RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Australasian Chapter of Addiction Medicine

TOP-FIVE RECOMMENDATIONS on low-value practices

Better care. **Better** decision-making. **Better** use of resources.

The Australasian Chapter of Addiction Medicine (AChAM) is a Chapter of the Royal Australasian College of Physicians (RACP) Adult Internal Medicine Division that connects and represents addiction medicine Fellows and trainees in Australia and New Zealand.

AChAM advances the study of addiction medicine in Australia and New Zealand through training, research and collaboration with health professionals and organisations. The Chapter provides training and continuing professional development to ensure excellence in skills, expertise, and ethical standards. AChAM advocate on behalf of its members and act as an authoritative body for consultation in addiction medicine to ensure quality care for individuals with addiction disorders.

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

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

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

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

5. Use a 'universal precautions' approach for all psychoactive medications that have known potential or liability for abuse including opioids, benzodiazepines, antipsychotic medications, gabapentinoids, cannabinoids and psychostimulants

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

The main aims of withdrawal management are to provide the means for safe withdrawal from a drug of dependence, including alcohol, and to link the patient to relevant ongoing treatment for their Substance Use Disorder (SUD) and health and social conditions. Evidence shows that withdrawal management results in better outcomes, including reduced readmission rates, when a structured post-withdrawal treatment plan is formulated in collaboration with the patient.

2 Do not prescribe pharmacotherapies as stand-alone treatment for Substance Use Disorders (SUD) but rather as part of a broader treatment plan that identifies goals of treatment, incorporates psychosocial interventions and identifies how outcomes will be monitored

Safe and effective pharmacotherapies exist for the management of substance use disorders (e.g. methadone, buprenorphine, naltrexone for opioid dependence; acamprosate, naltrexone, disulfiram for alcohol dependence; nicotine replacement, varenicline, bupropion for nicotine dependence; and benzodiazepines as part of benzodiazepine withdrawal). However, the vast majority of studies of these pharmacotherapies have either evaluated their effectiveness in combination with psychosocial interventions or demonstrated them to be more effective when prescribed in combination with psychosocial interventions. Therefore, practitioners should always ensure that patients have clinical pathways available to access psychosocial interventions and that these interventions are incorporated into treatment care plans.

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

Efforts to reduce opioid-related harm must be carefully balanced against considerations of potential harms that might result from abrupt discontinuation or rapid tapering of drug dosages. These include risks related to withdrawal symptoms and increased pain as well as to seeking other, at time more dangerous, sources of opioids. The adverse physical and psychological outcomes of abrupt reduction or discontinuation of long-time medication include uncontrolled pain, related loss of function and quality of life, depression, accidental overdose and suicide. Clinical decisions must account for unique circumstances of patients as clinicians compassionately work with them to minimise opioid-related harms, be it by mitigating risks associated with high-dose opioids for patients who continue to use them, dosing at a rate minimising withdrawal symptoms for those who agree to taper and/or maximising non-opioid treatment options as appropriate.

4 While managing patients with Substance Use Disorder (SUD), exercise caution in the use of treatment approaches that are not supported by current evidence or involve unlicensed therapeutic products

Informed consent and treatment decision-making can be complicated in the field of addiction medicine where at times 'desperate' patients and/or their carers are attracted to treatment approaches that may not be supported by available evidence. In considering treatment options, it is our responsibility to present patients and carers with the available evidence regarding safety and effectiveness and to clearly identify where a proposed medication is not licensed for an indication.

There are several medications in the field of addiction medicine for which the evidence is still emerging, such as the use of baclofen or topiramate in the treatment of alcohol dependence, amphetamine-based medications in the treatment of methamphetamine dependence, flumazenil for benzodiazepine withdrawal, or nabiximols in treating cannabis dependence. Other products (e.g. long acting naltrexone implants, medical cannabis products) may not be licensed by local regulatory bodies (the Therapeutic Goods Administration in Australia and Medicines Control in NZ).

In these circumstances, clinicians should a) follow RACP guidance regarding off-label prescribing or relevant therapeutic advisory bodies such as the Council of Australian Therapeutic Advisory Groups, the TGA and Medicines Control's medicine safety updates and procedures for unlicensed medications, b) provide clear and written information to patients and carers and c) consider such treatment approaches as 'second line' options for those not responding to conventional treatment approaches. A second opinion from another Addiction Medicine specialist is often advised.

5 Use a 'universal precautions' approach for all psychoactive medications that have known potential or liability for abuse including opioids, benzodiazepines, antipsychotic medications, gabapentinoids, cannabinoids and psychostimulants

The misuse of a prescription drug or drug class (e.g. benzodiazepines, opioids) is often followed by warnings to medical practitioners to avoid use of that medication or drug class. This may result in doctors using alternative psychoactive medications (e.g. quetiapine, pregabalin) which, in turn, become identified as 'drugs of misuse' and become 'problem drugs'. Underlying this trend is an overreliance on medication in preference to psychosocial and physical therapies and a failure to adopt a broader universal precautions approach to the use of psychoactive medications.

Continued next page

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Australasian Chapter of Addiction Medicine

5

As all psychoactive medications have the potential to be abused, a universal precautions approach to prescribing such medicines is recommended, based upon the following principles:

1. risk screening: identifying patients at risk of poor adherence to medications and/or at risk of developing harms related to their use of a medication
2. identifying clear treatment goals with the patient and considering the role of medication and other treatment options, including the potential harms and benefits of use of a medication
3. structuring treatment according to patient risk including instalment dispensing, approaches to increase medication adherence such as urine drug screens and prescription monitoring, written treatment agreements and regular clinical reviews, and
4. regular monitoring of patient outcomes and medication-related issues associated with adherence and adverse events.

For the list of references supporting these recommendations and further information on the development process, see **evolve.edu.au/recommendations/AChAM**
Version one published May 2020.

WHAT IS EVOLVE?

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.

Evolve works with specialties to identify their 'Top-Five' clinical practices that, in particular circumstances, may be overused, provide little or no benefit, or cause unnecessary harm. Evolve 'Top-Five' recommendations on low-value practices are developed through a rigorous, peer-reviewed process; led by clinical experts, informed by evidence and guided by consultation.

Evolve enables physicians to:

- safely and responsibly phase out low-value tests, treatments and procedures, where appropriate
- enhance the safety and quality of healthcare
- provide high-value care to patients based on evidence and expertise, and
- influence the best use of health resources, reducing wasted expenditure and the carbon footprint of the healthcare system.

The RACP, through Evolve, is a founding member of Choosing Wisely Australia® and Choosing Wisely New Zealand, with all Evolve 'Top-Five' recommendations part of the Choosing Wisely campaign.

evolve

Choosing Wisely Australia
An initiative of NPS MedicineWise

CHOOSING WISELY AOTEAROA NEW ZEALAND