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Auckland

Friday, June 9, 2017

(Room 9)

16:30 - 17:25 WS #73: Managing Real Addiction Cases in General Practice

17:35 - 18:30 WS #85: Managing Real Addiction Cases in General Practice (Repeated)

MANAGING REAL ADDICTION CASES IN GENERAL PRACTICE

Graham Gulbransen,

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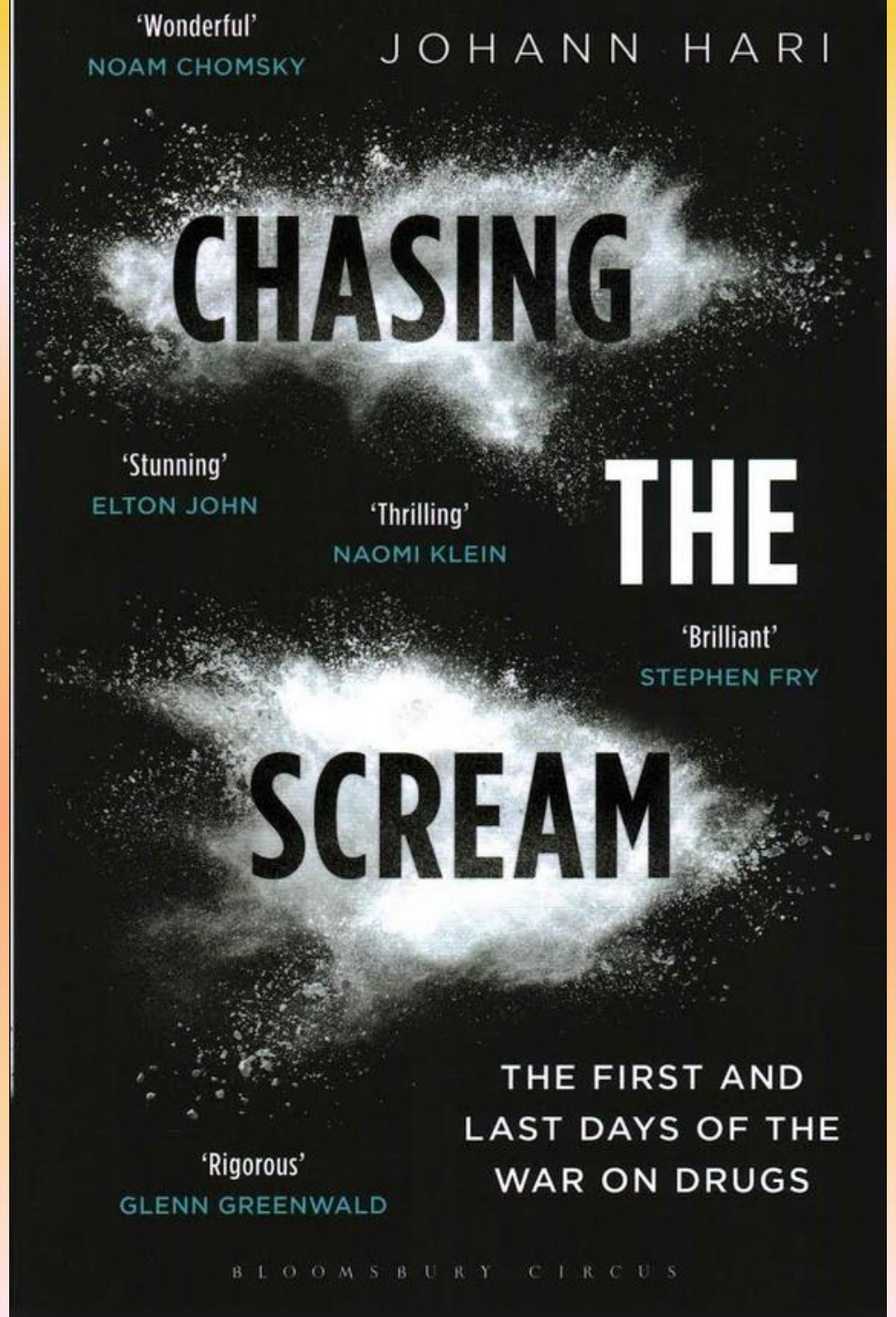
- **Ex-Senior Medical Officer [1996 – 2012],**

Community Alcohol & Drug Services [CADS] Auckland

Rotorua GPCME 9 June 2017

The opposite of addiction is connection

- Google YouTube Rat Park
- https://www.youtube.com/watch?v=ao8L-0nSYzg
- Johann Hari, Chasing the Scream


'Wonderful'
NOAM CHOMSKY
JOHANN HARI
CHASING
'Stunning'
ELTON JOHN
'Thrilling'
NAOMI KLEIN
THE
'Brilliant'
STEPHEN FRY
SCREAM
THE FIRST AND LAST DAYS OF THE WAR ON DRUGS
'Rigorous'
GLENN GREENWALD
BLOOMSBURY CIRCUS

4 Take Home Points:

- Non-judgemental, harm-minimisation approach - compassion

- 1 in 6 of our adult patients are risky drinkers

'How many drinks do you have

in the average 7 day week?'

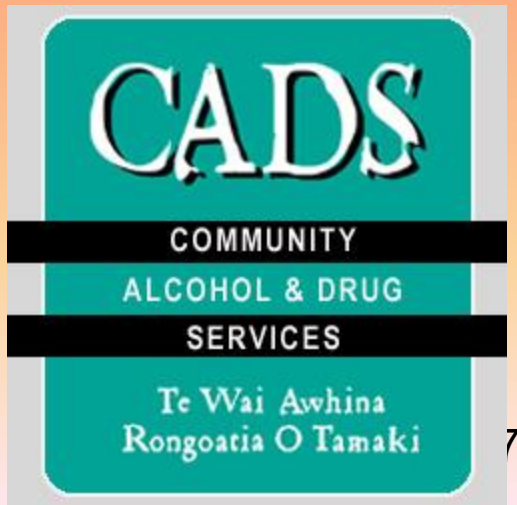
- Brief Interventions are effective, but require patience: 'for every 8 interventions, 1 patient will reduce drinking to safer levels'

- So.... RECORD A SMOKING & ALCOHOL HISTORY ON EVERY TEEN & ADULT PATIENT!

- Auckland Medical Detoxification Inpatient Unit (Detox IPU), SMO on duty 24 hours: 845 1818, 815 5839 or 815 5830.
- CADS website is great: www.cads.org.nz.
- CADS walk in-clinic, 50 Carrington Rd; 10am – 1pm.
- Auckland University papers:

Biology of Addictions, Mental Health.

For advice about managing drug and alcohol problems →



Managing addictions in General Practice

- Alcohol withdrawal, controlled drinking
- Prescription drug misuse & drug seekers
- Disulfiram
- Naltrexone
- Controlled drugs
- Coming off benzos
- Methadone & Buprenorphine/Naloxone [Suboxone]
- Addiction – a perspective. Pleasure centre
- Addiction defined – continuum of use
- Screening
- Cannabis, methamphetamine
- Gambling
- Brief intervention

PROFESSIONAL APPROACH

Non-judgemental
‘maintain high standard of human rights’
Empathic, compassionate, acknowledge positives

<u>Addiction</u>
Compulsive behaviour
Outside substance users personal consciousness
50% heritable
Most have psychiatric comorbidities
Chronic relapsing disorder
Different therapies → similar outcomes
Change takes time.

Biopsychosocial model

Harm reduction

Case History: Michael
alcohol, BZs & depression

How do we manage this common presentation?

- Michael: 46 yo single male caterer known to the practice for 15 years
- Previous episodes heavy drinking & SSRI use

Now feeling depressed again:

- 2 – 3 bottles of wine daily past 4 months
- Wants to stop drinking, but feels shaky and down after work without a drink

- On triazolam 0.25mg on nights not drinking
- Work: either the pressure of too much work or the worry of down times in catering
- Attends church most Sundays
- No hx of self harm, appears to be safe

– **ask about suicidal thoughts & document**

- Kessler 10 score = 40
- Recent LFTs normal
- ‘I’m depressed, drinking again and need help’

HISTORY TAKING

History of presenting complaint
Explores quantity, frequency, duration, last use of substance/s
Explores route of use, risk-taking behaviours
Explores source and cost of substance/s used
Explores problems related to use
Explores dependence criteria
Explores precipitants for presentation
Explores relevant past use:
- e.g. heaviest period of use; first use
Explores relevant treatment history

Other drug and alcohol history
Explores relevant history for:
- Alcohol
- Opioids
- Benzodiazepines
- Marijuana
- Stimulants
- Ecstasy and Related Drugs
- Nicotine
- Other substances

Medical history
Explores Hepatitis & HIV status
Explores history of seizures and head injuries
Explores other relevant medical history

Medication
Reviews current medication
Explores previous relevant medication

Past Psychiatric History
Explores history of anxiety, depression, psychosis
Explores history of self harm, suicidality
Explores past admissions
Explores previous treatments

AChAM Training Program – Patient Assessment Interview Score Sheet

HISTORY TAKING CONT'D...

Criminal history
Explores history of violence
Explores history of convictions & current charges
Explores history of imprisonment

Family and Social History
Explores family history: medical, psychiatric, addiction
Explores family structure and nature of relationships
Explores experience of growing up
Explores education, training and employment
Explores social relationships and supports

EXAMINATION

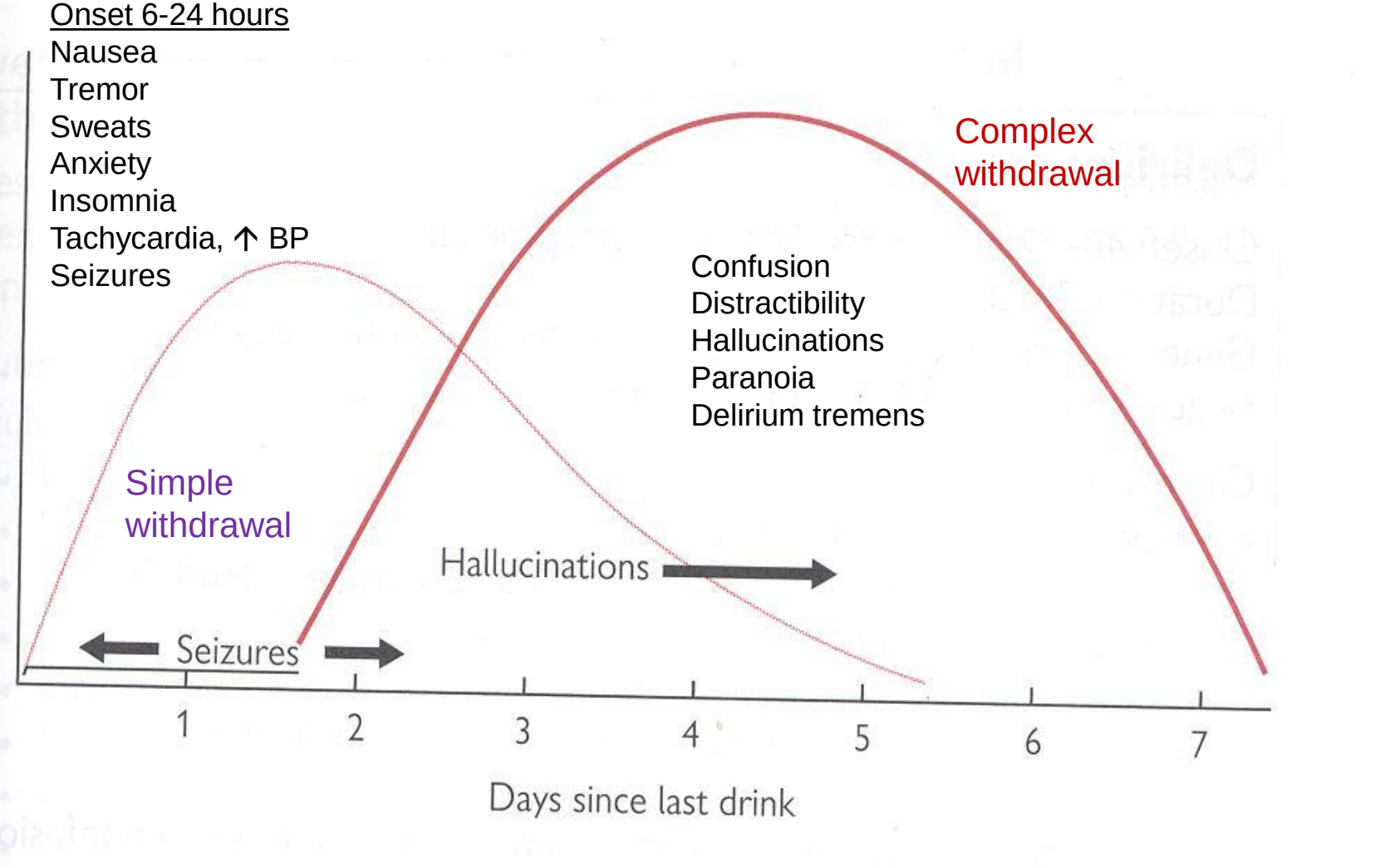
Mental state examination
Explores important mental state features eg anxiety, depression, psychosis, cognitive impairment
Identifies important risk issues (risk of harm to self or others)

Physical examination
Performs appropriate physical examination
If not possible: able to discuss appropriate physical examination

TREATMENT PLAN

Explores motivation for change
Able to give personalised feedback
Able to discuss broad range of treatment options (biological, social, psychological)
Involves patient in treatment decisions

MEDICATION FOR ADDICTION



Alcohol withdrawal timecourse

From Addiction Medicine, Oxford University Press, 2009

Mild Alcohol Dependence

Example:

- Person < 35 years old
- Long term drinker
- 15 – 20 Standard Drinks per day
- Unwell on non-alcohol days: nausea, restless, craving, insomnia, tremor
- GGT normal, or up to maybe 100
- Sober at time of detox (Breath alcohol <400)

℞ Mild Alcohol Dependence

- Thiamine 50mg qid
- Multivitamin bid
- Metoclopramide 10mg tid prn
- Diazepam [25mg/day]
  Days 1 & 2: 5mg tid, 10mg nocte
  Day 3: 5mg bid, 10mg nocte
  Day 4: 5mg tid
  Day 5: 5mg bid
  Day 6: 5mg nocte
- Dispense daily with Sunday takeaway dispensed on Saturday.

℞ Mild Alcohol Dependence cont

- Ask your local CADS for their preferred diazepam regime. Or
- Diazepam [Taper from 25mg/day]

  Day 1: 5mg tid, 10mg nocte [25mg]

  Day 2: 5mg bid, 10mg nocte [20mg]

  Day 3: 5mg tid [15mg]

  Day 4: 5mg bid [10mg]

  Day 5: 5mg nocte

Dispense daily with Sunday takeaways dispensed Saturday.

Back to Michael
alcohol, BZs & depression

- How do we manage this common presentation?

- Michael: 46 yo single male caterer known to the practice for 15 years
- Previous episodes heavy drinking & SSRI use

Management of Michael

- Thiamine 50mg qid
- Diazepam tapered from 25mg in divided doses on day 1
- Previously felt worse on fluoxetine, no better on citalopram, some benefit but hard to get off paroxetine
- Venlafaxine 37.5mg week 1, 75mg week 2
- CADS recommended
- Review 1 – 2 weeks.

Michael a week later

- Abstinent one week
- He has spoken to his family about financial stressors, feels supported
- Has an appointment to see CADS counsellor
- Kessler 10 score 32
- Feeling better – is it the social support, abstinence, venlafaxine, all of the above?

Moderate Alcohol Dependence

Example:

- Older person
- Long term drinker
- 15-25 Standard Drinks per day
- Unwell on non-alcohol days: nausea/vomiting, restless, craving, insomnia, tremor – symptoms moderately severe
- LFTs raised, possibly in the hundreds
- Consider support of Addiction Service.

℞ Moderate Alcohol Dependence

- Thiamine 50mg qid
- Multivitamin bid
- Metoclopramide 10mg tid prn
- Diazepam
  Days 1 & 2: 10mg qid [40mg daily]
  Days 3 & 4: 5mg tid, 10mg nocte
  Day 5: 5mg bid, 10mg nocte
  Day 6: 5mg tid
  Day 7: 5mg bid
  Day 8: 5mg nocte
- Dispense daily with Sunday takeaway dispensed on Saturday.

Severe Alcohol Dependence

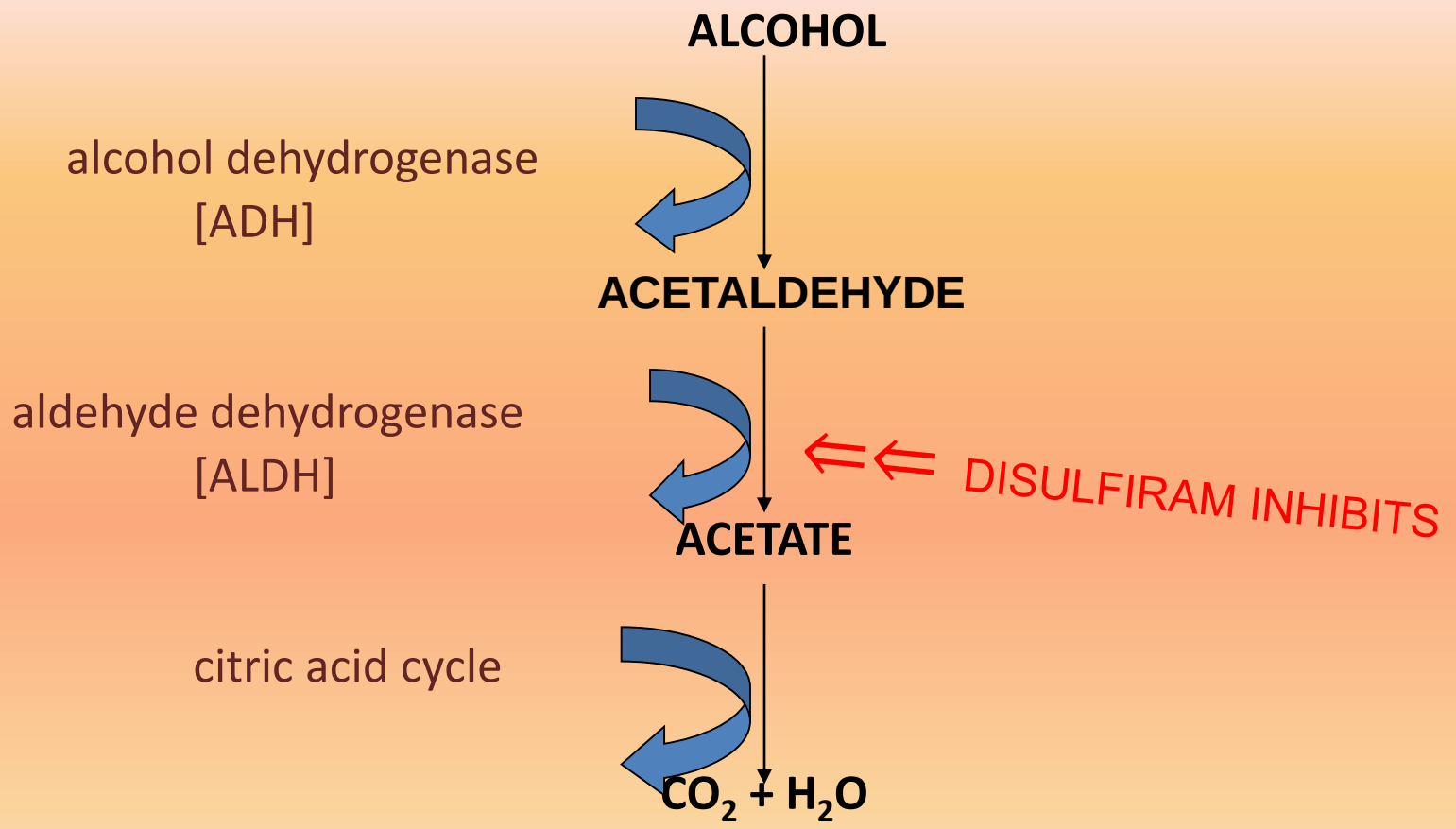
30 Standard Drinks per day, long term, very sick on cessation

24

Refer for specialist care

[maintenance drinking until Detox]

Disulfiram (antabuse)



Disulfiram – alcohol reaction

Within 5 – 30 minutes of alcohol:

- Hot flushed face
- Throbbing of head and neck
- Dyspnoea, nausea, vomiting, sweating, thirst, chest pain, hypotension, weakness, vertigo, blurred vision, confusion, marked distress
- Lasts up to several hours, may be ill several days
- Exhaustion, sleep

Clinical use

- Start 12 – 48 hours after last alcohol
- 100 – 500mg daily, usually 200mg
- Warn re sauces, mouthwash, cough mixt, perfume, aftershave
- Sensitisation to alcohol may continue for

  6 – 14 days after last dose of disulfiram
- Continue 6 – 12 months, or long term

Cautions

- Frailty, hx serious heart disease, stroke, hypertension, diabetes
- Psychotic illness, severe personality disorder
- May be teratogenic
- May interact w metronidazole, isoniazid

Naltrexone (revia, naltraccord)

- Opioid antagonist
- Alcohol facilitates brain opioid systems
- Reduces craving
- Reduces intoxication
- Reduces continuation of drinking
- Dose: 50mg daily
- Alcohol dependence: Special Authority requested by Addiction Specialist only, for patients in treatment programs. GP reapplication.

Modified for GPEP
by Dr Graham Gulbransen, Kingsland Family Health Centre

Controlled Drinking
The Science and the Art

Assoc Prof Simon Adamson
National Addiction Centre
Dept Psych Medicine
University of Otago
APSAD, Adelaide November 2014

Why cover this topic?
Because we're doing it, but there's little formal discussion of when and how

Conclusions

- A large proportion of our clients want to reduce, not stop
- A goal of abstinence predicts better outcome, but this doesn't mean prescribing abstinence would be as effective
- Controlled drinking is an appropriate goal for less severe drinkers
- Effective CD is negotiated with clients, contains clear guidelines and ongoing supervision and support.

Why would I offer CD?

- It's what my client wants
- The benefits of choice
  - improved engagement
  - does this improve outcome?
- Horses for courses – titrate intervention to problem severity
- Learning experience for client
- *"People are more likely to be persuaded by what they hear themselves say"*

(Motivational Interviewing helping people change, 3rd Edition)

The risks of offering CD

- Poorer outcome
- Sub-optimal treatment/selling your client short
- Increased risk of relapse

Who is CD appropriate for?

- Lower severity
  - dyscontrol
  - Health and other consequences
- Track record – past attempts
- Social support for moderation
- Those who would drop out if not given the choice

Controlled drinking despite contra-indications

- i.e. severe dependence
- Evidence that a (very small) proportion of this group can succeed
- Controlled drinking as harm reduction
- Controlled drinking as an intermediate goal
- Not succeeding would be a good learning experience

NZ Low Risk Alcohol Guidelines 2012

Choosing a limit

- National guidelines are “Low Risk” for the general population
- Is this too high for someone with an alcohol use disorder?
- Is this too low to be realistic for someone reducing from a much higher level?

Choosing a limit

- Aim for ALAC figures as a maximum
- Aim for a higher number of non-drinking days
- Engage client in conversation about at what level:
  - Problems might occur
  - Ability to control consumption is diminished

Agree to limits

- Per occasion
- Per week/fortnight
- Define week (eg Mon-Sun = 7 days)
- Drinks/hour
- Stop drinking after x hours
- Dos and Don’ts

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together to
develop so
parameters
guidelines
know what
trying to ac
and to kee

More than just a limit

- Do:
  - Only have one sometimes
  - Take my time and enjoy it
  - Have spacers
  - Abstain when around high risk people
  - Share these rules with my partner/friends
  - Keep a drinking diary

More than just a limit

- Don't:
  - Drink on an empty stomach
  - Drink alone
  - Drink with people I don't like
  - Stay out after 1am
  - Drink when feeling stressed or to drown feelings
  - Drink spirits
  - Drink Red Bull and vodka
  - Preload

More than just a limit

- Don't
  - Drink before dinner
  - Drink while cooking dinner
  - Continue drinking after dinner
  - Start drinking before 7pm
  - Drink if I haven't already decided it's safe
  - Drink if I feel like I *need* a drink
  - Drink at work functions
  - If in doubt, don't drink

More than just a limit

- If I break a rule:
  - Discuss with my partner
  - Work out why and do something about it
  - Stop and think about how it's going. Review treatment material
  - Have a week/month off
  - Contact counsellor

But first….

- Initial period of abstinence
  - 1-3 months
  - “sobriety sampling”
  - Developing new skills
  - Establishing a “new normal”
  - Consider whether to extend this period indefinitely

And then….

- Monitor progress
- Utilise relapse prevention strategies
  - Identify High Risk Situations
    - Avoid
    - Mitigate
  - Deal with craving
  - Drink refusal skills
- Revisit and adjust as required
- Maintain an open door to abstinence

Support for Controlled Drinking

- Is the goal supported by others around the client?
- The value of engaging family in the treatment process
- Support group options

Before we talk about benzodiazepines and opioids:

SECTION 24 OF THE MISUSE OF DRUGS ACT (MODA) – THE RULES

Treatment of people dependent on controlled drugs (see Section 24 of The Misuse of Drugs Act 1975)

Section 24(1) states that "...every medical practitioner commits an offence against this Act….who prescribes, administers or supplies any controlled drug for or to any person, whom the practitioner has reason to believe is dependent (on that or any other controlled drug) in the course, or for the purpose of treatment of dependency **except....**

....**except** if the medical practitioner is acting with the permission in writing, given in relation to that particular person by an authorised medical practitioner."
S24(2)(d).

Only gazetted specialist services (e.g. Alcohol & Drug Services), gazetted GP's and Authorised GP's can prescribe for people dependent on controlled drugs. See S24(2)(a)(b)(c)

Classification of Controlled Drugs

- Class A drugs pose a very high risk of harm
- Class B drugs pose a high risk of harm
- Class C drugs pose a moderate risk of harm

- Class A: eg. heroin; methamphetamine

- Class B1: eg. morphine; opium; cannabis oil

  B2: eg. methylphenidate; amphetamine

  B3: eg. fentanyl; pethidine

- C1:eg. cannabis plant; Catha edulis plant (Khat)
- C2:eg.codeine; dihydrocodeine
- C3:eg. Pholcodine
- C4:eg. buprenorphine; barbiturates (no longer prescribed)
- C5:eg. benzodiazepines; phenobarbitone; ephedrine; pseudoephedrine
- C6:eg. codeine/paracetamol; (mixtures of class C drugs with other substances)

REDUCING BENZODIAZEPINES

- You must have authorisation from a gazetted service eg CADS to prescribe for someone dependent on benzos

- You may be able to reduce or increase BZ doses if you are not treating dependence, eg anxiety or epilepsy – but you may want to take advice.

http://www.benzo.org.uk/bzequiv.htm

BENZODIAZEPINE EQUIVALENCE TABLE

(Benzodiazepine Equivalency Table)

Revised April 2007

This Benzodiazepine Equivalence Table is based on the extensive research and clinical experience of Professor C Heather Ashton, DM, FRCP, Emeritus Professor of Clinical Psychopharmacology at the University of Newcastle upon Tyne, England. Sources: NRHA Drug Newsletter, April 1985 and Benzodiazepines: How they Work & How to Withdraw (The Ashton Manual), 2002. The approximate equivalent doses to 10mg diazepam (Valium) are given.

For a discussion of half-lives and equivalencies see also the Benzo FAQ document.

Benzodiazepines[1]	Half-life (hrs)[2] [active metabolite]	Approximately Equivalent Oral dosages (mg)[3]	Market Aim[4]
Alprazolam (Xanax, Xanor, Tafil)	6-12	0.5	a
Bromazepam (Lexotan, Lexomil)	10-20	5-6	a
Chlordiazepoxide (Librium)	5-30 [36-200]	25	a
Clobazam (Frisium)[5]	12-60	20	a,e
Clonazepam (Klonopin, Rivotril)[5]	18-50	0.5	a,e
Clorazepate (Tranxene)	[36-200]	15	a
Diazepam (Valium)	20-100 [36-200]	10	a
Estazolam (ProSom, Nuctalon)	10-24	1-2	h
Flunitrazepam (Rohypnol)	18-26 [36-200]	1	h

See full table for more

http://www.benzo.org.uk/bzequiv.htm

Diazepam (Valium)	20-100 [36-200]	10	a

Non-benzodiazepines with similar effects [1], [6]			
Zaleplon (Sonata)	2	20	h
Zolpidem (Ambien, Stilnoct, Stilnox)	2	20	h
Zopiclone (Zimovane, Imovane)	5-6	15	h
Eszopiclone (Lunesta)	6 (9 in elderly)	3	h

REDUCING BENZODIAZEPINES

- Helen, 55, fibromyalgia, breast cancer 2 yrs ago
- Headache, fatigue, depression, feeling all her meds are making her worse, want to stop them
- Sertraline 100mg
- Zopiclone 3 nocte, sometimes 4
- Lorazepam 2 – 2.5mg daily
- Tramadol 50mg x 6 daily

diazepam equivalent [half life 20 – 100 hours]

- zop x 3 = diaz 15mg
- loraz 2.5mg = diaz 25mg
- Total = 40mg

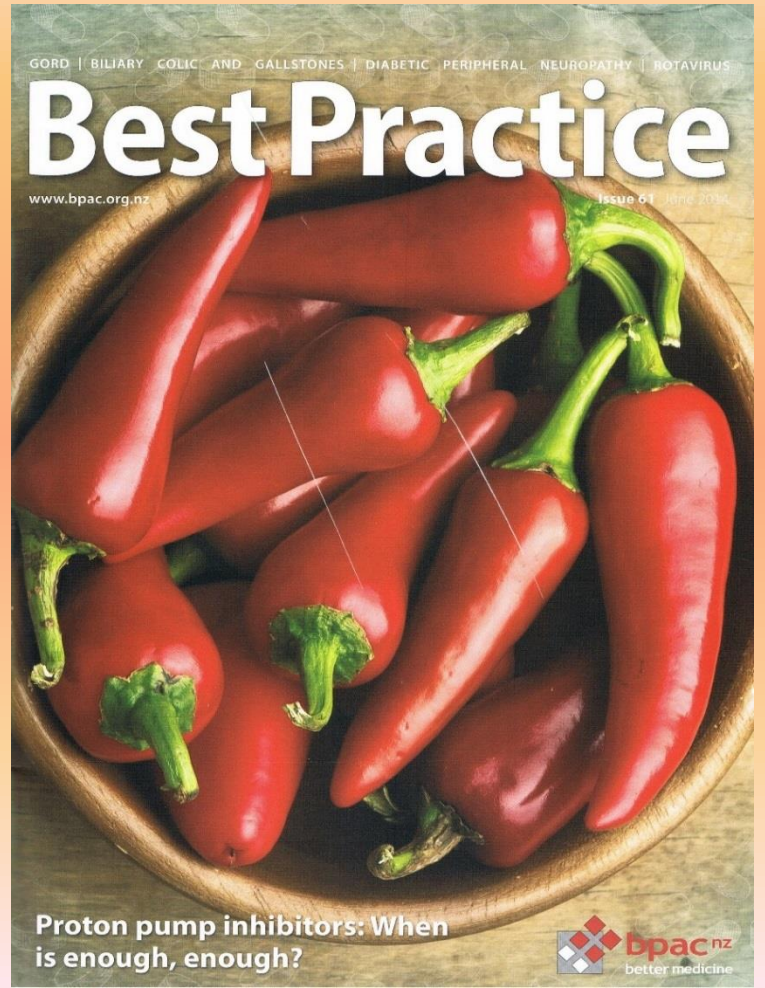
Change to diazepam 40mg per day:

- 10mg at 7am
- 7.5mg at midday
- 7.5mg at 5pm
- 15mg at 9:30pm
- Review in 1 week or SOS

- Reducing diazepam by 2.5mg per day every 2 weeks
- Feeling more energetic, clearer thinking, better vision

“A disaster in the making”: oxycodone. Best Practice, June 2014

http://www.bpac.org.nz/BPJ/2014/June/upfront.aspx



‘In New Zealand, we have had the good fortune to be last off the starting line, with oxycodone coming to us later.
Even so, it is clear from [national dispensing] data that our prescribing of oxycodone has followed comparable trajectories to that seen in Australia and the United Kingdom.
There is no good reason for this – oxycodone is more expensive than morphine and more addictive, and is no safer in renal [impairment] or other conditions…’

Prescription opioids

- Kill more people in USA than road crashes
- NZ prescribing rate is increasing
- Oxycodone 60mg = morphine 100mg approx.
- Oxy more expensive
- Oxy has no advantages over morphine
- Dependence features in 25-30% oxy users
- Best for acute pain only – reduce dose ASAP
- Opioids in chronic pain controversial

Drug seekers:
see Best Practice June 2014

- Targets: new GPs, late appointments
- New patient without convincing documentation
- Hx of lost or stolen meds
- Some are very expert professionals – we all get conned sometime
- Often requesting opioid or BZ by name
- Stating that nothing else works
- May threaten to call Hlth & Disab Commisioner
- Seeking drugs for personal use or to sell

Drug seekers: what to do

- Refuse inappropriate requests
- If uncertain a prescription up to 3 days max
- If threatened ask patient to leave, call staff or police.
- Stay calm, stay safe – difficult consultations
- ‘I suspect you have a drug problem. I can help you arrange an appointment with CADS’
- Don’t expect them to pay!
- Check MoH Restricted List
- Talk to colleagues.

Opioid Substitution Therapy - OST

- Methadone
- Suboxone

Methadone maintenance therapy

- GP requires CADS authorisation to Rx
- Average dose around 120mg daily
- Biodone 5mg/ml
- Often consume a dose at pharmacy Mon, Wed & Fridays. Takeaway other doses
- Often using other drugs or alcohol
- Often mental health issues
- Many are fully functional
- Some manage to slowly withdraw from MMT.

Buprenorphine/naloxone (suboxone) sublingual

- Buprenorphine previously temgesic sublingual, [now subutex NOT available in NZ]
- Approved indication in NZ = ONLY for treatment of opiate dependence, within framework of medical, social and psychological treatment
- 2mg buprenorphine + 0.5mg naloxone
- 8mg buprenorphine + 2mg naloxone
- Naloxone to deter intravenous misuse
- Used as maintenance or to wean opioid users
- 16/16/16/8mg, Mon/Wed/Fri/Sun

Dual diagnosis
or comorbid conditions

- What do we treat first?
  - Addiction
  - Mental health
  - Both

CANNABIS

Trevor, 29, labourer
poly-drug dependence

Cannabis daily after work, no other drugs, never IDU

- Motivational chat

6 months later: smoking methamphetamine every weekend

2 years since first consult: seen w mother

- On bail for cooking P, possession firearms
- Cannabis daily
- No tobacco or alcohol
- Poor sleep, afraid of being attacked
- Not suicidal
- Talks to friends
- Kessler 10: 32 => moderate risk anxiety/depression
- Declines SSRI or referral to CADS
- For Sickness Benefit.

2 years + 2 months since first seen

- Cannabis daily ‘to cope’
- Alcohol 3 days a week
- No other drugs
- Car was stolen
- Depressed
- Kessler 10 gone from 32 to 36
- Declines SSRI, ‘dont want to turn into a zombie’
- Will try melatonin, but not CADS.

2 years + 3 months since first seen

- Court hearings, more charges
- No money
- Social isolation, friends are stoners
- Some house painting, kitchen hand
- Looks depressed, K10 = 32

Plan: Sickness Benefit, but wont go to CADS.

2 years + 7 months since first seen

- Seen at ED: anxiety on stopping cannabis
- Given zopiclone 15mg, advised to see GP.

3 years since first seen

- K2 or Illusion (synthetic cannabis) on waking, all day and thru night
- Stops 12 hours max, then craves more
- Working full time, plumber
- Started synthetic drugs to pass drug tests at work
- Methamphetamine twice a month
- Smoking cigarettes

Plan: recommend CADS, citalopram 20mg, zopiclone x 10.

5 years since first seen

- Moved to another town
- Final court case due later in the year
- Never went to CADS
- Acupuncturist told him K2 was destroying him, so he stopped synthetic cannabis!
- Gone back to natural/normal cannabis, daily
- Works as plumber
- Cannabis at work, but feels safe because job mainly involves lying on the ground!

BACKGROUND

- After caffeine, alcohol & tobacco the most widely used drug in developed countries
- Cannabis sativa has >60 cannabinoids, terpenes
- Present in resin, seeds, flowers, leaves, stalks, varying with plant genes, sunlight, humidity, soil
- Δ9-tetrahydrocannibinol (Δ9-THC or THC) found to be active component (Mechoulam and Gaoni, 1965)
- Cannabidiol (CBD): calming, possibly antipsychotic benefits.

Vaporisers: The Hemp Store

www.hempstore.co.nz

Focus handheld

Vaporite digital desktop

Herb chamber

mouthpiece

Arizer Air handheld

Cannabis: Problematic use

- Using most days or daily
- Starting on waking
- Poor energy, low motivation
- Patient may present intoxicated
- Irritability, insomnia on stopping

- Management: see FLAGS later, consider a sedative eg zopiclone 15mg nocte for 3 nights. CADS, NA

Cannabis withdrawal

- Supportive network, counselling
- Consider tapered diazepam eg from 25mg/day
- Consider night sedation eg short course of zopiclone, quetiapine or promethazine

(Anecdotal evidence from my experience.)

METHAMPHETAMINE – ‘P’

Bruce, 38, liquor outlet manager amphetamine dependence

HISTORY

Late 2012: seen w ex-partner

Referred by CADS, and will be doing their program

Alcohol

-heavy drinking as part of his job, over 20 years

-less in recent years.

Methamphetamine, 6 years, no other stimulants or other drugs

-helped him reduce alcohol

-eased depression

-had more days using than not, never IDU

-last meth use was a week ago. He is being offered free drugs by ‘friends’

-difficulty sleeping

-waking feeling flat

-irritable

-not motivated.

Depression

-when marriage split

-went thru a breakdown

-saw a private psychiatrist

-tried fluoxetine, quetiapine

-no recent meds prescribed

-his ex- gave him amitriptyline 75mg: good nights sleep, getting into a routine, dry mouth

- while he is sick his insurance covers him
- thoughts of death, has wondered if it is worth living, being a burden to others, but safe.

- Kessler 10 score 40 = high risk of anxiety/depression

PLAN

- Continue CADS program, increase exercise, work part-time
- Rx: Amitriptyline 25mg Tab - 1 - 3 FOR SLEEP
- Review in 1 week.

- Seen a week later
- Attended CADS once
- Made excuses to visit a ‘drug buddy’ to say he had stopped P, and used once with this friend
- Mind is clearer
- Sleeping better
- Coffee increased to 7 daily
- Reduced libido off P

- Reduced P use to once in 2 weeks cf most days past 6 years.

- Wants to feel less depressed, but ‘actually reasonably happy with myself’
- ‘looked’ at John Kerwins Journal
- Not suicidal
- Agrees to increase amitrip from 75 to 125mg nocte

2 weeks later

- Seen with his ex-
- Used P once in 4 weeks
- Spending more time w his kids
- Missed 2 CADS group sessions, one w the flu, the other out of guilt from missing the 1st one
- Amitrip 125mg nocte

- See in 2 weeks.

3 weeks later

- Completed CADS starter course
- Will do the next program
- Head clearer, joy in lifes simple pleasures
- Weight 112 → 120kg off P
- A few beers, cannabis twice, no more P

- See in 4 weeks: no show....

- He completed the 8 wk Bridge program
- Stayed alcohol- & drug-free
- Increased exercise
- Attends AA meetings & psychotherapy
- Reports ‘great mental health’
- Reunited w his ex
- Excited she is pregnant!

What can we do???

Self management

would you want to stop using something that gave: euphoria, increased energy & mental alertness, wakefulness, weight loss & increased libido???

- Non-dependent experimental or recreational use – majority of users
- Expense
- Tolerance
- Dysphoria, paranoia, the Crash, withdrawal
- Loss of relationships, family, job etc

Harm Reduction for ‘P’ – Brief Advice

- No use is the safest Use. Needle exchange if IDU
- Awareness of your sources re: potency
- Small amount first - to check potency and your response to the drug
- Methamphetamine is an illegal drug - An awareness of the potential legal ramifications as ‘P’ is a Class A drug
- At risk sexual behaviours - amphetamine consumers are far more likely than other drug consumers to engage in risky sexual behaviours
- Risk of increased violent offending. Consumers who are experiencing psychotic symptoms may also be more prone to irrational acts of violence

Harm Reduction for ‘P’

- Overdose - is less likely with amphetamines than with many other drugs, especially CNS Depressants. Dysphoria, tachycardia, psychosis
- Food, sleep and hydration - amphetamine users may need to remind themselves/each other to eat, drink, sleep
- Depression, suicide –vulnerable during the Crash or withdrawal. Also vulnerability to psychosis. Consider support networks. Withdrawing from the drug may also reinforce feelings of hopelessness, guilt, or shame
- Pregnancy – low birth wt, behavioural changes
- Breast feeding – contraindicated
- Driving – Contraindicated!

Psychological Treatment

- Motivational interviewing
- CBT [problem solving, relapse prevention]
- Counselling
- Group work eg AA, NA
- Include whanau
- Lifestyle changes
- Refer, refer, refer

Pharmacological Treatments - Intoxication

- Calm supportive environment
- Hydration, cooling, monitor
- History. Urine Drug Screen (UDS)
- Acute agitation: diazepam 10-20mg q2h prn orally
- Extreme agitation/violence: GET HELP.

  [IV BZs, olanzapine or quetiapine]

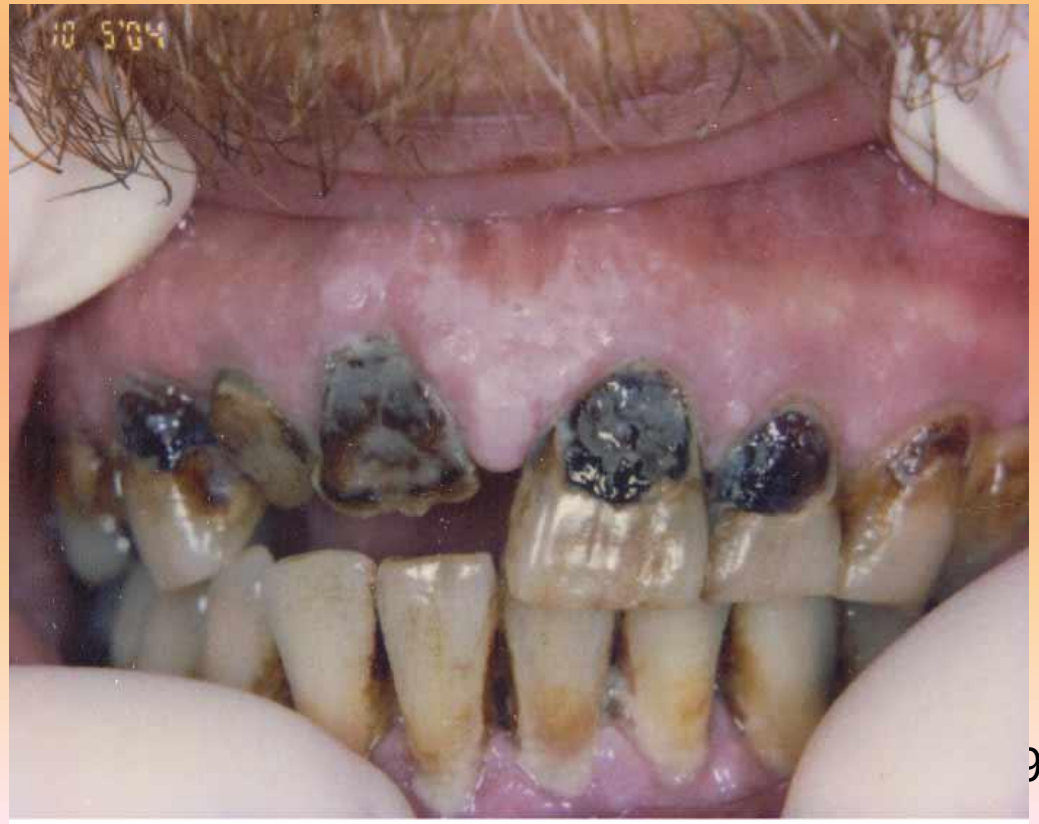
Trials

- Paroxetine
- Imipramine
- Bupropion
- Modafinil
- Dexamphetamine
- Methylphenidate

Treat Co-morbidities

- Poor self care
- Mental health
- Dental health

- Continuity of care



Meth mouth

All you need to know:

Contact your local Alcohol & Other Drugs Service

GAMBLING

‘Lie-bet’ brief gambling screen

1. Do you feel you have ever had a problem w gambling? [Ask only if not obvious]
2. If ‘yes’ – Do you feel you currently have a problem with gambling?
3. Have you ever felt the need to bet more and more money?
4. Have you ever had to lie to people about how much you gambled?

- If yes to any of these
  - Would you like some information?
  - Would you like to talk to someone in confidence?

MedTech Problem gambling assessment

Forms /

New Patient Form /

Problem Gambling Assessment

What to do?

- Problem Gambling Foundation
- http://pgfnz.org.nz
- Gambling helpline 0800 664 262

- PGs dont like groups, tending to isolate, secretive
- May prefer 1:1 work rather than Gamblers Anon
- Budgeting advice

BRIEF INTERVENTIONS FOR ADDICTIONS

NNT Alcohol

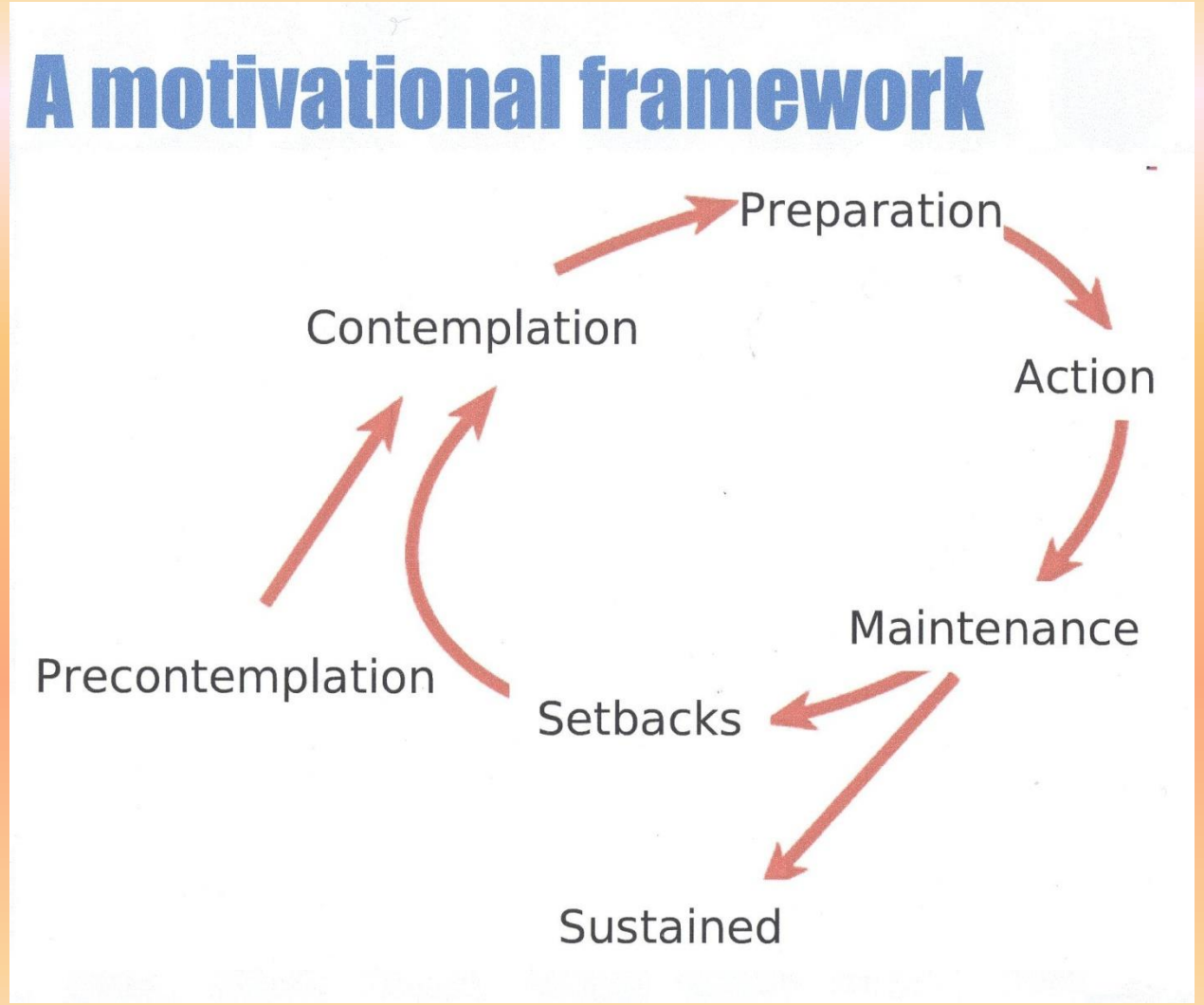
For every 8 interventions,

1 patient will

reduce drinking

to safer levels

A motivational framework



How does it work in practice?

The Whanganui ABC Alcohol pilot, Dr John McMenamin explored how ABC interventions could be delivered in a New Zealand Primary Care Setting to address alcohol related risk and harm.

As detailed in RNZCGP *Implementing the ABC Alcohol Approach in Primary Care*:

- **A**SK
- **B**RIEF ADVICE
  - Safe drinking, where to get advice
- **C**OUNSELLING
  - 'Establish rapport
  - Identify goals
  - Choose strategies'.

[Motivational Interviewing, Miller & Rollnick, 2nd Edition, p274]

“People are more likely to be persuaded by what they hear themselves say”

Motivational Interviewing helping people change 3rd Edition

4 Take Home Points:

- Non-judgemental, harm-minimisation approach - compassion

- 1 in 6 of our adult patients are risky drinkers

'How many drinks do you have

in the average 7 day week?'

- Brief Interventions are effective, but require patience: 'for every 8 interventions, 1 patient will reduce drinking to safer levels'

- So.... RECORD A SMOKING & ALCOHOL HISTORY ON EVERY TEEN & ADULT PATIENT!

If you need help

Contact

or

Refer patient to

Your local Community Addiction Service

Acknowledgements

- CADS Auckland colleagues
- Prof Ross McCormick, Uni of Akl
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- *Addiction Medicine* – Oxford Specialist Handbooks, 2009
- Internet
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Thank You