TADPole: Treating Alcohol & other Drugs in Primary Care

Assessment

The following are issues to consider in assessment.

Drug use and treatment	❑ Quantity and pattern of use of all licit and illicit drugs ❑ Previous treatment and complications ❑ Dependence (tolerance, withdrawal, compulsion, loss of control, persistence with use despite harm, neglect of alternative interests)
Medical & psychiatric problems	❑ Drug use related ❑ Other medical problems ❑ Psychiatric problems
Psychosocial factors	❑ Support ❑ Barriers ❑ Expectations and Goals
Physical assessment	❑ Effects of drug use ❑ Intoxication and withdrawal ❑ General physical assessment
Laboratory tests	❑ Confirmation drug use ❑ Screening for illnesses predisposed by the drug used ❑ Investigation of abnormalities uncovered in assessment
Opportunities for Harm reduction	❑ Injecting behaviour ❑ Sexual behaviour ❑ Immunisation

Withdrawal

In general the effects of withdrawal are the opposite of the effects of the drug so that withdrawal from:

- ❑ sedative drugs is associated with arousal of systems;
- ❑ stimulatory drugs is associated with sleep and lethargy

Drug	**Withdrawal symptoms**	**COMPLICATIONS**
Tobacco	❑ CNS stimulation – agitation, anxiety, tremor, insomnia, irritability	
Alcohol	❑ CVS, Respiratory stimulation – tachycardia, hypertension, tachypnoea ❑ GI stimulation – Nausea & vomiting, diarrhoea ❑ CNS stimulation – agitation, anxiety, tremor, insomnia ❑ Skin - perspiration	❑ Delirium tremens ❑ Seizures ❑ Wernicke's encephalopathy
Benzodiazepines	❑ CNS stimulation – agitation, anxiety, tremor, insomnia, muscle twitches, aches, panic attacks, sensory symptoms, ataxia	❑ Seizures ❑ Confusion, delusions and hallucinations
Opiates	❑ Flu-like – sweats, goosebumps, headache, N&V, diarrhoea, runny nose, watery eyes, malaise, aches ❑ Fright-like – agitation, anxiety, insomnia, pupillary dilation	❑ Unlikely unless other medical problems
Methamphetamines & Cocaine	❑ "Crash" phase (1-3 days) in which lethargy, sleep and depression occurs is followed by hunger, agitation and craving.	
Ecstasy, LSD & other party drugs	❑ Ecstasy "hangover" of drowsiness, muscle aches, depression and difficulty concentrating ❑ LSD may be associated with flashbacks later	
Cannabis	❑ CNS effects - lethargy, agitation, anxiety, tremor, insomnia, irritability, panic	
Solvents	❑ CNS – headache, drowsiness, muscle cramps, hallucinations ❑ GI – nausea, abdominal cramps	❑ rarely DTs have been noted

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Offering Treatment

Treatment options may include one or more of the following

OPTION	COMPONENTS	SITE OPTIONS

Detoxification with the aim of
❑ abstinence
❑ reduction or
❑ stabilisation
	❑ Supportive care
	❑ Monitoring for complications
	❑ Counselling – individual and group
	❑ Medication
	  ❑ Reduction of withdrawal symptoms
	  ❑ Treatment of other problems such as depression
		❑ Next Step (inpatient/outpatient specialist multidisciplinary)
		❑ Hospital (especially if other medical complications)
		❑ Community (including general practice and non-Government organisations)

Relapse prevention with the aim of reducing return to problematic drug use	❑ Counselling – individual and group
	❑ Self-help groups
	❑ Medication
	  ❑ For alcohol – naltrexone, acamprosate or disulfuram
	  ❑ For opiates – naltrexone
		❑ Next Step and non-Government organisations
		❑ General practice with other community support including private sector

Harm reduction for those in whom detoxification and abstinence is not possible/realistic	❑ Counselling – individual and group ❑ Self-help groups ❑ Practical harm reduction advice (not sharing injecting equipment, not driving when drinking) ❑ Medication ❑ For opiates – methadone & buprenorphine maintenance	❑ Non-residential at Next Step ❑ General practice ❑ Community Drug Service teams and other community agencies

Counselling

Some examples of counselling techniques used are outlined below.

Brief intervention	❑ single most effective form of intervention when potentially harmful consumption of a range of drugs (particularly smoking and alcohol) is detected ❑ robust evidence for brief intervention in general practice worldwide in a range of health systems ❑ involves **assessment** of drug consumption and harms related to this, **feedback** on personal effects, **advice** on drug use (preferably accompanied by written material since this increases effectiveness) and planning of **follow-up** ❑ aimed for use in the early stages of drug use when function and relationships are intact
Motivational interviewing	❑ technique which helps a person to clarify ambivalence to a behaviour such as drug use and to make decisions about ongoing behaviour ❑ widely practised in the alcohol and other drug field and can be used in many areas such as diet, exercise and other lifestyle issues
Supportive counselling	❑ provision of empathy as well as interest in drug use, progress and well-being ❑ practical help in various psychosocial areas may be provided ❑ the effect of this should not be underestimated especially in the context on continuing care ❑ in studies on naltrexone for alcohol dependence, intensive coping skill treatment showed no advantage over supportive treatment
Skills based treatment	❑ in cognitive behavioural therapy (CBT) the patient is taught to identify feelings and the thoughts that lead to the emotional response and to modify these ❑ coping skills can also be taught so that the client learns to deal with situations of high risk and learns strategies to cope with various symptoms and emotions.

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Notification of Oversupply or Drug Dependence

Statutory regulations require that a practising medical practitioner who encounters a person who is oversupplied (obtained drugs of addiction in quantities that are greater than is reasonably necessary for therapeutic use) or drug dependent (acquired an overpowering desire for continued administration of a drug of addiction) to the CEO of the Department of Health.[1] to inform the Drugs of Dependence branch of the Health Department of Western Australia. If a patient is a notified addict, S8 drugs may NOT be prescribed for them without authorisation from the Drugs of Dependence branch. In emergencies when strong analgesia is required, eg. obvious fracture, S8 drugs may be administered (from the Doctor's Bag) but not prescribed without authority.

A registered medical practitioner does not have to seek authorisation to prescribe S8 drugs in the following circumstances:

- Patient is at least 18 years old and has not history of substance abuse in the past 5 years
- The drug is an opioid which is approved for the treatment of pain (other than methadone)
- The combined daily does is no more than the equivalent of 90 mg of morphine per day[2]
- The formulation is non-injectable and the immediate release component is the equivalent of no more than 45 mg of morphine per day
- The medication and indications are TGA approved.
- Where prescribing is anticipated to continue beyond 30 days, a treatment contract is in place.

In all other circumstances authorisation from the CEO of the Department of Health is required.

Prescribers should not prescribe or supply an S8 medicine to any new or unknown patient without first contacting the S8 Prescriber Information Service for a prescription history. Where it is not possible to validate a person's identity or prior history, only limited supplies should be prescribed until the required information can be obtained. It is recommended that a maximum 2 days (or the next working business day during holiday periods) should be prescribed, where clinically appropriate and safe to do so.

Options for Treatment

The following table outlines briefly the options for treatment.

Drug	Detoxification	Relapse prevention	Harm reduction
Tobacco	❑ Weigh up pros and cons, set a quit date ❑ Consider nicotine replacement gum, patches or inhaler and bupropion	❑ Supportive treatment ❑ Regular follow up and encourage to see long term benefits	❑ Reduce other risk factors for heart disease ❑ Discuss diet, exercise and healthy lifestyle
Alcohol	❑ Inpatient or outpatient detoxification depending on quantity of consumption and risk of problems ❑ Diazepam is the mainstay (5-10 mg qid to be weaned over 3-5 days, higher doses may be used as an inpatient) ❑ Thiamine 100 mg IM/IV for 5 days to prevent Wernicke's encephalopathy ❑ Other symptomatic treatment, eg. for vomiting, diarrhoea	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via Alcohol and Drug Support Line - ADSL) ❑ Consider naltrexone or acamprosate	❑ Reduce likelihood of accidents by discouraging driving while drinking ❑ Work with the family to avoid harm in cases of domestic violence
Benzodi	❑ Convert to diazepam equivalent	❑ Deal with issues of	❑ Reduce likelihood of

[1] Department of Health, (2017), *Schedule 8 Medicines Prescribing Code,* Medicines and Poisons Regulation Branch, Department of Health, Perth, Western Australia

[2] ANZCA conversion chart. http://fpm.anzca.edu.au/documents/opioid-dose-equivalence.pdf

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Drug	Detoxification	Relapse prevention	Harm reduction
a-zepines	(approximately 5 mg diazepam = 10 mg temazepam = 30 mg oxazepam = 5 mg nitrazepam = 2 mg flunitrazepam) ❑ Gradual detoxification off diazepam (eg. 10% reduction every 1-2 weeks) ❑ Caution of taking more than 40 mg diazepam equivalent daily. Discuss with medical officer at Next Step first.	insomnia or anxiety/ panic which may have caused initial use of benzodiazepines ❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	accidents by warning about risks of driving ❑ Reduce other risk factors for falls ❑ Consider other preventive issues such as STIs and contraception ❑ Avoid using temazepam capsule as often injected
Opiates	❑ Clonidine - as outpatient not more than 75 micrograms tds. As an inpatient consider up to 3 micrograms per kilogram each dose qid (starting with 50, increase by 50 each dose, gradually wean over days for total treatment of 1 week). ❑ May consider sedation (eg. diazepam 5-10 mg up to qid, wean over 3 days, caution re causing BZD dependence) ❑ Symptomatic treatment for nausea, vomiting, cramps ❑ If authorised to prescribe buprenorphine, this is likely to result in the best outcomes	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	❑ If injected reduce blood borne virus transmission by discouraging shared injecting equipment ❑ Consider other preventive issues such as STDs and contraception ❑ Teach significant others about overdose and CPR. In addition offer significant others support and access to helplines (eg. PDIS) ❑ Consider methadone or buprenorphine maintenance program
Methamphetamines & cocaine	❑ Generally no specific medication required as during withdrawal patients tend to sleep ❑ Following initial withdrawal period, mood changes and depression can cause problems and antidepressants may be considered	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	❑ If injected reduce blood borne virus transmission by discouraging shared injecting equipment ❑ Consider other preventive issues such as STDs and contraception
Ecstasy, LSD & other party drugs	❑ Generally no specific medication required	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	❑ If injected reduce blood borne virus transmission by discouraging shared injecting equipment
Cannabis	❑ Generally no specific medication required	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	❑ Reduce likelihood of accidents by warning about risks of driving ❑ Warn about risk of psychosis in the predisposed
Solvent use	❑ Generally no specific medication required	❑ Supportive treatment ❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	❑ Offer significant others support and access to helplines (eg. PDIS)
Polydrug	❑ Withdrawal more complicated	❑ Supportive treatment	❑ Reduce likelihood of

Drug	Detoxification	Relapse prevention	Harm reduction
use*	because of unpredictable effects ❑ Admission into residential treatment is often safer for this group. ❑ Where drug regimes are used withdraw from each drug in a stepwise fashion. eg, in a case of alcohol and benzodiazepine dependence, maintain a stable but safe level of benzodiazepines while withdrawing from alcohol. Following alcohol withdrawal, benzodiazepine withdrawal can be planned.	❑ Regular follow up ❑ Encourage to follow up with counselling or groups (via ADSL)	accidents by warning about risks of driving and other activities ❑ If injected reduce blood borne virus transmission by discouraging shared injecting equipment ❑ Teach significant others about overdose and CPR. In addition offer significant others support and access to helplines (eg. PDIS)

*Polydrug use is increasing, as is its contribution to drug-related mortality. Benzodiazepines are commonly used in addition to alcohol, opiates, amphetamines and other drug groups. Many people who use multiple psychoactive drugs seek intoxication and will use any combination of drugs that they can access, often in large and uncontrolled quantities. This results in increased accidents and mortality.

Setting Limits

Setting limits in the management of dependence can have very positive effects

- ❑ Sets clear expectations for both doctor and patient
- ❑ Consequences are clear
- ❑ Doctor and staff can feel more secure and less used and compromised

The basic principles in setting limits are

- ❑ Be clear, concrete and "up front" in what you say
- ❑ Mean what you say and say what you mean
- ❑ Follow through with what you say, ie. be consistent in words and action

Remember

- ❑ Human nature resists change and initially this will be the response. Persist.
- ❑ Refusal to comply is a choice and the patient has responsibility for the consequences of this choice
- ❑ There is help available if you want to talk through these issues. Call CAS (see under Resources).

Chronic Pain

Regular use of opiates results in tolerance and physical dependence. The decision to start opiate treatment in chronic pain situations is a significant one and should generally be done only in consultation with a multidisciplinary Pain Clinic. All reasonable attempts to seek a cause for pain should be made prior.

In particular, avoid even short-term opiate treatment outside hospital for anyone with the following characteristics:

- History of previous or continuing drug addiction
- Previous problems with opioid use
- Psychologically unstable
- Young patients with obscure pathology
- Complex compensable patients

In the context of opiate use for chronic pain, problematic dependence is characterised by the following:

adverse consequences associated with the use of opioids	❑ intoxication ❑ deterioration in function despite analgesia ❑ increase in pain-associated distress eg. anxiety, insomnia, depression
loss of control over the use of opioids	❑ escalating doses and inability to confine doses to agreed amounts
preoccupation with obtaining opioids despite the presence of adequate analgesia	❑ perception of no impact whatsoever from and non-compliance with non-opioid components of treatment ❑ inability to recognise non-physical components of pain

Planning for chronic treatment with opiates

If following discussion with the Pain clinic, chronic opiates are considered necessary the following issues should be covered:

Goal definition	❑ Define specific goals & timelines for review of this. Outline cessation of medication if goal is not achieved. Goals may include: improved function (be specific about what function is to be achieved, eg. Able to go for a walk), at least partial analgesia, tolerability of side effects. ❑ Opiate use is initially trialled for 4-6 wks. If the expected outcome is not achieved, the dose will be tapered and ceased. ❑ Opioid-naive patients whose dose escalates quickly within one month should be considered inappropriate for long term treatment.
Dependence & long-term outcomes	❑ Likelihood of dependence and physical withdrawal ❑ Lack of long term published data on long term outcome
Sedative	❑ Interaction with other medications (sedative) ❑ Potential for cognitive impairment (NB. driving and operating machinery)
Side effects	❑ Side effects of opiates – constipation
Pregnancy	❑ Effects on pregnancy – physical dependence of foetus
Responsibility	❑ Responsibilities re security of medication and consequences of medication losses as well as ensuring that the supply does not run out after hours.
Plan	❑ Understands plan for times of increased pain – alternative medications, a specific amount of extra “rescue doses”, or an expectation that extra medication for breakthrough will be made up from smaller doses later. ❑ Understands plan for after hours care and undertakes to not seek other supply
Behaviour & Cessation	❑ Consequences of aberrant behaviour ❑ Indications for cessation of treatment

Where opiates are used for chronic pain the following principles for drug regimes hold:
- ❑ Long acting drugs given at set regular times control pain better
- ❑ International agreement that parenteral opioids should not be used for chronic non-cancer pain

It is important to

❑ Document all plans and clinical contact ❑ Reinforce agreed plans regularly ❑ Set limits and follow through with consequences

In assessing adequacy of treatment the following should be considered:
- Pain (achievement of analgesia, duration of analgesic effect)
- Side effects
- Functional status (physical and psychosocial)
- Aberrant drug behaviours (see below)

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The Management of Aberrant Behaviour[3]

The following outlines aberrant behaviour in a person on chronic opiate treatment for pain which should result in action being taken.

Major aberrant behaviour predicting developing addiction	Management options for Major aberrant behaviour
❑ prescription forgery or sale of drugs ❑ obtaining prescription drugs illicitly ❑ injecting oral formulations ❑ multiple non-sanctioned dose escalations ❑ multiple prescription losses ❑ repeatedly seeking alternative supplies from other prescribers despite advice not to ❑ deterioration of function that appears to be drug related ❑ resistance to therapy changes despite clear evidence of adverse effects from drug	❑ Wean and cease opioid ❑ Notify Health Department and consider joint management with Next Step ❑ Consider very frequent (weekly or daily supply) ❑ **supervised methadone maintenance treatment may be an option**
Minor aberrant behaviour predicting developing addiction	**Management options for Minor aberrant behaviour**
❑ Aggressive complaining about the need for more drug ❑ Drug hoarding during periods of reduced symptoms ❑ Requesting specific drugs ❑ Openly acquiring similar drugs from other medical sources ❑ Unsanctioned dose escalation ❑ Unapproved use of the drug to treat other symptoms	❑ Reassess medication, expectations, underlying nociceptive source ❑ Consider changing to another drug ❑ Reinforce previous discussions concerning restrictions of supply from other sources ❑ Consider reducing the time interval between supply of medication ❑ Consider urine testing ❑ Warn that further aberrant behaviour may lead to cessation of drug

Resources

Resource	Characteristics
Clinical Advisory Service* (CAS) 9442 5042 or 1800 688 847	❑ For health professionals only ❑ Access to medical officer at Next Step ❑ If answering machine, please leave message as medical officer is probably on the telephone ❑ Please do not give out to patients
Alcohol and Drug Support Line* (ADSL) 9442 5000 or 1800 198 024	❑ For general public and health professionals ❑ Confidential counselling, information and referral service
Parent and Family Drug Support Line* (PFDSL) 9442 5050 or 1800 653 203	❑ For general public specifically to help parents ❑ Confidential counselling, information and referral service ❑ Can link with volunteer parents who can offer support
Meth Helpline (Mental Health Commission)* 1800 874 878	❑ For general public and health professionals ❑ Confidential counselling, information and referral service ❑ **https://www.mhc.wa.gov.au/about-us/our-services/alcohol-and-drug-support-service/meth-helpline/**
Health Department of WA 9222 4424 (M – F, 8.30am-4.30pm)	❑ Authority to prescribe S8 drugs, information on notification ❑ Information on patients who are being prescribed S8s and information about queries by other GPs on that patient

[3] Portenoy RK. Journal of Pain and Symptom Management, 1996: 11:203-217 Manchikanti L. Pain Physician 2008; Opioids Special Issue: 11:S155-180

Prescription Shopping Information Service 1800 631 181	❑ Can provide verbal advice on the PBS medicines supplied to the patient, including the number of prescribers who have prescribed to the patient during the defined period. It's accurate up to the last 24 hours.
Health Pathways	❑ https://wa.healthpathways.org.au Username: connected Password:healthcare

*These resources are 24 hr services but staffing levels are best between 8 am and 10 pm every day.

Moira Sim

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Agreement on the Use of Pain Medication

I, ____ understand that I am about to be prescribed (____), a regulated medication for the purpose of helping me with my pain by Dr ______________________.

For this reason I agree to the following special conditions.

- I understand that my pain will probably not be completely controlled. However these medications will be used in order to achieve the following aims.

  ____
  ____
  ____

  This is a trial of medications. If these aims are not achieved by ______________ the medication will be slowly ceased

- I will obtain these medications only from my doctor as named above. It is my responsibility to ensure that my medication supply is sufficient and to plan review appointments with my doctor so that my medication does not run out after hours.

In extreme emergencies, should I need to seek an alternative supply, I will inform him/her as soon as possible after and see him/her in order to discuss the management plan and future prescribing options.

- I understand that there is a risk of becoming dependent on these medications. It is therefore important to use these as prescribed.
- I understand that initially, I may feel sleepy and less alert and that this may mean it is dangerous to drive or operate machinery. At all times this medication can interact with other sedative medications, making this effect worse.
- I understand that this medication can be dangerous if taken by others and that it cannot be replaced if lost. I understand that it is **my responsibility** to ensure the safety of this medication.
- I understand that if I do any of the following, my medication may be terminated immediately and I may become notified as a drug addict.
  - Become aggressive at the surgery
  - Forge scripts or sell the medications
  - Obtain other supply of regulated medication without informing my doctor
  - Use the medication in a way that it was not prescribed
  - Repeatedly lose medication and request further supplies

- I understand that my doctor needs to review me regularly in order to ensure safety of this medication. It is my responsibility to make sure that I attend appointments as planned.

- I give permission for my doctor as named above to obtain information from other doctors, hospitals and health departments in relation to my medication use and medical attendances.

Signature ______________________________ Witness signature______________________________
Name: ______________________________ Witness Name: ______________________________

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BENZODIAZEPINE INFORMATION AND AGREEMENT

Benzodiazepines are sedative drugs which have been used to treat anxiety and insomnia. However there are a number of problems that can occur with the use of these drugs.

Benzodiazepines include diazepam (Valium, Antenax, Ducene), oxazepam (Serepax, Alepam, Murelax), nitrazepam (Alodorm, Mogadon), temazepam (Temaze, Temtabs, Normison), clonazepam (Rivotril, Paxam) and alprazolam (Xanax, Kalma). They can cause sleepiness, confusion, short-term memory loss and unsteadiness (therefore increasing the risk of accidents, injury and falls). Benzodiazepines can be dangerous when combined with alcohol, street drugs or many prescription medicines. Use of benzodiazepines can also make driving dangerous.

While they are often effective in the short term, within a matter of weeks after starting to use them the body becomes used to it. That is, the body develops tolerance. This means that the same dose of the drug has less effect and the body needs more of the drug to get the same effect. At that point the body becomes dependent or addicted to the drug.

Because of the risk of developing and increasing dependence, benzodiazepines will only be prescribed in a controlled manner.

Agreement

I, _________________________ have read the information above and understand the following.

1. Benzodiazepines are addictive drugs and will only be prescribed in a controlled manner. In order to make sure that these are prescribed safely, my GP will only prescribe it with full authority to obtain information from the pharmacist, __________________________ and the Health Insurance Commission about any other alternative supplies that I may have sought.
2. I agree to attend appointments on time as agreed and I will not seek benzodiazepine supplies earlier than the agreed date.
3. I agree not to seek supplies from other practices except in extreme emergencies. Should such an emergency occur, I will attend this practice at the first available chance to discuss the plan for further prescribing.
4. I understand that once a prescription has been written or a drug has been dispensed it is my responsibility to make sure that the script or the drug is safe. No repeat scripts will be written for lost scripts.
5. I agree not to give away or sell any of these supplies. I will not inject any of these drugs since injection can cause a loss of fingers, hands or even arms.
6. If I am not able to stay within this agreement, I understand that my prescriptions may be ceased and that I may be referred to Next Step, Specialist Drug and Alcohol services.

Signature: ________________ Date: ____________ GP signature: _____________