Managing Alcohol and Other Drug (AOD) Presentations in the GP Setting

Hunter Primary Care &
Hunter New England and Central Coast Primary Health Network
Wednesday 03/02/21, 7pm - 8.30pm

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The worlds most commonly used psychoactive drug: Caffeine

Coffee fueled sedition, and arguably, the Enlightenment and the American Revolution

The sufferer is tremulous and loses his self command; he is subject to fits of agitation and depression. He loses colour and has a haggard appearance..... As with other such agents, a renewed dose of the poison brings temporary relief, but at the cost of future misery

Caffeinism: from a medical textbook published in 1909 by Sir T Clifford Allbutt and Dr. Humphrey Rolleston

Once illegal punishable by death; now remarkable only in its absence.

By the King.
An Additional
PROCLAMATION
Concerning COFFEE-HOUSES
CHARLES R.
GOD SAVE THE KING.
The Form of the CONDITION.

Proclamation against coffee houses by Charles II, 1676

Roadmap

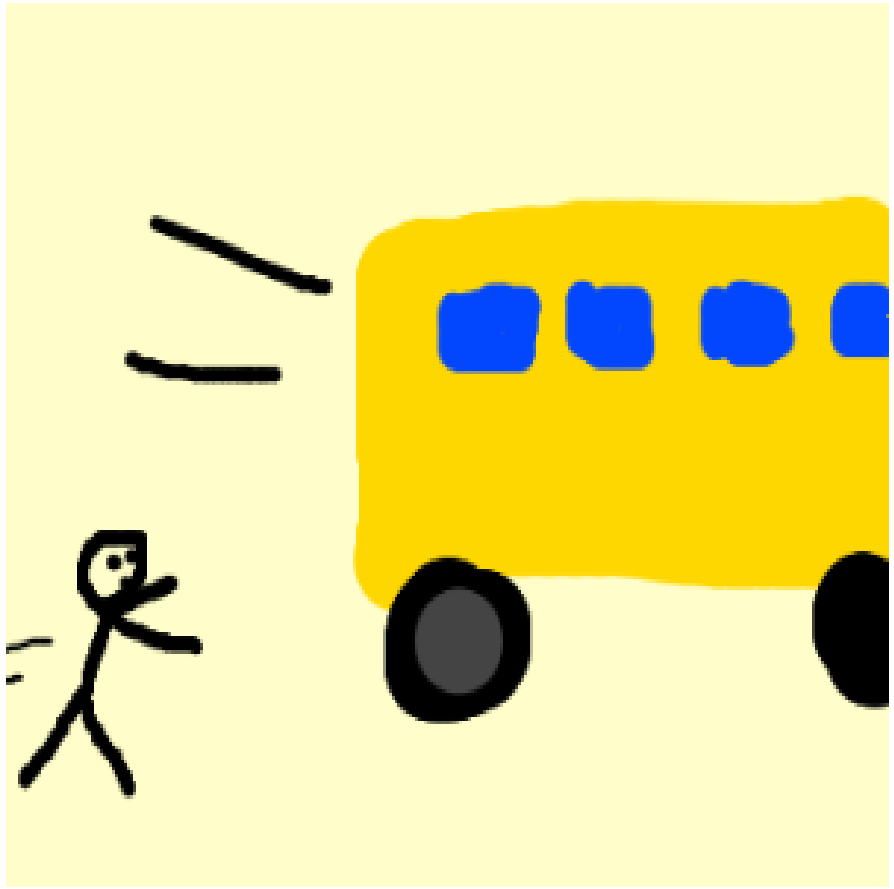
How to identify/screen

How to assess

How to manage

- Nonpharmacological
- Pharmacological

The (non-) detection of AOD problems



What are the consequences of our missing AOD problems?

Should we apply selective screening or universal screening?

Screening for alcohol problems with just one question

How many times in the past year have you had 5 or more standard drinks in a day?

Screening for all other drug problems with just one question

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

NB “Non-medical reasons", means “for instance because of the experience or feeling it caused.”

What do we do if the screen is positive?

‘Rather than by diagnostic codes, explore each drug class by the amount & pattern of use, the social consequences of use, & any experience of loss of control/compulsion/craving.’ (Room 2011).

“I like to have a bit of a smoke after work”

Tobacco associations with mental health.

Tobacco cessation association with AOD treatment outcomes (Piercy 2021)

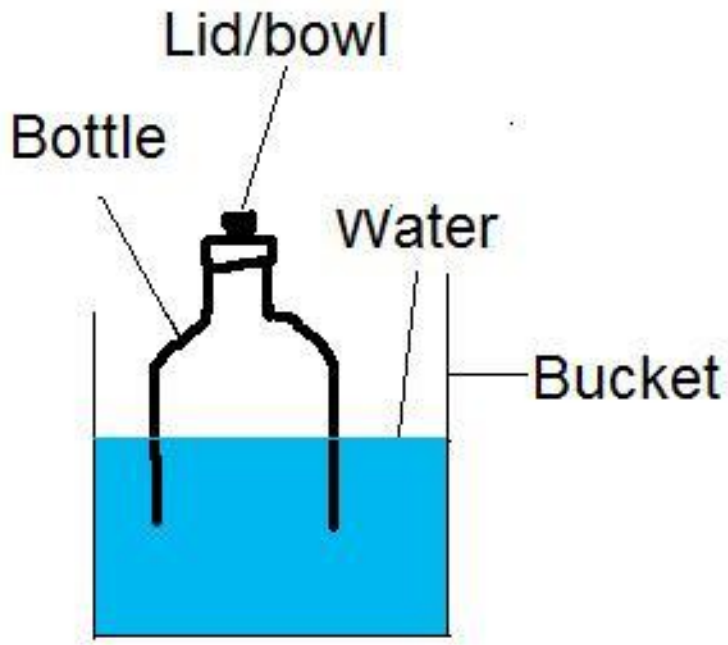
“I’m just a social drinker…”

How to assess?

Guidelines www.nhmrc.gov.au/about-us/news-centre/no-more-10-week-and-4-day

“But I just want to drink moderately.” (Vaillant 1995, 2003)

“I like a couple of cones at night…”



Cannabis may function as a stimulant, a depressant or a hallucinogen.

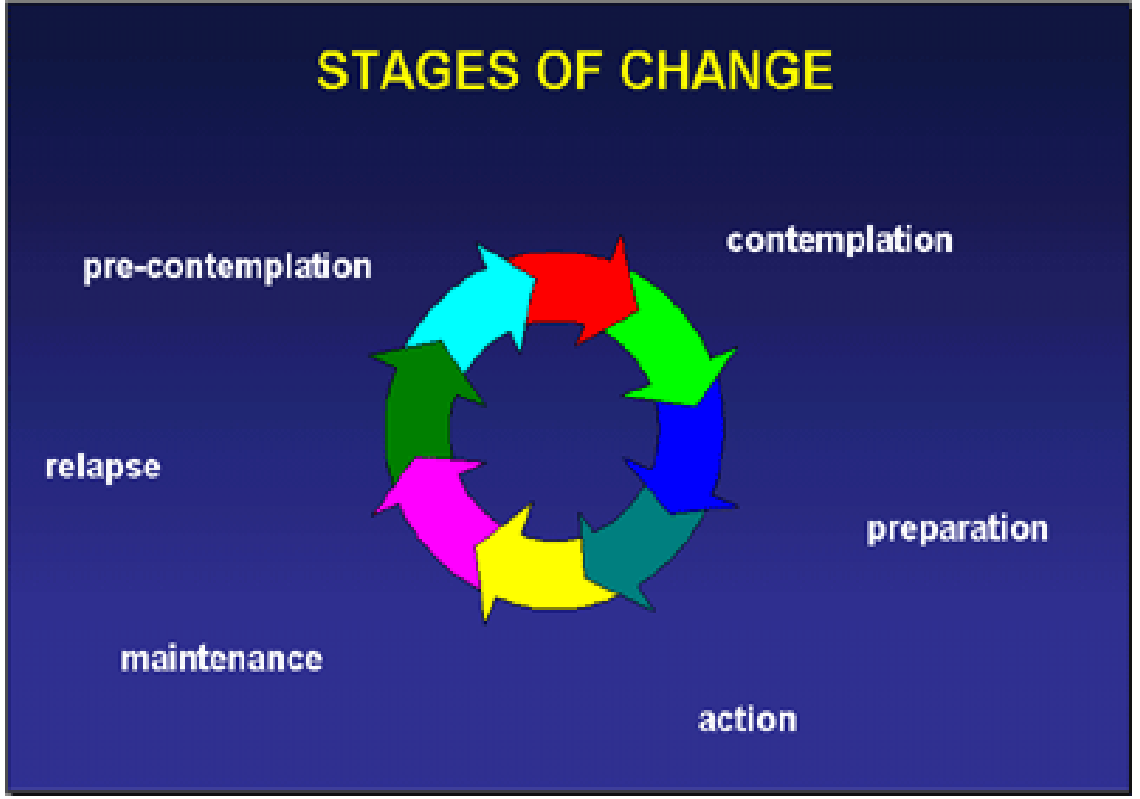
“I just ran out of my pain killers and can’t get back to my usual GP”

16% of the Australian adult population use pharmaceutical opioids each financial year and half of all opioid initiations were by GPs (Lalic et.al. 2019)

In those on pharmaceutical opioids over three months, rates of misuse ~1 of 4 or 5 patients (21.7%-29.3%) and addiction ~ 1 of 10 or 11 patients (7.8%-11.7%) (Vowles 2015)

Over 50% heroin users reach the criteria for dependence.

Nonpharmacological Brief Interventions #1: The 5 A's



Ask: Regularly

Advise: quitting

Assess: Readiness rulers (i.e., "On a scale of 1 to 10, where 10 is very ready, how ready are you to quit smoking?") or Stages of Change assessments

Assist: A plan, some meds or counselling

Arrange: Early and regular follow-ups.

Nonpharmacological Brief Interventions #2: F.R.A.M.E.S.

Feedback re personal risk.

Responsibility for change is clients

Advice given non-judgmentally

Menus of self-directed change or treatment options are offered.

Empathic counselling.

Self-efficacy is encouraged

Nonpharmacological Brief Interventions #3: Motivational interviewing

Express empathy

Develop discrepancy (the gap between values/goals & actual behaviour)

Roll with resistance

Support self efficacy

Scaling questions

Good things Vs Not-So-Good things

Pharmacological: Tobacco & Cannabis

Tobacco:

- Nicotine Replacement Therapy
- Varenicline

Cannabis:

- Same (but off-label)
- Dozens of proposed therapies including baclofen, mirtazapine, gabapentin, N-acetylcysteine, agonists, antagonists and low-dose naltrexone.

Pharmacological: Alcohol

<u>Withdrawal</u>: see https://hne.healthpathways.org.au

Nutrition: Thiamine high-dose, folate, multivitamins (Vs Wernickes)

Monitor for withdrawal (CIWA-Ar, apps, inpatient detox if history of seizures/heavy use)

Anti-DT's treatments: usually diazepam. Many others described e.g. anti-epileptics.

<u>Relapse prevention</u>:

acamprosate &/or naltrexone (using both is off label and non-PBS)

varenicline

baclofen 10-20mg tds (Addolorato 2011)

disulfiram

Pharmacological: Opioids

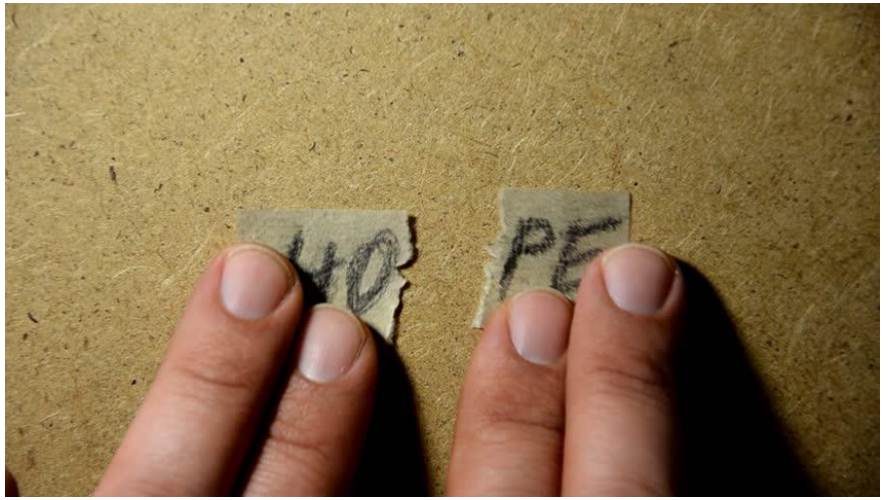
<u>Prevention</u>: don't start outside palliative care or dependency care.
Acute analgesia: keep to 3-7 days maximum.
In inherited patients on long-term opioids, negotiate weaning and introduce higher quality nonpharma care
Bystander naloxone

<u>Dependency care</u>:

There is a strong evidence base involving many RCTs that providing structured methadone or buprenorphine as opioid substitutes minimises harms and saves lives. The mortality rate was more than 10-fold higher for the nontreated Vs those on opioid substitutes (Peles 2013).

Depot buprenorphine (weekly or monthly) has revolutionized the challenge of long-term opioids. It stabilises serum levels & side-steps aberrant behaviours such as doubling up or diversion. It is simple to use, un-demanding of workforce and relatively COVID-safe.

Conclusion



Universal screening is necessary and can be simple.

Explore each drug class by its effect on the patient's physical, mental and social health.

Nonpharmacological care is aided by motivational interviewing.

Some substances have effective pharmacological options.

GPs can save lives and strengthen our community by evidence based therapy and not relying on stigma.

Questions…. simon.holliday@healthhubtaree.com.au

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Q & A

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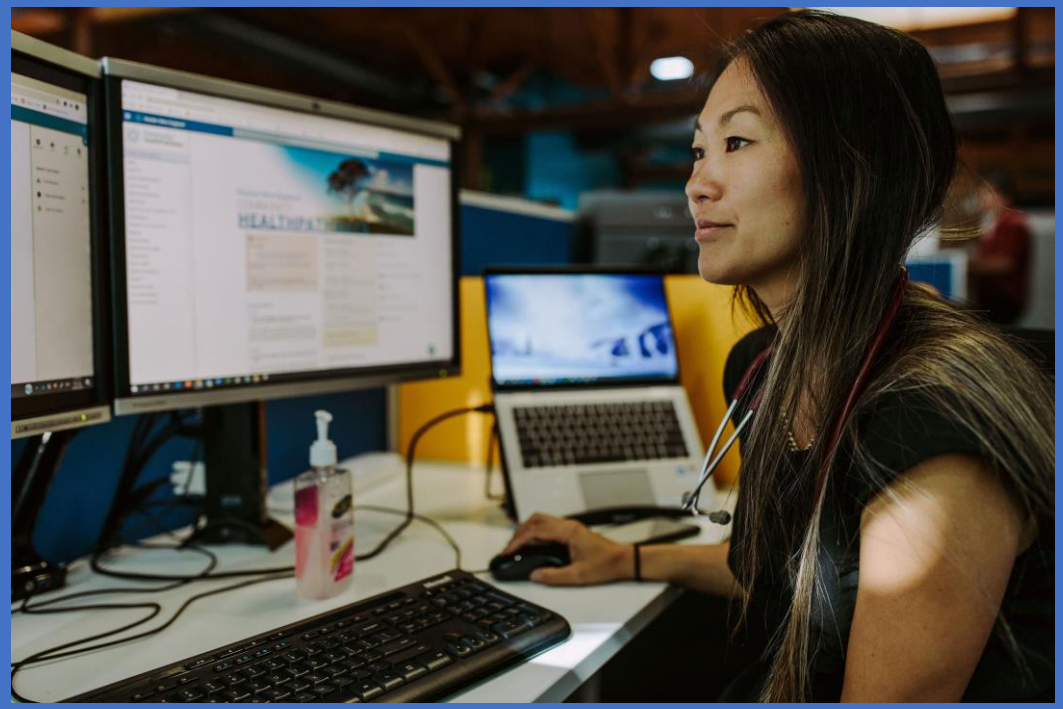

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