoff from ED/Hospital or jail (check court records)
- Sit down for a chat of a cup of coffee
- Crisis Intervention

Outpatient Alcohol Withdrawal Management

NATIONAL PRACTICE GUIDELINES







AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

WHO CAN BE MANAGED IN THE CLINIC

Support system

No history of severe withdrawal

Only mild or moderate symptoms

No significant comorbidities

Frequent check-ins

PAWSS score >4 = high risk for complicated AWS

Figure 3. Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

PART A: THRESHOLD CRITERIA:	**("Y" or "N", no point)**
Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" blood alcohol level (BAL) on admission?	_____
IF the answer to either is YES, proceed with test:	

PART B: BASED ON PATIENT INTERVIEW:	**(1 point each)**
1. Have you been recently intoxicated/drunk within the last 30 days?	_____
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., inpatient or outpatient treatment programs or AA attendance)	_____
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?	_____
4. Have you ever experienced blackouts?	_____
5. Have you ever experienced alcohol withdrawal seizures?	_____
6. Have you ever experienced delirium tremens, or DT?	_____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates during the last 90 days?	_____
8. Have you combined alcohol with any other substance of abuse during the last 90 days?	_____

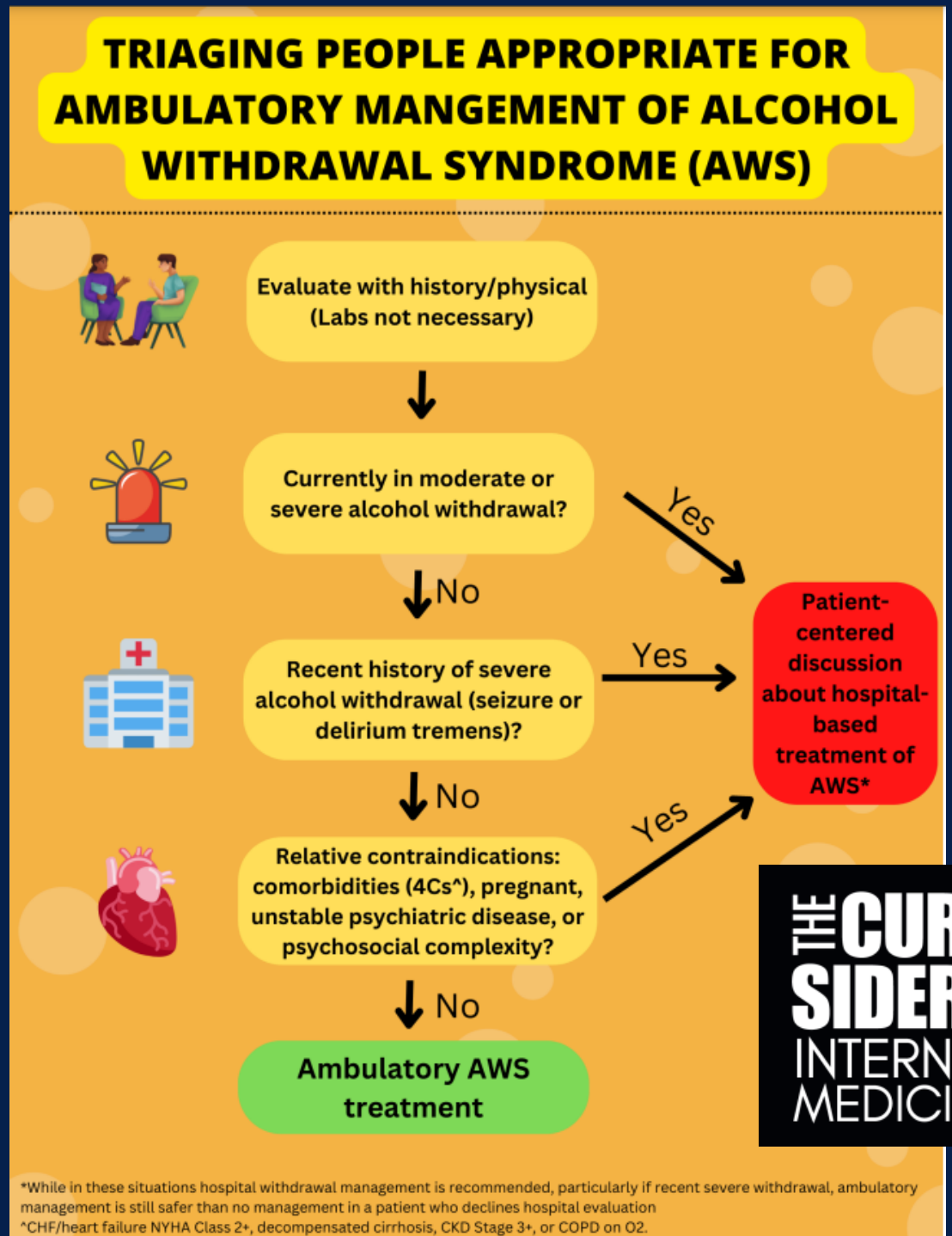
PART C: BASED ON CLINICAL EVIDENCE:	**(1 point each)**
9. Was the patient's BAL on presentation ≥ 200?	_____
10. Is there evidence of increased autonomic activity? (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea)	_____
	TOTAL SCORE: _____

Notes: *Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS. A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.*

Source: Adapted **Source:** Adapted from Maldonado JR, Sher Y, Ashouri JF, et al. The "prediction of alcohol withdrawal severity scale" (PAWSS): systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol.* 2014;48(4):375-390.

Harm Reduction Tip:

Some patients may decline to go to the hospital for AWS management, and for those certain individuals, it may be safer to trial supervised ambulatory withdrawal than receive no medical care at all.



THE CURB SIDERS INTERNAL MEDICINE

AMBULATORY ALCOHOL WITHDRAWAL TREATMENT

Best Practices

1. Start in the morning and don't taper alcohol before
2. Check in every other day, can use telehealth (video preferred) to make more accessible
3. Recommend hospitalization if:
seizures, altered mental status, using more PRNs than prescribed
4. Don't forget to address and treat AUD

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Short Alcohol Withdrawal Scale

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

Short Alcohol Withdrawal Scale to assess severity of alcohol withdrawal.

Mild symptoms: score < 12; moderate to severe symptoms: score > 12.

Adapted with permission from Elholm B, Larsen K, Hornnes N, et al. A psychometric validation of the Short Alcohol Withdrawal Scale (SAWS). Alcohol Alcohol. *2010;45(4):362.*

AMBULATORY ALCOHOL WITHDRAWAL REGIMENS

	Diazepam based^	Gabapentin based
Day 1	10mg q6hrs*	300mg q6hrs*
Day 2	10mg TID	300mg TID
Day 3	10mg BID	300mg BID
Day 4	10mg once	300mg once
Additional PRNs	5 x 10mg pills	5 x 300mg pills

^Can substitute chlordiazepoxide 50mg for diazepam 10mg

*If >10 drinks per day double dose on first day (Dr Holt Expert opinion)

AMERICAN SOCIETY OF ADDICTION MEDICINE FOUNDED 1954 ASAM

THE CURB SIDERS ADDICTION MEDICINE

Oral Medications Used to Treat Mild to Moderate AWS

Medications	Typical dosing	Comments
Nonbenzodiazepine anticonvulsants		Appropriate monotherapy in mild AWS
Carbamazepine (Tegretol)	600 mg to 800 mg	600 mg to 800 mg per day tapered to 200 mg to 400 mg per day over 4 to 9 days
Adjunctive therapy with benzodiazepines		Used if symptoms persist despite adequate benzodiazepine use
Beta blockers	Atenolol: 25 mg to 50 mg daily Metoprolol: 25 mg to 50 mg every 12 hours	For persistent hypertension and tachycardia
Carbamazepine	200 mg every 8 hours or 400 mg every 12 hours	For additional control; reduces craving
Clonidine	0.2 mg	For autonomic hyperactivity or anxiety
Gabapentin	400 mg every 6 to 8 hours	For additional control; reduces craving
Valproate (Depacon)	300 mg to 500 mg every 6 hours	Contraindicated in pregnancy and in patients with liver disease; should not be used as monotherapy for withdrawal

https://www.aafp.org/pubs/afp/issues/2021/0900/p253.html

Outpatient Phenobarbital

In a Level 2-WM ambulatory setting, phenobarbital monotherapy, managed by a clinician
experienced with its use, is appropriate for patients with a contraindication for benzodiazepine use who are experiencing moderate or severe alcohol withdrawal or who are at risk of developing severe or complicated alcohol withdrawal o complication of alcohol withdrawal. Discussion. There is disagreement in the literature regarding the appropriateness of phenobarbital in ambulatory settings, due to the risk of toxicity when used in combination with alcohol or in high doses. In general, phenobarbital should only be used by clinicians experienced with its use in settings that offer close monitoring. Phenobarbital may cause respiratory depression and over-sedation and its narrow therapeutic window makes it challenging to dose correctly compared to other medications used to treat alcohol withdrawal. As with benzodiazepines, effects on the central nervous system are exacerbated when other CNS depressants such as alcohol are also used.

The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management

Phenobarbital Options for Withdrawal

Mild

260 mg IV push or 100 mg PO

↓

130 – 260 mg IV push or 100 mg PO
x 2 prn q60 min

↓

Discharge

Moderate-Severe

10 mg/kg IV over 30 minutes

↓

130 – 260 mg IV push or
100 – 200 mg PO
x 2 prn q60 min

↓

3 day benzodiazepine taper of diazepam
or chlordiazepoxide

Mild: Oral Taper 60mg qid day1, 60 mg tid day 2,
60 mg bid day 3, 30 mg bid day 4

The American Journal on Addictions, 15:76-84, 2006.
Am J Addict 1998;189-197

Managed Alcohol Program (MAP) Outcomes

- Improvement in quality of life among MAP participants who were **less likely to report acute alcohol-related harms** such as seizures, acute intoxication, trauma, or assault
- Participants noted a positive change in their relationship with alcohol, from a decreased focus on alcohol procurement to an increased feeling of control regarding consumption levels…**increased sense of self-determination and motivation for positive change**
- **Reported a reduction in feelings of shame and guilt**
- MAP participants had greater number of drinking days, with one study finding an average of 27.8 alcohol days per month for MAP participants compared to 22.6 alcohol days for controls. Yet, this drinking pattern resulted **both in a reduction in overall quantity of alcohol and in a less hazardous consumption**

https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-022-00646-0

Create At-Home Alcohol Withdrawal Monitoring and Management Plan

- Managed alcohol intake, dosed by caregiver
- Homer breathalyzer?
- Train caregivers to calculate SOWS
- On-hand meds to treat withdrawal (including alternative to PO route)

Outpatient Benzodiazepine Withdrawal Management

Outpatient Benzo Taper Selection

- Reliable and motivated to stop
- Medical/MH stable
- Social support/transport to ED
- No/mild use disorder
- No h/o seizures
- Not pregnant

Generally, Taper Slowly!

Rapid Benzodiazepine Taper

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30 mg

RAPID TAPER

1. Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
2. Utilize concomitant behavioral supports.
3. Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.

https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf

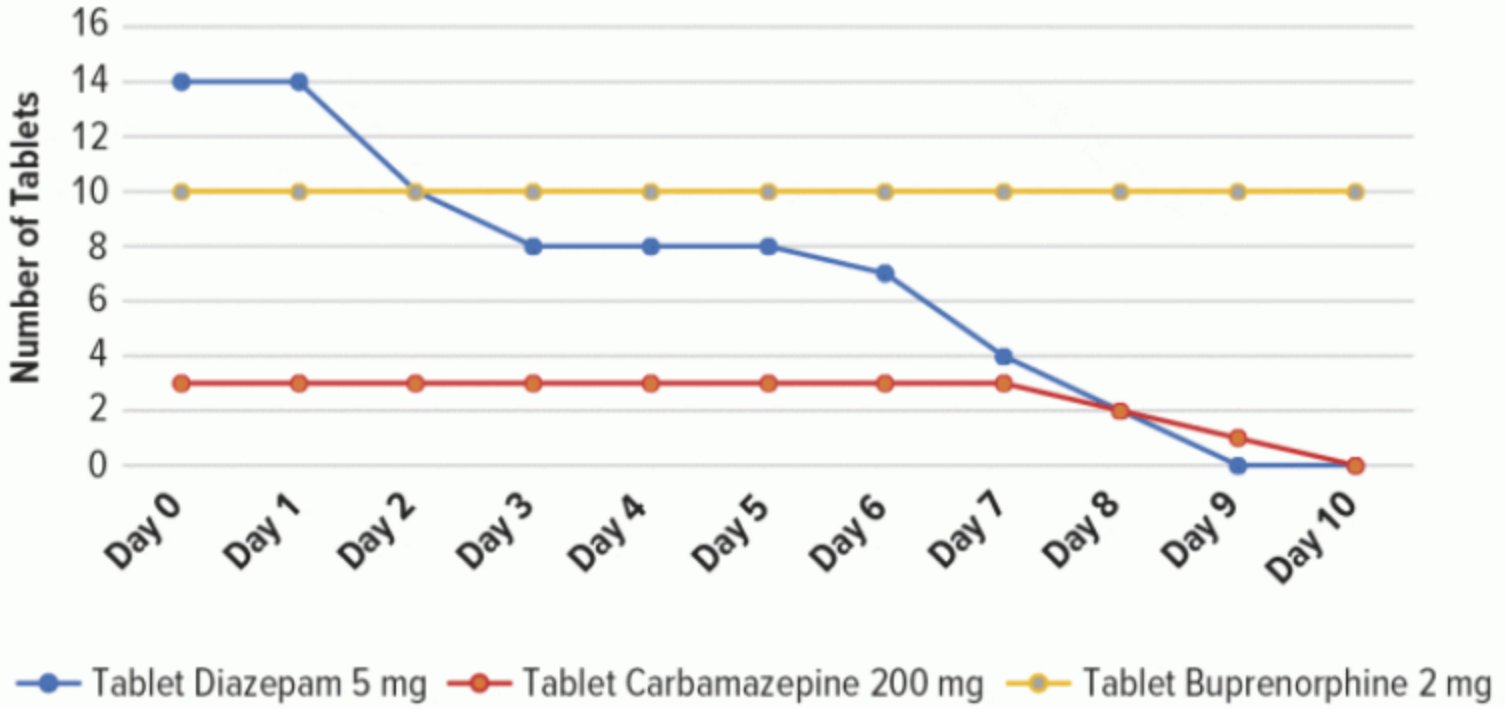
CASE REPORT

Rapid Detoxification in an Adult With Benzodiazepine Dependence With the Aid of an Antiepileptic

Diveesha Munipati, MBBS; Rahul Mathur, MD, DNB; and Siddharth Sarkar, MD, DNB

Published: August 17, 2023

Graphical Representation of Rapid-Tapering Schedule of Diazepam[a]



[a]Prior to tapering, an antiepileptic was added. Dose of opioid agonist (buprenorphine) was unchanged throughout the schedule.

https://www.psychiatrist.com/pcc/addiction/rapid-detoxification-adult-benzodiazepine-dependence-aid-antiepileptic/

Adjunctive Medications

Medication	Effect of Medication	Study
Hydroxyzine	Patients taking 25-50 mg had a decrease in anxiety during a benzodiazepine taper compared to placebo.	Lemoine et al., 1997
Carbamazepine	When given 200-800 mg/day during and after a benzodiazepine taper, it reduced withdrawal symptoms and promoted abstinence compared to placebo.	Schweizer et al., 1991
Trazodone	A significantly higher percentage of patients taking trazodone during a benzodiazepine taper were abstinent from benzodiazepines at 5 weeks post-taper compared to patients taking placebo, but there was no difference at 12 weeks post-taper.	Rickels et al., 1999
Sodium valproate	A significantly higher percentage of patients taking sodium valproate during a benzodiazepine taper were abstinent from benzodiazepines at 5 weeks post-taper compared to patients taking placebo, but there was no difference at 12 weeks post-taper.	Rickels et al., 1999
Imipramine	Pretreatment and use of imipramine during benzodiazepine taper increased taper success rate; a significantly higher percentage of patients taking imipramine were abstinent from benzodiazepines at 12 weeks post-taper compared to those taking placebo.	Rickels et al., 2000

Adjunctive Medications

Medication	Effect of Medication	Study
Pregabalin	Patients treated with pregabalin (150-600 mg/day) had significantly lower withdrawal symptoms compared to placebo, both during taper and 6 weeks after. Group treated with pregabalin had lower anxiety during taper.	Hadley et al. (2012)
Buspirone	Subjects given buspirone during BZD withdrawal had lower levels of anxiety than subjects given placebo.	Morton & Lader (1995) Udelman & Udelman (1990)
Gabapentin	In MMT patients taking doses up to 1200 mg TID, there were no significant differences between gabapentin and placebo on amount of BZD use per day (both groups reduced use), days abstinent per week, and CIWA-B scale.	Mariani et al. (2016)
Flumazenil	Randomized, placebo-controlled study found subjects given flumazenil infusion plus oxazepam significantly reduced withdrawal symptoms and cravings compared to oxazepam and placebo. Subjects given flumazenil infusion had lower relapse rates up to 30 days later.	Gerra et al. (2002)
Melatonin	Cross-over study, compared melatonin to placebo in MMT patients using BZD. Sleep quality improved with cessation of BZD, regardless of group. In each group, ~30% stopped using BZD.	Peles et al. (2007)

https://www.aoaam.org/resources/Documents/2018%20Convention%20Slides/Saturday%20-%2010-6-2018%20-%2011am%20-%20Management%20of%20Withdrawal%20-%20Alcohol%20Benzodiazepines%20Opioids%20-%20Kmiec.pdf

NATIONAL ARCHIVES
FEDERAL REGISTER
The Daily Journal of the United States Government

Rule

Schedules of Controlled Substances: Temporary Placement of Etizolam, Flualprazolam, Clonazolam, Flubromazolam, and Diclazepam in Schedule I

A Rule by the Drug Enforcement Administration on 07/26/2023

Paper that list some equivalency tables for Designer Benzos

https://academic.oup.com/jat/article/47/1/1/6549532

June 2022

Bromazolam Prevalence Surging Across the United States Driven In Part by Increasing Detections Alongside Fentanyl

cfsre
The Center for Forensic Science Research & Edu

NPS DISCOVE

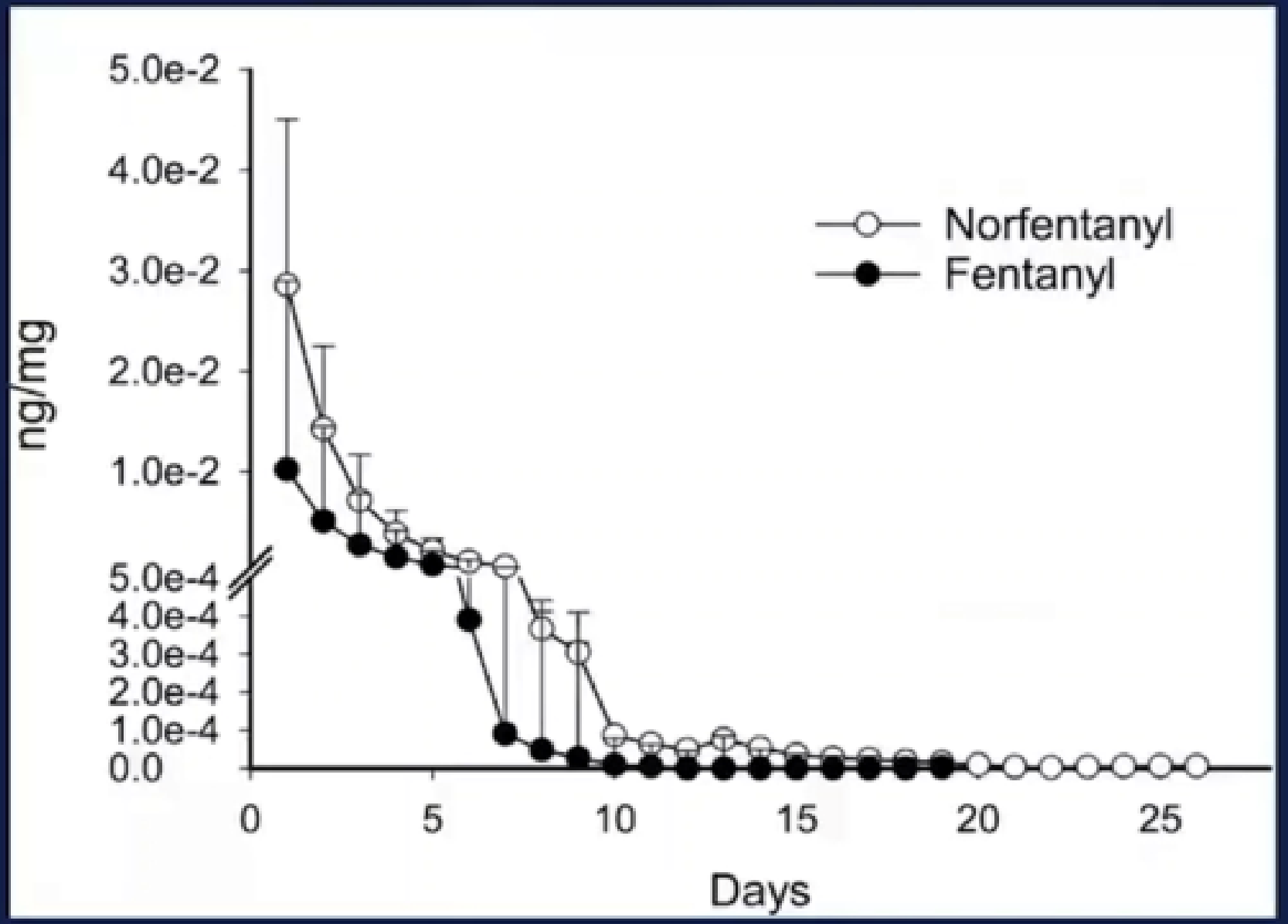
Pharmaceuticals (Basel). 2021 Jun; 14(6): 560.
Published online 2021 Jun 11. doi: 10.3390/ph14060560
PMCID: PMC8230725
PMID: 34208284

Designer Benzodiazepines: A Review of Toxicology and Public Health Risks

Pietro Brunetti,[1] Raffaele Giorgetti,[1] Adriano Tagliabracci,[1] Marilyn A. Huestis,[2,*] and Francesco Paolo Busardò[1]

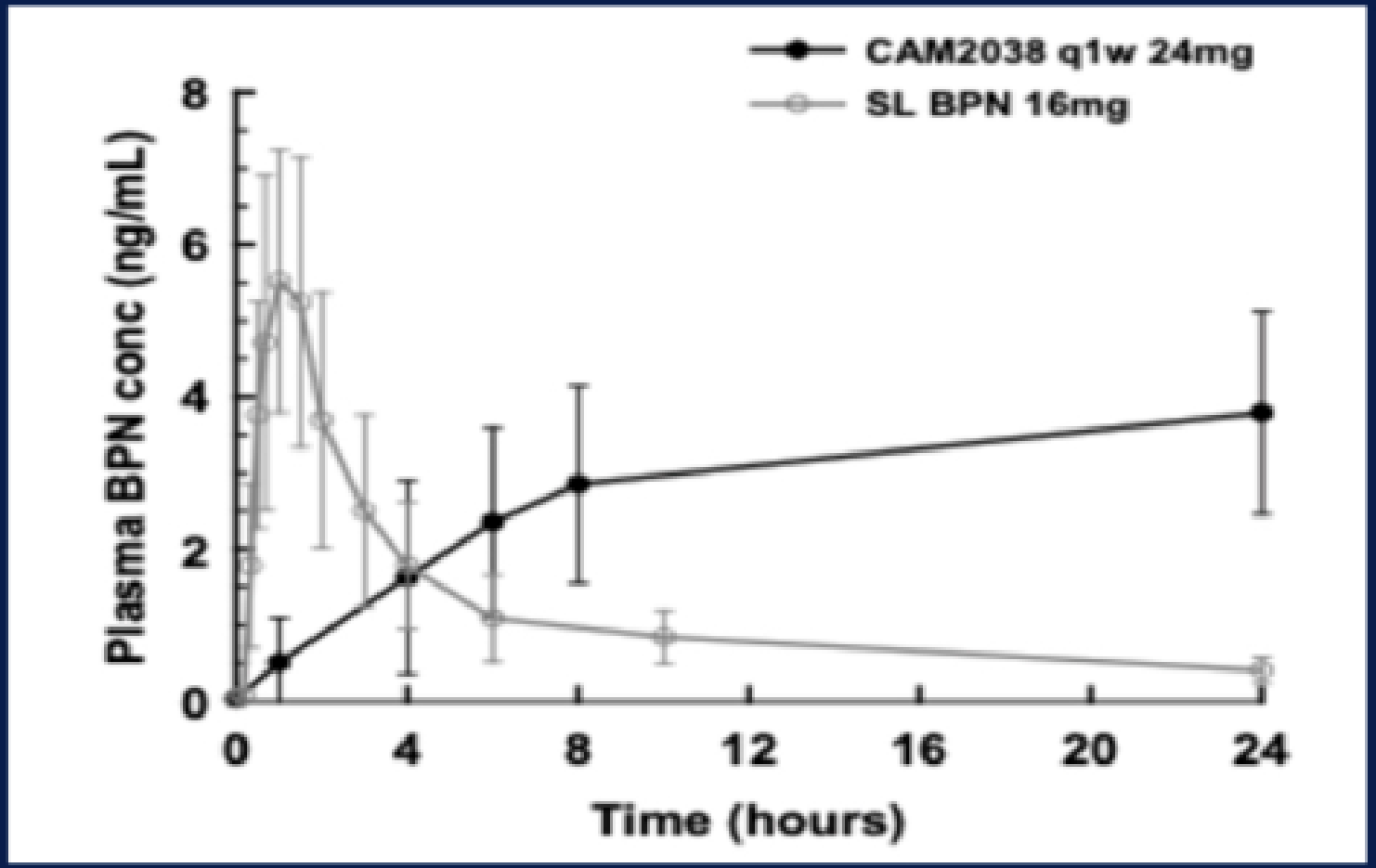
Outpatient Opioid Withdrawal Management for Patients Initiating Buprenorphine

FENTANYL NORFENTANYL ELIMINATION IN URINE



Huhn SA et al. Protracted renal clearance of fentanyl in persons with opioid use disorder. Drug Alcohol Depen. 2021

ED-INitiated BupreNOrphine VAlidaTION Network Trial ED INNOVATION



Pharmacokinetics of XR- & SL- Buprenorphine

XRBUP given in ED
1200 patients
9 cases of PW (0.76%)

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2802898

High dose buprenorphine initiation

California ED Bridge Program
https://cabridge.org/tools/resources/

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.

Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Low-dose Overlapping SLBUP Start

How to

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine dose	0.5mg daily	0.5mg BID	1mg BID	2mg BID	4mg BID	4mg TID	8mg BID
Film size	2mg	2mg	2mg	2mg	2mg	2mg	8mg
Morning dose							
Afternoon Dose							
Night dose							
Full agonist	Continue	Continue	Continue	Continue	Continue	Continue	STOP

https://journals.lww.com/journaladdictionmedicine/Fulltext/2022/07000/Low_Dose_Initiation_of_Buprenorphine__A_Narrative.9.aspx

Long-term buprenorphine treatment for kratom use disorder: A case series

Viktoriya R. Broyan , MS, Jessica K. Brar , BS, Tristen Allgaier, Student & **Jeffrey T. Allgaier** , MD, FACEP, FASAM

Pages 763-766 | Published online: 03 Feb 2022

Cureus. 2023 Jun; 15(6): e41146.
PMCID: PMC10386870
Published online 2023 Jun 29. doi: 10.7759/cureus.41146
PMID: 37519540

Successful Management of Kratom Use Disorder With Buprenorphine and Naloxone

Monitoring Editor: Alexander Muacevic and John R Adler

Martin Arhin,[1] Julian Mobley,[1] Hamad Hamad,[2] and Paul Remick[2]

J Addict Med. 2021 Apr 1;15(2):167-172. doi: 10.1097/ADM.0000000000000721.

Treatment of Kratom Withdrawal and Dependence With Buprenorphine/Naloxone: A Case Series and Systematic Literature Review

Stephanie T Weiss [1], Heather E Douglas

Management of Co-morbid Stimulant Use Disorder

ASAM and AAAP Announce New Clinical Practice Guideline to Address Rising Stimulant Use Disorders

Nov 7, 2023

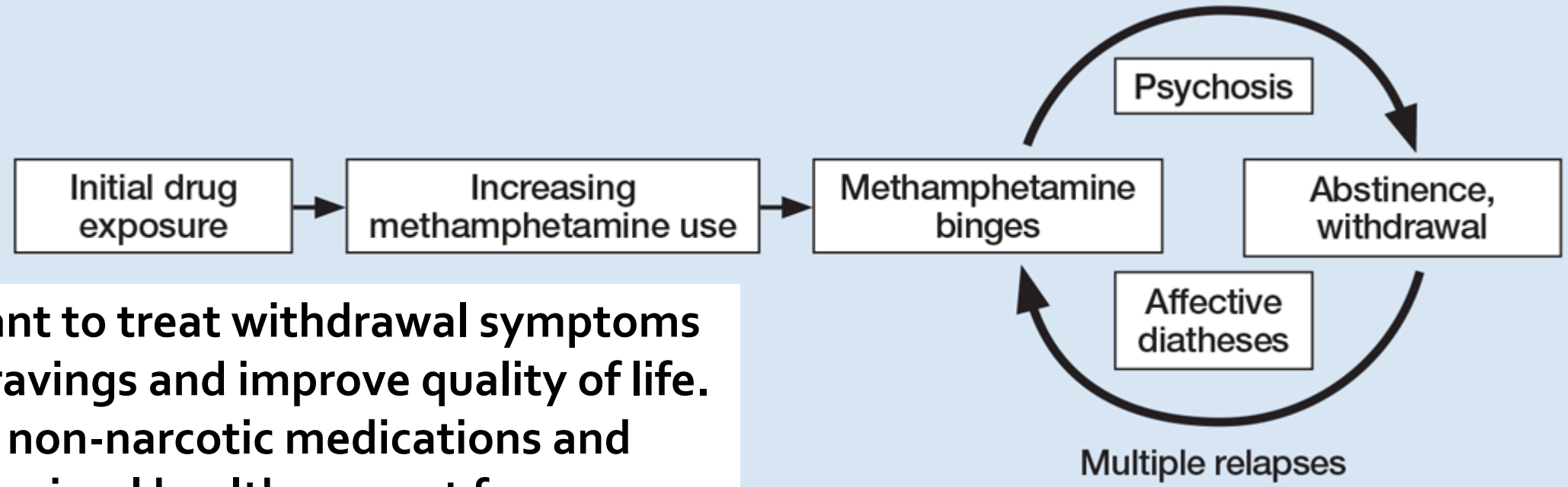
Download

https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/quality-science/stud_guideline_document_final.pdf?sfvrsn=71094b38_1

Contingency Management is #1

Board certified providers may consider Rx stimulants in select patients with close monitoring

Supporting patients in the cycle of stimulant use



It's important to treat withdrawal symptoms to reduce cravings and improve quality of life. Provide non-narcotic medications and behavioral health support for:

Depression
Anxiety
Insomnia
Pain
Thought disorders

Pharmacological Management of Psychosis

- *"Recent research suggests that **olanzapine or quetiapine may be preferred for the management of methamphetamine-induced psychosis**; however, the evidence is considered low quality… When managing psychosis prior to confirming the etiology of stimulant intoxication or withdrawal, clinicians should conduct an evaluation with a focus on identifying potential causes of the patient's psychosis other than stimulant intoxication. Clinicians should focus treatment of psychosis on management of the underlying causes of the patient's psychotic symptoms and monitor for medication side effects with usual care"*

ASAM Clinical Practice Guideline on the Management of Stimulant Use DIsorders

ASK ABOUT ANXIETY AND DEPRESSION

Mirtazapine helps insomnia and anorexia

Bupropion helps with energy and appetite suppression

Less evidence for SSRIs

Avoid Benzos → try buspirone instead

Consider treating physiological WD sxs that mimic anxiety with prn clonidine, hydroxyzine, propranolol

Ask About Sleep

- Make a differential diagnosis to determine whether a client's sleep problems likely stem from protracted withdrawal or are the result of other causes.
- Educate clients about good sleep habits: adopting a regular sleep routine (going to bed and getting up at the same times), exercising early in the day, minimizing caffeine intake, eating well, and avoiding late afternoon naps.
- Utilize non-narcotic meds, consider co-treating comorbid pain/mood disorders: eg TCAs, mirtazapine, trazodone, doxepin, quetiapine (all off label), low-dose melatonin
- Test for sleep apnea (opioids=central vs obstructive)
- CBTI (free VA app)

Treating Sleep Problems of People in Recovery From Substance Use Disorders https://store.samhsa.gov/sites/default/files/sma14-4859.pdf

Harm Reduction

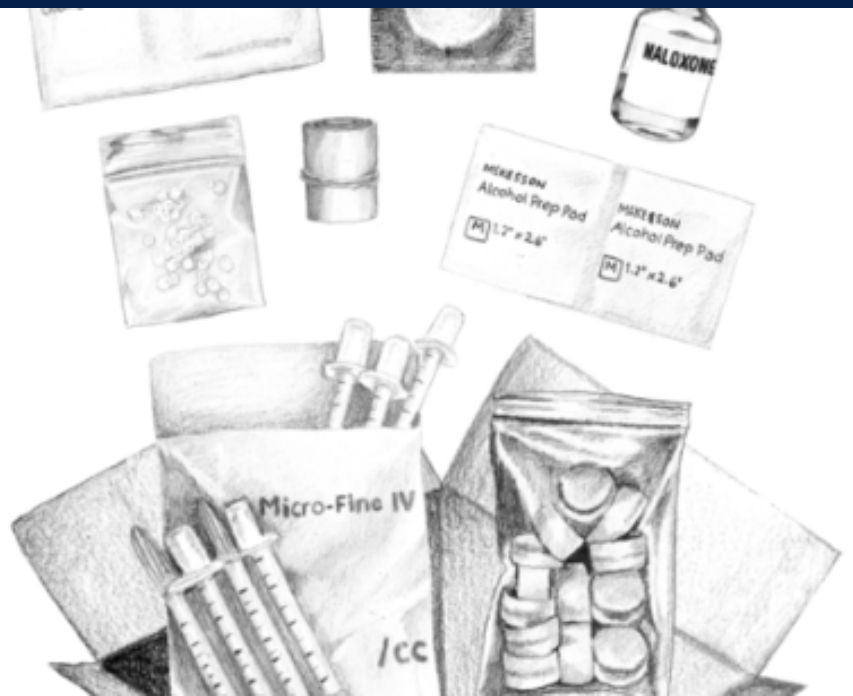
Harm Reduction Based Low Threshold Care

- Don’t discharge patients for ongoing drug use
- Flexible walk-in/same day/tele-med appointments
- Peer support (via text)
- Treatment of co-morbid medical/MH issues
- Contingency Management
- Contraception
- Hep C treatment/ PREP for active users
- Naloxone kits
- Injection and smoking supplies
- Fentanyl/xylazine test strips
- Low threshold MOUD access

ANTHC Harm Reduction Training and Supplies

https://www.iknowmine.org/topic/harm-reduction/

https://www.iknowmine.org/wpcontent/uploads/2021/01/ANTHC_Harm-Reduction_Toolkit.pdf



WHAT IS NEXT Distro?

An online and mail-based **harm reduction service** designed to reduce opioid overdose death, prevent injection-related disease transmission, and improve the lives of people who use drugs. Https://nextdistro.org/

An example of a prescription for syringes

Diabetic syringes

29g, 1/2in *"longs" or* ***31g, 5/16in*** *"shorts"*
(ask patient which they prefer)
½ or 1 cc
(ask patient which they prefer, ½ cc is more common)
Dispense #__ boxes of 100 syringes
Refill PRN X 1year

Allows for online ordering

Patient Cases

Groups will work together to apply their clinical knowledge and unique experience to develop a proposed treatment plan for their group's case.

Community Resources

- In a roadless village: Community health aid, Behavioral health aid, village clinic with emergency medication, Medivac required for hospital care, Rx get mailed to patient or clinic.

- On road system: Peer supports, Primary care clinic, critical access hospital, pharmacy (all may require transportation).

- Not available locally: inpatient withdrawal management facilities, OTP, homeless shelter, residential SUD facility.

Your plan should address:

- Medical management options, including standard of care recommendations vs level of care patient is willing to accept and outlining a risk-benefit conversation

- Creative utilization of available supports at home and in the community (virtual recovery supports, telemedicine, family/friends, peer support, village CHAP/behavioral health aides, clergy, tribal elders and traditional healers, social services)

- Harm reduction options

- Safety and follow-up planning

#1. A 25 yo single female with PTSD at 16 WGA 1st pregnancy, referred to your addiction specialty clinic from a local primary care practice to take over her SLBUP prescribing. She has been intermittently taking SLBUP but has moved between 3 different practices in the past 2 months due to chaotic life circumstances, currently couch surfing. She frequently no-shows for visits and has many gaps in medication continuity. She reported to her PCP last week that she has been struggling to take her SLBUP daily and has continued to inject fentanyl most days, as well as using about 6mg/day of non-prescribed alprazolam and methamphetamine daily. She has had 2 admissions to WD management but left AMA on 1st day. The nearest OTP is 200 miles away and she refuses residential treatment. She is interested in stopping all drugs but unsure how she can possibly manage her anxiety without benzos. She lives 10 miles outside of town, staying with mom (strained relationship) and has no sober friends.

#2. 69 yo male veteran, PMH CAD, MI x2 (stent 6 mos ago), Leukemia CLL (off meds), Chronic Hep C and had been prescribed methadone 50mg/day for chronic pain. He has been injecting fentanyl daily for the past year due to worsening pain, along with methamphetamine to treat fatigue. His methadone prescriber discharged him from care after he tested positive for stimulants. He presents requesting assistance with withdrawing off methadone. He's interested in buprenorphine but scared about PW and worried it won't be strong enough to treat his pain and wonders what will happen if he injects fentanyl while on BUP. He says he cannot stop using meth, he needs it to function due to severe fatigue. He refuses residential treatment, he has to care for home/dog. Nearest neighbors are also PWUD. His truck is broken down and he lives 10 miles from the clinic and 20 miles from the pharmacy. He has not had labs done in over 2 years.

#3. 24 yo AK Native fisherman with h/o anxiety and chronic back pain, who lives in a roadless village (seen by telemed) requests withdrawal management for kratom (drinks 8 cups of tea/day) and bromazolam (4-6 mg/day), both ordered online, so that he can leave in 2 weeks for his 2-month commercial fishing season. When he has run out of kratom he experiences significant withdrawal and has smoked heroin a few times which helped symptoms. He has experienced a seizure once when he ran out of benzos in the past, and sometimes drinks alcohol to help with insomnia when running low on bromazolam. He will be on boat with a sober crew with no access to medical care or pharmacy for at least 2 months. He is an established patient at the local village clinic staffed by a CHAP.

#4. 54 yo AK Native female (who lives in a roadless village, seen by telemed) with schizophrenia, RA, AUD with compensated cirrhosis, and opioid dependence. She lost her opioid prescriber 3 years ago when the itinerant provider lost their DEA, then transitioned to smoking fentanyl to treat her pain. She ran out of her mood stabilizers 6 mos ago, triggering increased fentanyl use to help with sleep and hallucinations. She wants to stop using fentanyl. She drinks 1/5 of vodka daily and had seizures in the past with abstinence. She often experiences blackouts from drinking and injuries from falls, last year medi-evaked to ANMC for hip fracture. She wants to cut down on her alcohol consumption, but she is apprehensive about stopping. She presents with her husband today, also seeking treatment, who revived her from an overdose last week. He is also dependent on fentanyl but does not drink. She relies on him to obtain alcohol for her and describes him as supportive. She refuses to go to the ANMC hospital for inpatient care (her mother died there) but she does utilize the village clinic staffed by a CHAP.

Final Takeaways/Summary

- Current society guidelines for withdrawal management do not always address the management of patients with complex needs in resource limited communities.
- Some patients can benefit from a low-threshold, harm reduction approach to withdrawal management when a higher level of care is not accessible.
- Providers should discuss risks and benefits of various withdrawal management options while considering creative usage of available supports to reduce harms and maximize quality of life for patients with severe, complex SUDs.

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Resources

1. Bridge to Treatment https://bridgetotreatment.org/tools/resources/
2. Curbsiders' Addiction Medicine, Get in the Spirit of Ambulatory Alcohol Withdrawal, July 2022 https://thecurbsiders.com/addiction-medicine-podcast/2-get-in-the-spirit-of-ambulatory-alcohol-withdrawal
3. Oregon Pain Guidance Opioid and Benzodiazepine Taper Flowsheets https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf
4. The Ashton Manual; Benzodiazepines: How They Work and How to Withdraw https://www.benzoinfo.com/ashtonmanual/#contents
5. Alaska Native Tribal Health Consortium Harm Reduction Toolkit https://www.iknowmine.org/topic/harm-reduction/
6. NEXT Distro: online and mail-based harm reduction services https://nextdistro.org/

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