Drug & Alcohol capacity building program

for primary care providers

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Hunter PRIMARY CARE

Assist

D&A (& comorbid MH) primary care treatment

Assist - D&A (& comorbid MH)

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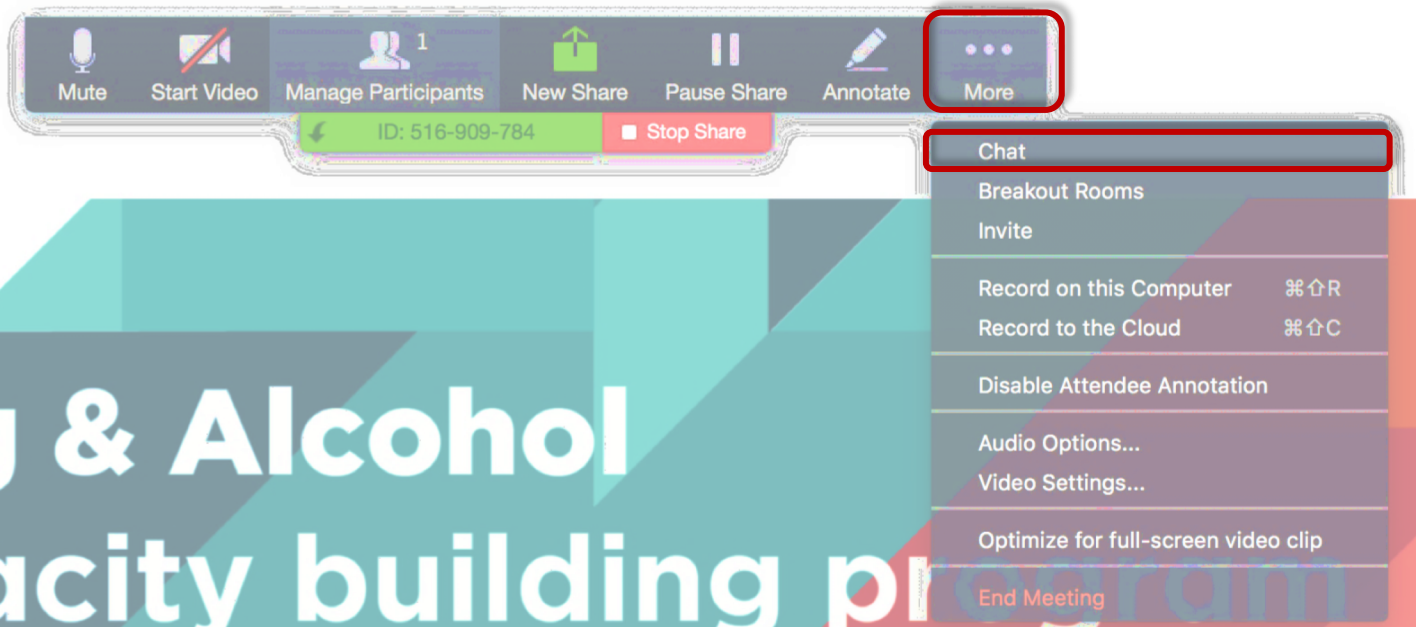

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Amanda


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Drug & Alcohol
capacity building pro
for primary care providers
Zoom Group Chat
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Re-cap: ASK - 6th Feb 2018

Ask

- Substance use is common in GP setting
- How to approach patients: SNAP, other drugs

> ***'As part of my routine review of all my patients, I always ask about lifestyle factors, including things like exercise, diet, stress, alcohol and other drugs. Is it ok if I ask you about these?'***

- What, how often, how much, how?
- Substance use disorder: harmful use or dependence?
- Co-morbidities
- (screening tools e.g. AUDIT – alcohol)

Re-cap: ADVISE - 13th March 2018

Advise

- Brief interventions: effective
- Motivational Interviewing
  - Ambivalence
- Nursing role in drug and alcohol, SNAP
- Patient's motivation to change
- Goals setting

Assist

- Treatment is effective
- Combination of pharmacotherapy and counselling effective
- Treatment may need to be longer and repeated as the person may not have made as many change attempts
- Context of stress management is important (overlap of symptoms of mental illness and withdrawal)

Assist

- Monitor mental health symptoms and smoking, alcohol and other drug use; adverse side effects of psychotropic medication
- Refer to Quitline; D&A Services etc and maintain ongoing relationship
- At the beginning of treatment sometimes mental health symptoms can seem a bit worse – talk about this, normalize it, monitor
- People begin to feel mentally and physically better

Assist

- Sustaining change – grief (show understanding, empathy)
- Monitor over the longer term, step up intervention for smoking, AOD or mental health symptoms as necessary
- Maintain optimism, reinforce small changes and each change attempt
- Clustering of behaviours like smoking and drinking – can be helpful to address both at once with counselling, NRT and other medications as appropriate

Long-term change

- Mutual support groups (SMART Recovery, AA etc)
- Social contact / activities
- Employment
- ‘Flourishing’ life

Co-existing mental ill-health and substance use in primary care settings

Presentations can be complex and good outcomes can take longer

BUT

GP practice settings are ideally placed because

- extended intervention has better outcomes
- mental and physical health problems effected by smoking, AOD
- good long-term relationship with the person

Assist

What can a GP/practice nurse/psychologist do in primary care?

- Assess & diagnose – give feedback
- Provide brief interventions
- Manage dependence

Summary

ICD 10	DSM 5	Intervention
Harmful use	Substance Use Disorder (mild)	Brief interventions, drug and alcohol counselling
Dependence	Substance Use Disorder (moderate - severe)	Counselling, withdrawal, medication

✳ Dependence often involves regular (e.g. daily) use

Case example - Dylan

- Dylan, 36 yo motor mechanic
- Alcohol
  - Beer - ~12 -18 ‘stubbies’ (~17-25 std drinks), Thurs, Fri, Sat, Sun nights
- Hx DUI (x 2 , mid range, high range)
- Separated from partner – arguments
- How to assist?

Case example - Dylan

Advise

- Period of abstinence – e.g. 12 weeks
- Then resume – Australian alcohol guidelines
  - 2 drinks/day (lifetime), 4 drinks 'special occasion' (short term) to reduce risk of harm from alcohol
- Monitor progress www.acar.net.au/cdcp01.html

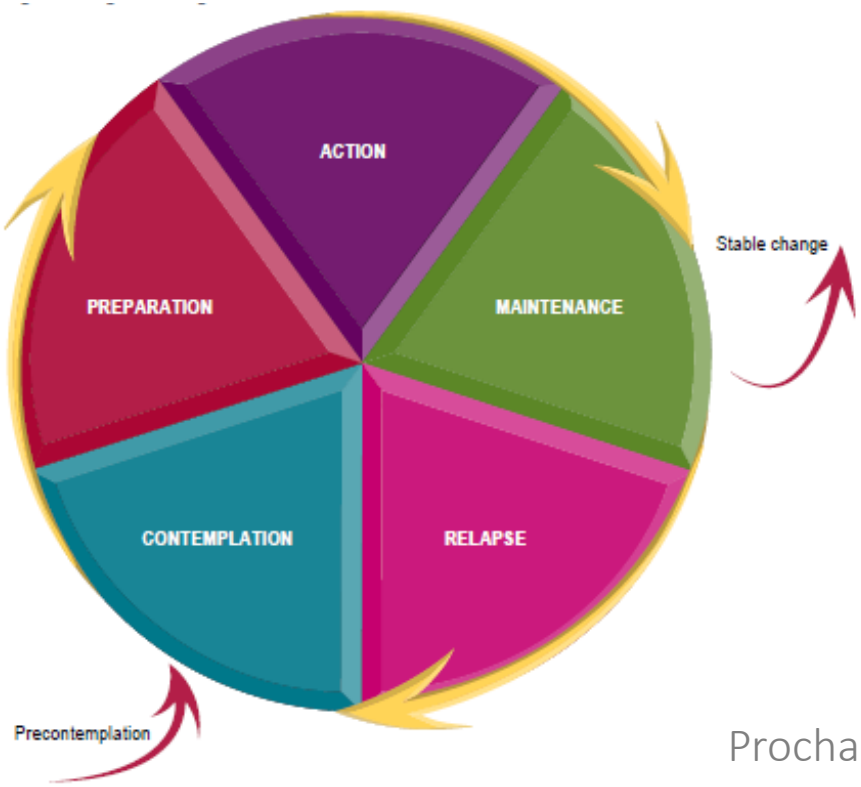
Or

- Cut down - Australian alcohol guidelines
  - 2 drinks/day (lifetime), 4 drinks 'special occasion' (short term) to reduce risk of harm from alcohol
- Monitor progress www.acar.net.au/cdcp01.html

Effective interventions – harmful use/mild SUD

- Motivational interviewing
  - Use with stage of change model
- Cognitive behavioural therapy
- Medical N.b. harm reduction interventions may be important
  - e.g. for IDU
    - Needle syringe provision
    - HBV, HCV, HIV testing
    - Vaccinate HBV
    - Treat HCV (direct acting agonists e.g. sofosbuvir/velpatasvir – Epclusa™®)

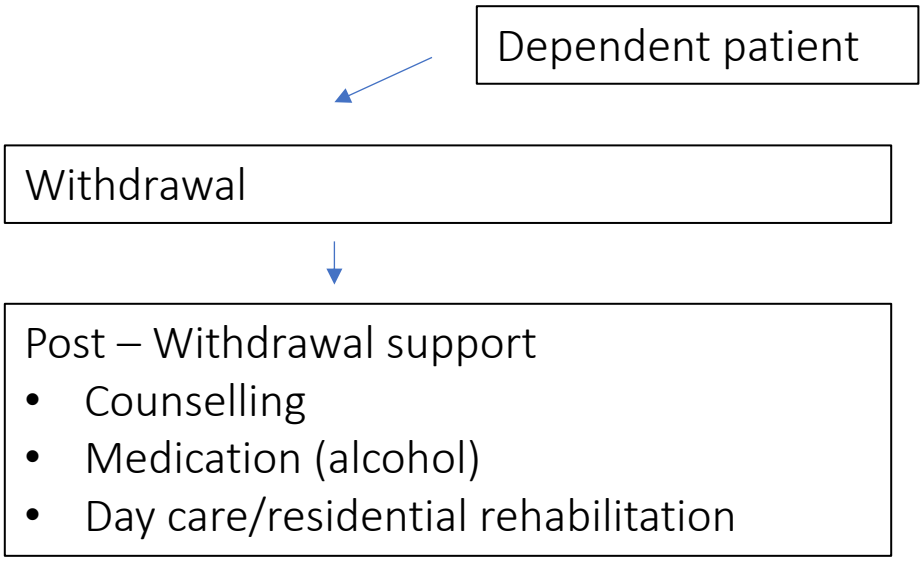
Stage of change model



Prochaska & DiClemente, 1997

Effective interventions – dependence mod-severe SUD alcohol, amphetamines, cannabis

Counselling – motivational interviewing



Effective interventions – dependence mod-severe SUD opioids (Rx opioids: e.g. oxycodone, morphine; heroin), (BZDs)

Counselling – motivational interviewing

Dependent patient

Withdrawal

Post – Withdrawal support
- Counselling
- Medication (alcohol)
- Day care/residential rehabilitation

Opioid agonist treatment
- buprenorphine
- methadone

Withdrawal

- Treatment:
  - Withdrawal Counselling: education, coping strategies, sleep hygiene
  - Medication:
    - Alcohol: diazepam e.g. 10-20 mg daily in divided doses for 5 days
    - Amphetamines: (diazepam)
    - Cannabis: (diazepam)
    - BZDs: diazepam reductions
    - Opioids: buprenorphine – high dose, short course
  - Beware: risk of iatrogenic dependence
    - Risk mitigation:
      - Short courses (e.g. 5 day course)
      - limited supply (e.g. 10 tabs total provided)

Withdrawal (setting)

Setting	Home environment - supportive	Risk of complicated withdrawal (e.g. withdrawal seizures)	Concurrent unstable significant medical/mental health problems
Home			
Withdrawal unit	+/-		low-moderate level
Hospital bed	+/-		significant problems

Case example - Ruari

- 48 yo male, unemployed (lost job mining)
- Alcohol – 12-18 schooners beer/day (19-29 std drinks)
  - Goes to pub when opens
- Cant remember last day off, daily drinking, since early 20s
- Drinking increased over time
- Separated from partner, minimal contact with 3 children
- Gets ‘shakes’ if doesn’t drink late morning

- No history withdrawal seizures, delirium tremens

Case example – Ruari - management

- Suitable for home withdrawal
- Education, counselling (from local D&A service)
- Rx
  - diazepam 5-10 mg qid 3/7, then cease by day 5
  - thiamine 100 mg daily (should give IM if suspect Wernicke's)
- Post withdrawal options
  - Counselling + anti-craving medications

Anti-craving medications

Medication	Action	Dose	PBS
Acamprosate (Campral)	GABA, glutamate, Ca^{++}	666 mg tds (↓ if <60kg)	Authority, alcohol abstinence, part of a comprehensive treatment program
Naltrexone (Revia)	Opioid antagonist	50 mg daily	Authority, alcohol abstinence, part of a comprehensive treatment program
Disulfiram (Antabuse)	Inhibits aldehyde dehydrogenase – ↑ acetaldehyde	200-300mg daily	Private, ~$60/month (MHSUS)

Opiate treatment (methadone, buprenorphine)

- Indication: opioid dependence
- Long term (usually > 12 months)
- Require an authority (state) from NSW Health PRU
- Buprenorphine
  - Can initiate treatment
  - No training required (if <20 patients)
- Methadone
  - Training required to initiate treatment
  - Opiate Treatment Accreditation Course (U Syd) – contact NSW Health

Principles of nursing care

- Engagement and rapport building are key
- Do not assume that the patient perceives their drug and alcohol use as a problem
- Pt's might have a low level of self-efficacy / confidence
- Be positive, provide hope

High level of awareness if:-

- Insomnia
- Anxiety
- Depression
- Other psychiatric conditions (PTSD, aggression, violence, suicidal tendency)
- Repeated injuries
- Clusters of chronic physical conditions
- Repeated social problems

Withdrawal management

- Objectives of withdrawal management
  - Interrupt a pattern of heavy dependent use
  - Promote engagement in treatment
- General principles
  - Assessment of withdrawal risk
  - Early recognition
  - Prevent progression to severe withdrawal
  - Provide supportive care

Withdrawal monitoring scales

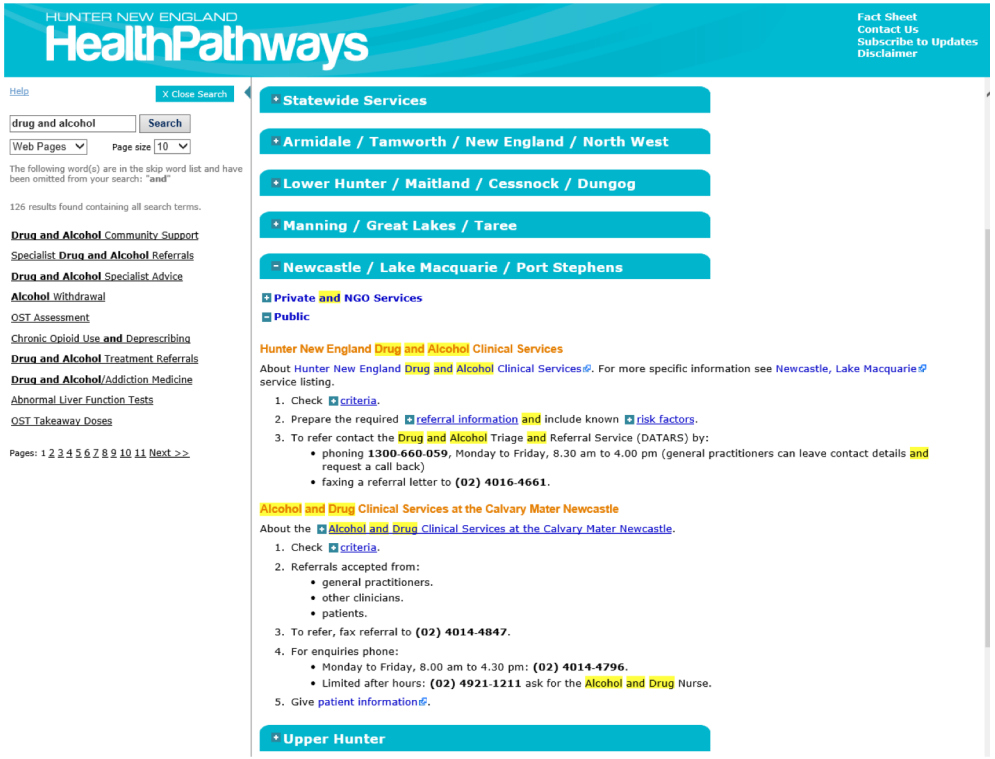
- Withdrawal monitoring scales exist for
  - Alcohol (CIWA-Ar)
  - Benzodiazepines
  - Cannabis
  - Opioids (COWS)
- Not diagnostic, but can be useful monitoring tools

HealthPathways - hne.healthpathways.org.au

Various D&A related HealthPathways exist

- Medical > Drug and Alcohol > Addiction Medicine

- Alcohol Brief Intervention
- Alcohol Withdrawal
- Benzodiazepine Withdrawal
- Cannabis Withdrawal
- Psychostimulant Withdrawal
- Chronic Opioid Use and Deprescribing
- Opioid Substitution Treatment
- Drug Seekers
- Drug and Alcohol Treatment Referrals



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Drug and Alcohol Specialist Advisory Service

- Phone support for professionals 24/7/365
  - Phone support (only) – speak to an addiction medicine specialist
- **Regional and rural NSW** 1800 023 687
- **Sydney Metropolitan** (02) 9361 8006

- Patient line ADIS (Alcohol & Drug Information Service) 24/7/65
  - Regional and rural NSW 1800 422 599
  - Sydney Metropolitan (02) 9361 8000

What's next in this series?

ARRANGE - 8th May

- When & how to refer to D&A & MH services