ADDICTION Issues In Primary Care

Graham Gulbransen,
FRNZCGP, FAChAM
- General Practitioner, Kingsland
&
- Senior Medical Officer,
CADS Auckland

Rotorua GPCME 11 June 2011

CADS
COMMUNITY
ALCOHOL & DRUG
SERVICES
Te Wai Awhina
Rongoatia O Tamaki

Professional approach

- Non-judgemental, 'maintain high standard of human rights'
- Empathic

<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.

4 Take Home Points:

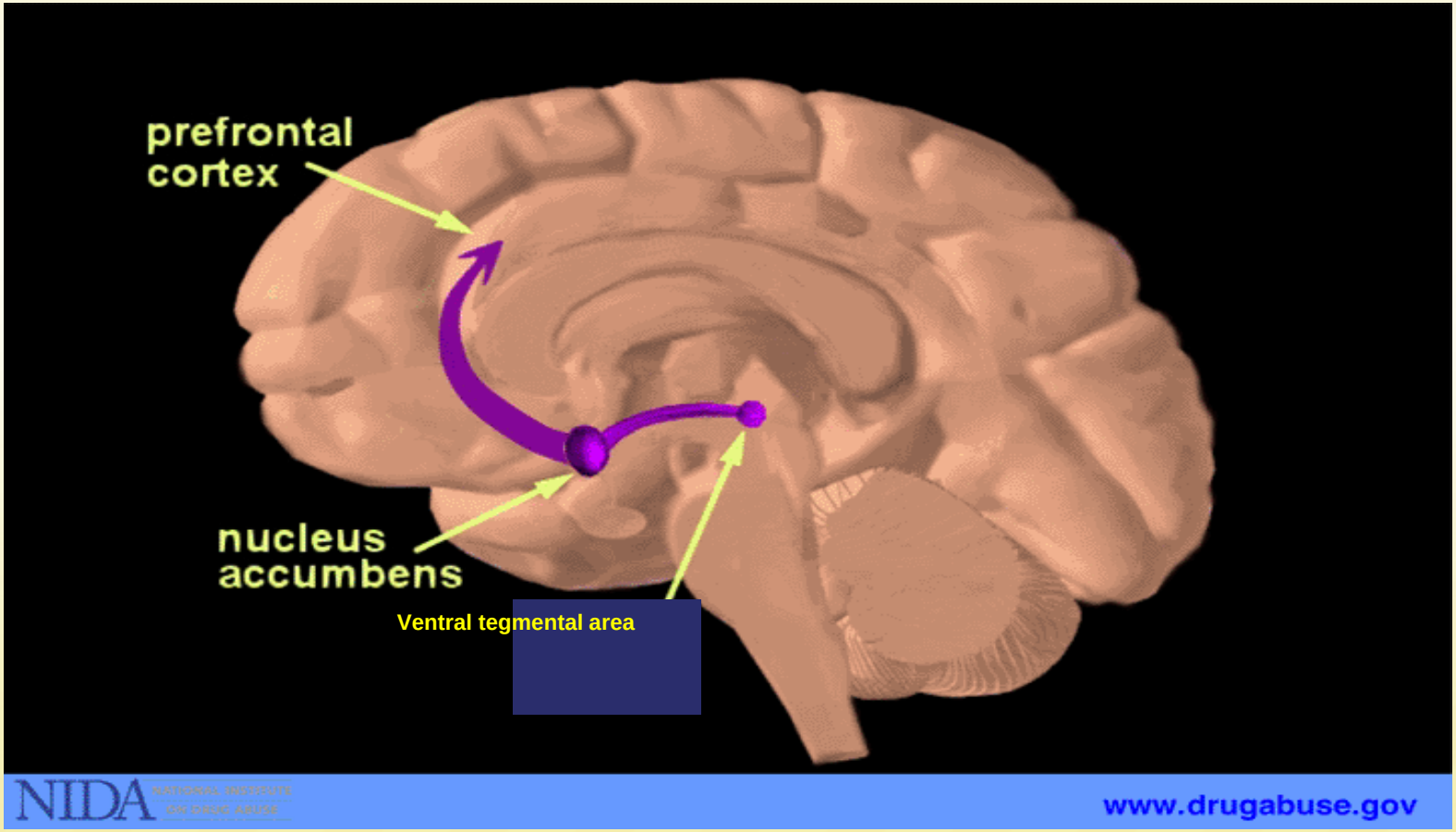
1. 1 in 6 of our adult patients are risky drinkers
2. Brief Interventions are effective, but require patience: 'for every 7 interventions, 1 patient will reduce drinking to safer levels'
3. So.... RECORD A SMOKING, DRUG & ALCOHOL HISTORY ON EVERY TEEN & ADULT PATIENT!
4. Non-Judgemental approach

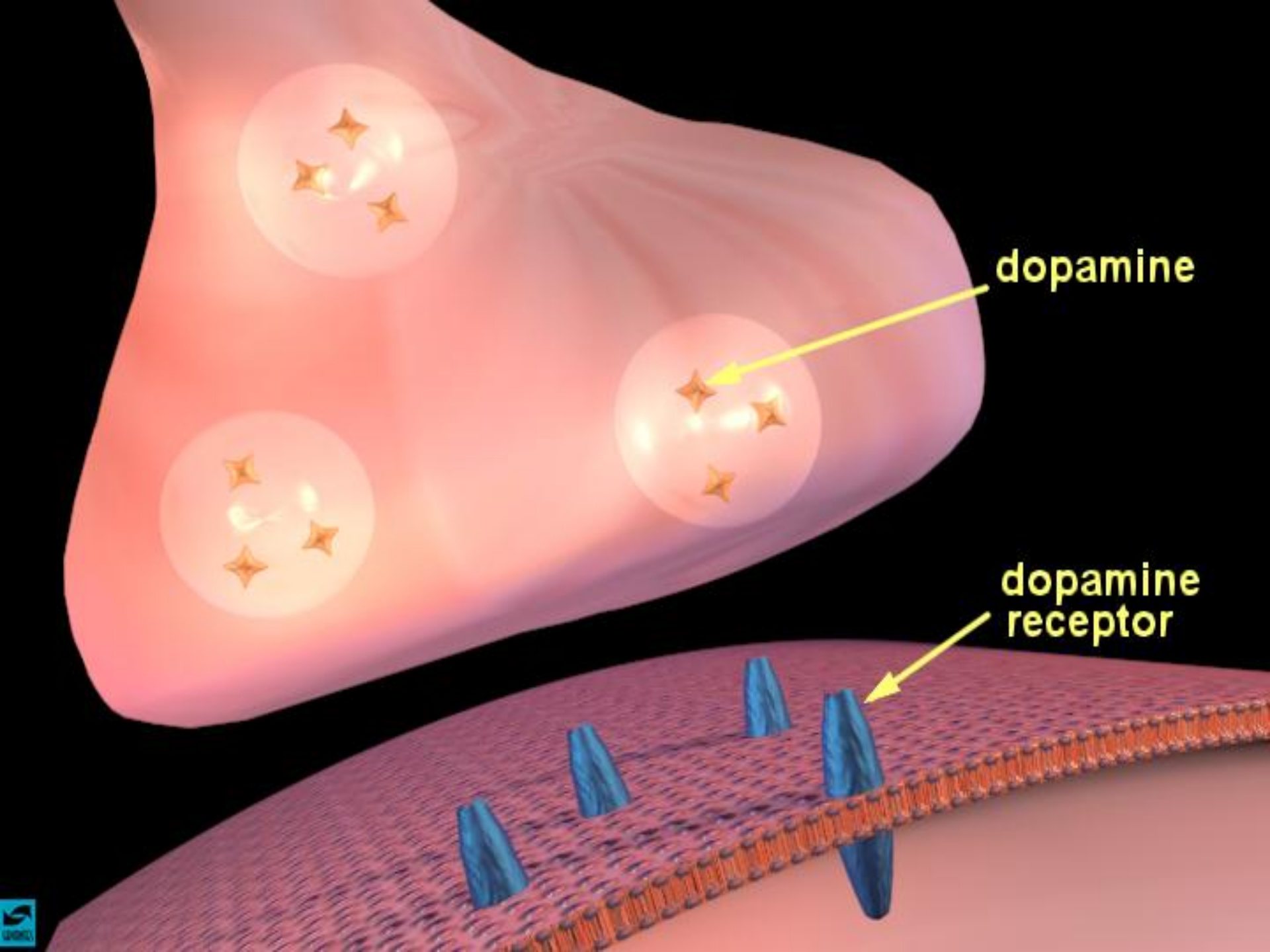
Community Alcohol & Drug Service Units

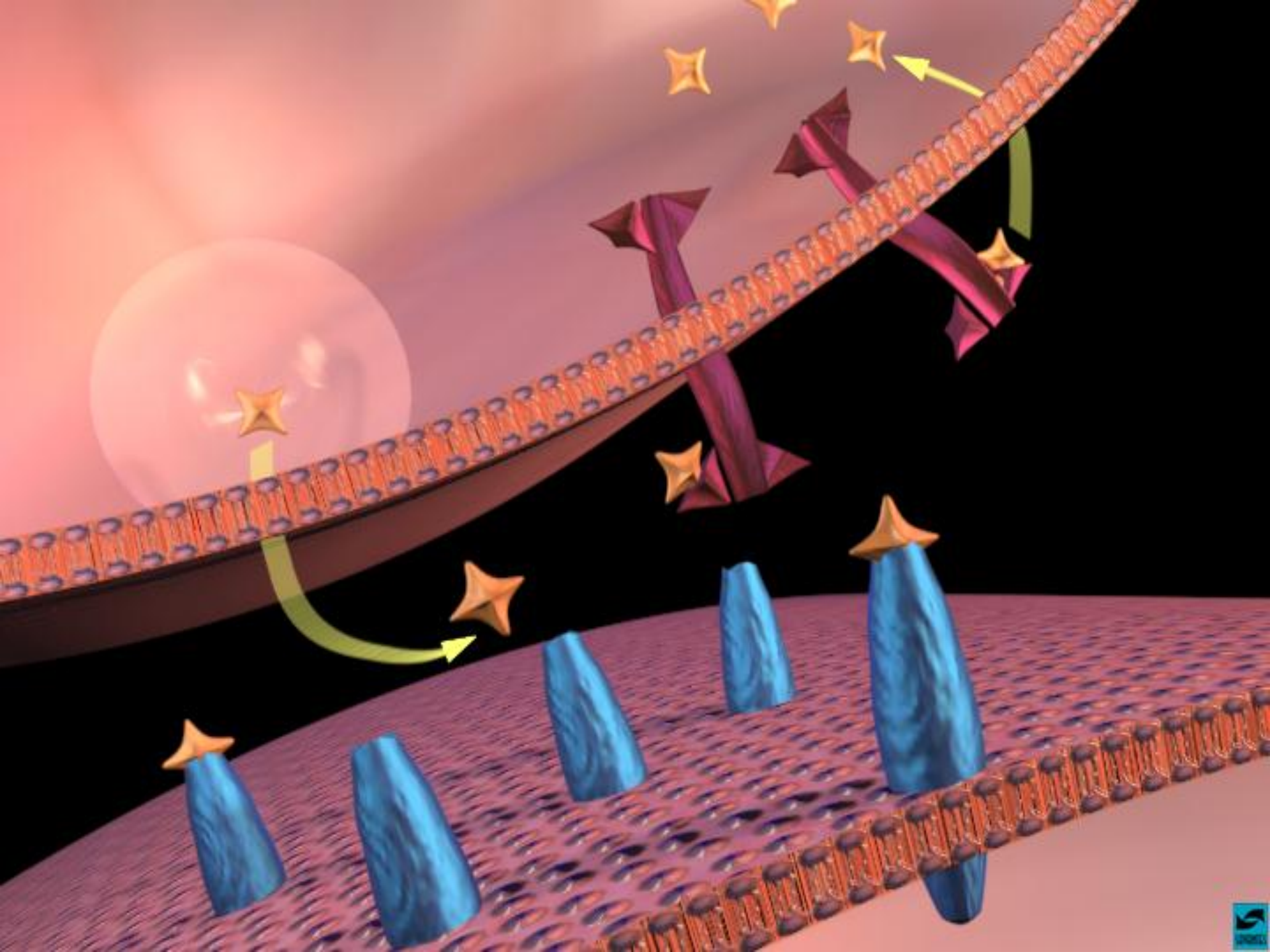
- Are the first point of contact for all other CADS services.
- Counselling, information and support for people who have concerns about their own, or a friend /family /whānau /fanau's alcohol or drug use.
- Provide a range of educational and therapeutic groups
- Discusses all treatment options with clients
- Provides consultation and support to health and social agency workers.

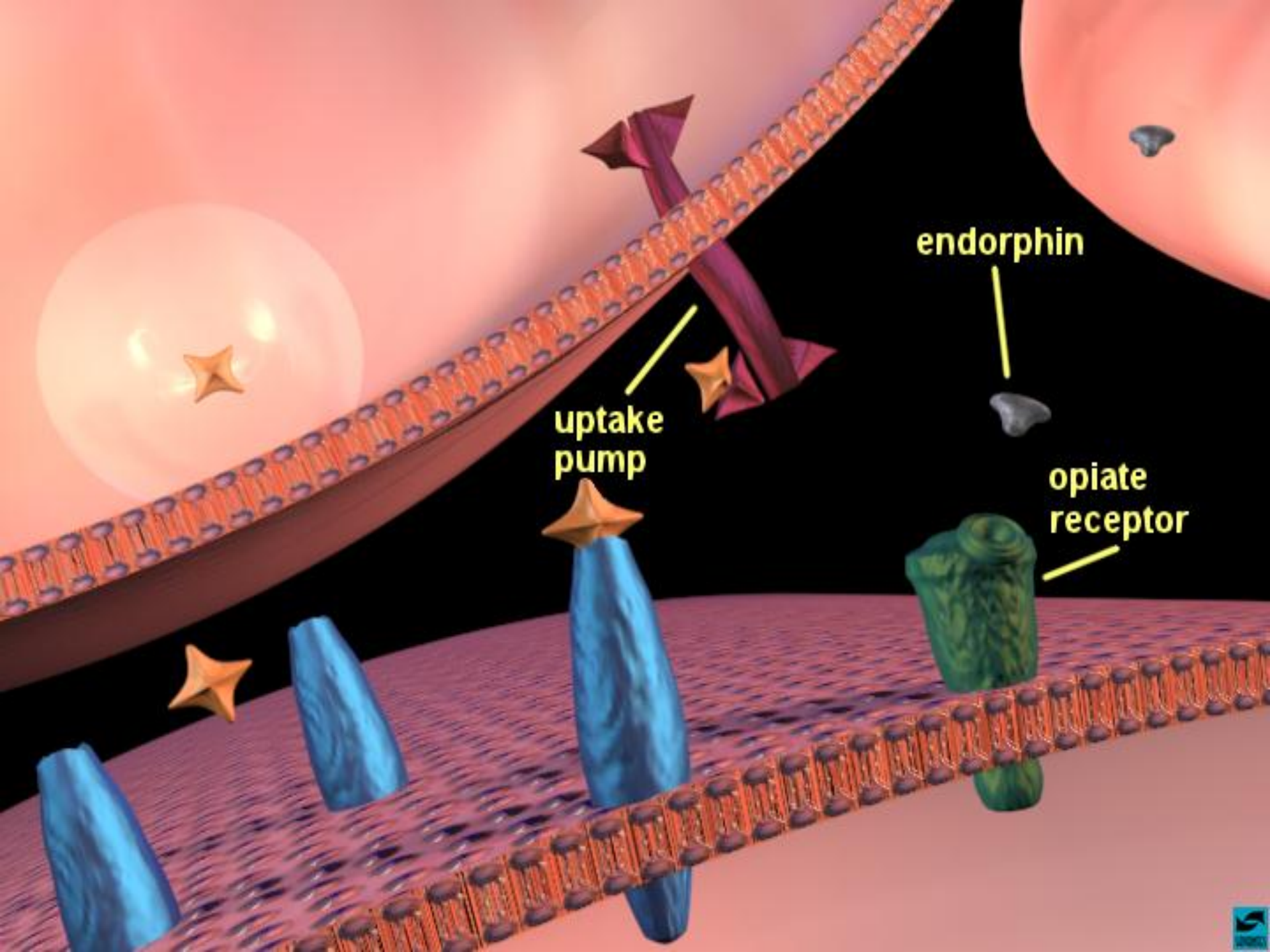
Dopamine Theory of Addiction

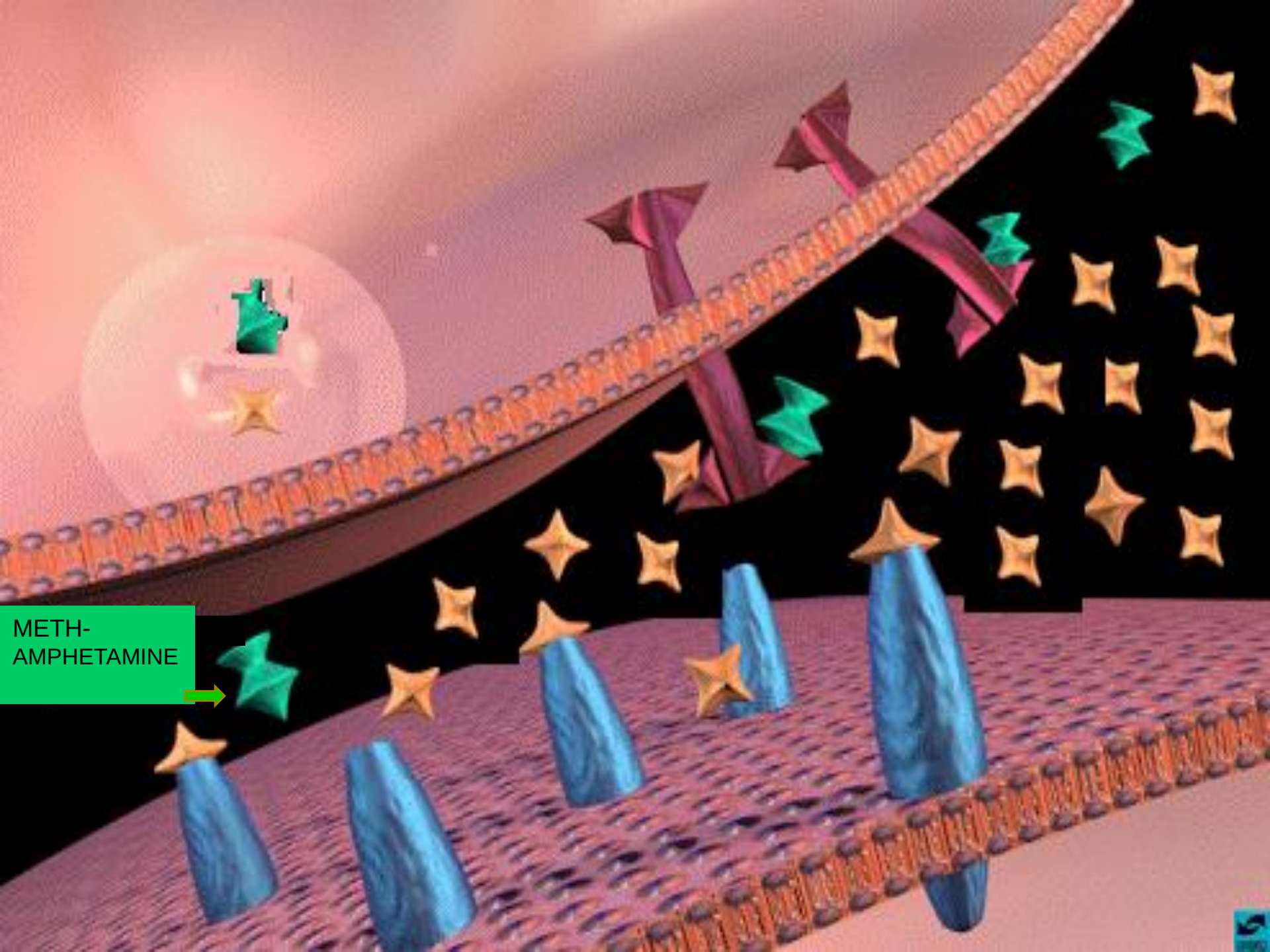
The Reward Pathway



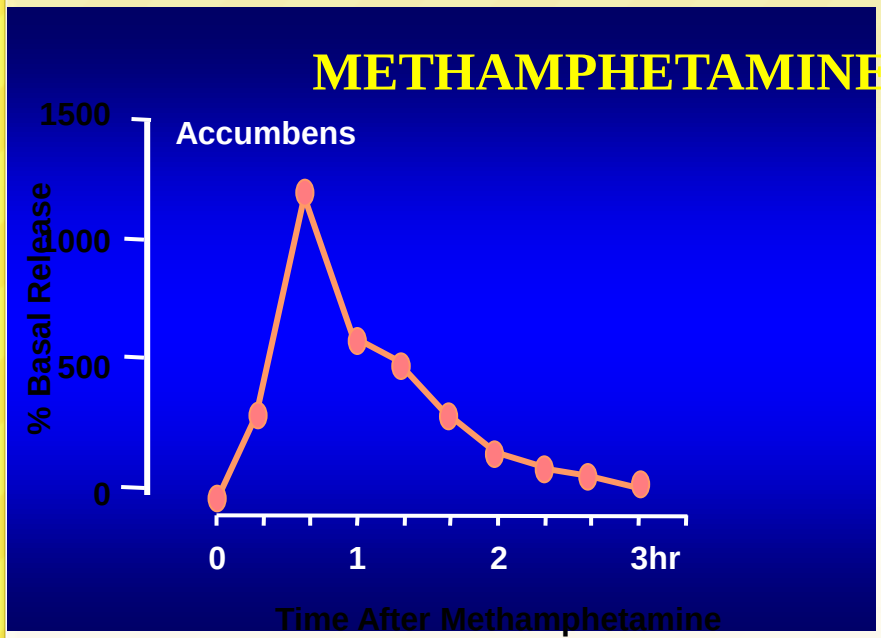

dopamine
dopamine receptor

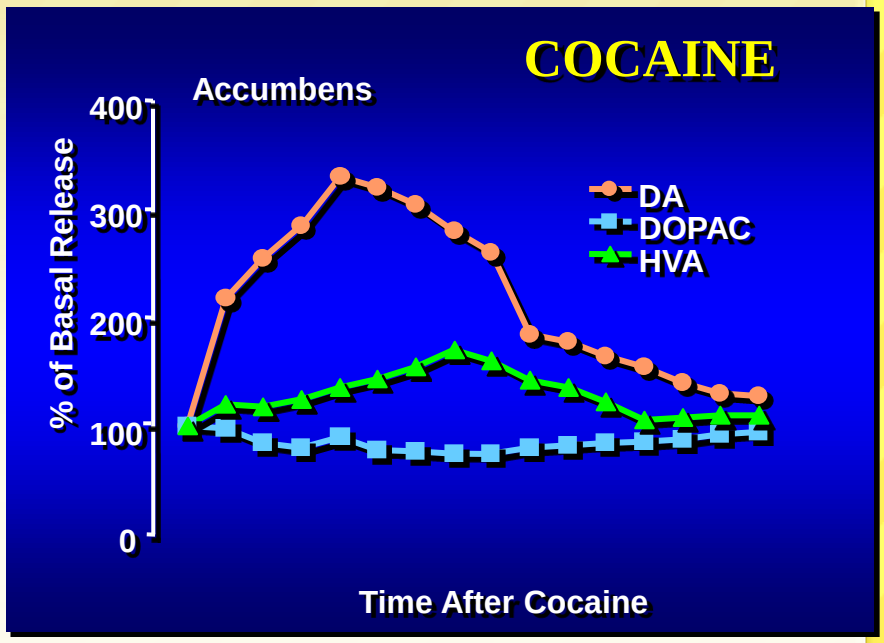


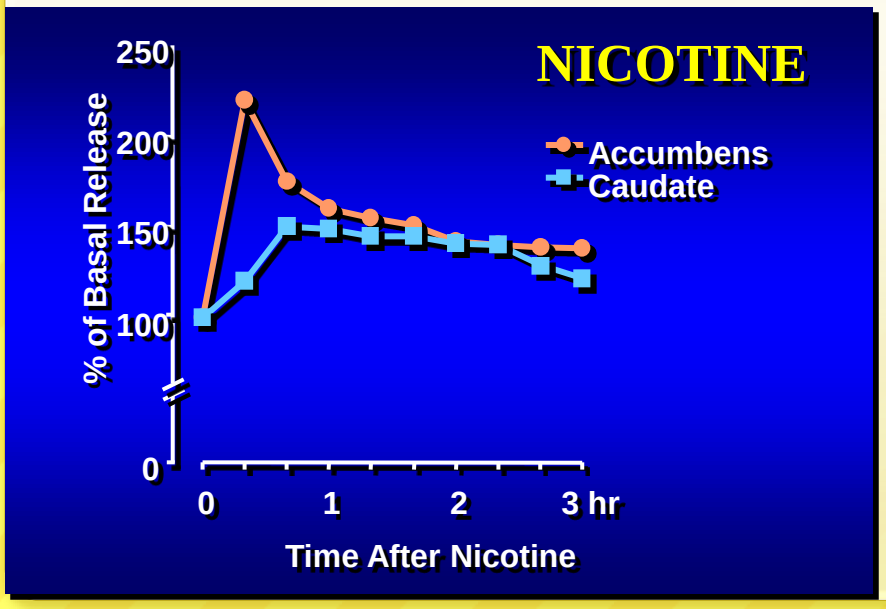

endorphin
uptake
pump
opiate
receptor

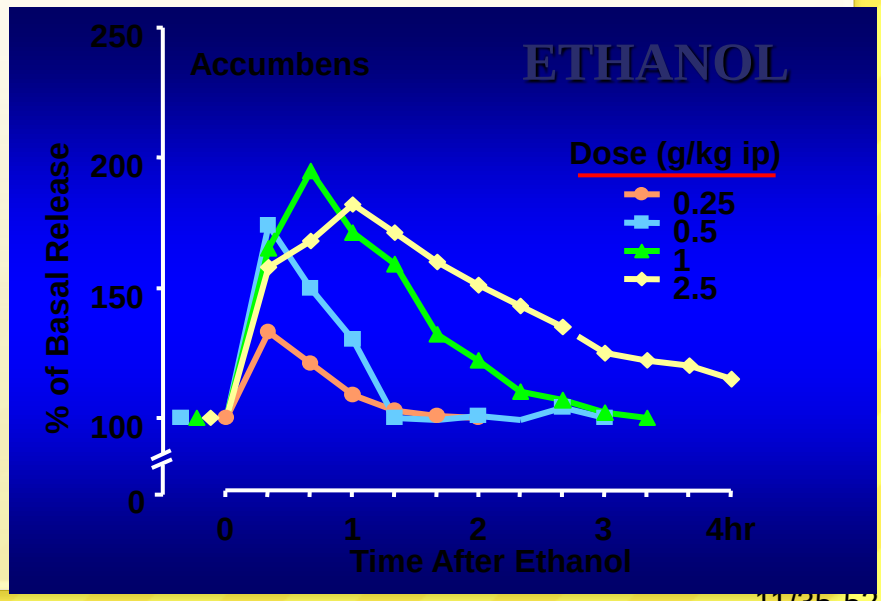

METH-
AMPHETAMINE

Effects of Drugs on Dopamine Release









The Moral Model

A model that theorises that there is something inadequate or degenerate in the persons makeup:. they are weak willed, sinners.
Generally not used in modern times.

Prior to A.A. in 1933 this was the theory most prevalent.

Biological Theories/Disease Model

Theorise that there are underlying biological factors such as genetic predispositions and metabolic imbalances (diseases) that cause an individual to use/abuse drugs. Strains of rodents can be bread with a genetic predisposition to drinking alcohol, other rat strains are the opposite.

Human family and twin studies show almost 50% lifetime risk among sons and brothers of alcoholic fathers.

Specific genes have been located. Epigenetics: genes switched on or off by environment.

Individuals with an addiction tendency are at risk from whatever substances are readily available.

Psychological Theories

Include behavioural reinforcement both positive (it feels good so I will do it again) and negative reinforcement (use drugs to avoid pain or feel normal).

These theories take into account physical addiction including avoiding withdrawals.

Other psychological theories take into account attachment, emotional/psychic deficits, low self esteem, psychological defence mechanisms & transitional behaviour i.e. teen to adult.

Social Theories

Consider the impact of groups and social networks on an individuals behaviour, take into account behaviour is learned and that certain behaviour can be rewarded by groups or other individuals. Drug use can be a definitional process, obey a different set of norms to align with a subculture. People mix and interact with others who are similar in their values and attitudes.

Bio-Psycho-Social Model

CADS clinicians generally work under a modern model that incorporates theory from Biological, Psychological & Social schools of thought.

Substance Abuse – DSM IV

- Focus is on social and interpersonal consequences of substance abuse
- Failure in role obligations
- Recurrent legal, social, relationship problems because of drinking

Substance Dependence – DSM iv

- Persistent substance use despite the negative consequences

- While a user may know their relationships and health are impaired, the immediate reinforcement from the effects of substances have a stronger influence than negative consequences

Continuum Of Use

NO USE	MODERATE	PROBLEMATIC	HAZARDOUS	HARMFUL [ABUSE]	DEPENDENCE
	Experimental use / Social use • No Major problems	Some Problems: • Missed Work • Comedown /Hangover • Family/ Whanau quarrels	Problems **and** ↑ risk of long-term harm • relationship problems • crime	Problems **and** ↑ risk of harm **and** long term damage • Health • Violence • Break-ups • Loss of Job	All problems **and** 3 or more of the following: • Withdrawal • Using to relieve withdrawals • Not able to predict or control use • Persist despite harm • Rapid return to dependence if relapse after abstinence

Screening

Standard Drink

- NZ: 10g alcohol [12.7ml ethanol]
- 330ml beer
- 100ml wine
- 30ml spirits

- 1 can RTD (ready to drink, alcopops) = 1.5 SD

- http://alac.org.nz/WhatsInAStandardDrink.aspx

Standard Drinks

Wine | **Spirits** | **Beer**

Port/ Sherry	Small glass	Large Glass	1 nip	2 nips	3 nip cocktail	Small glass	Handle
1 SD	1 SD	2 SD	1 SD	2 SD	3 SD	1 SD	2 SD

1 Standard drink = 10 g alcohol

Safe Alcohol Limits

WOMEN	MEN
• No more than 4 drinks per day	• No more than 6 drinks per day
• No more than 14 drinks per week	• No more than 21 drinks per week
• And have some alcohol-free days each week	• And have some alcohol-free days each week

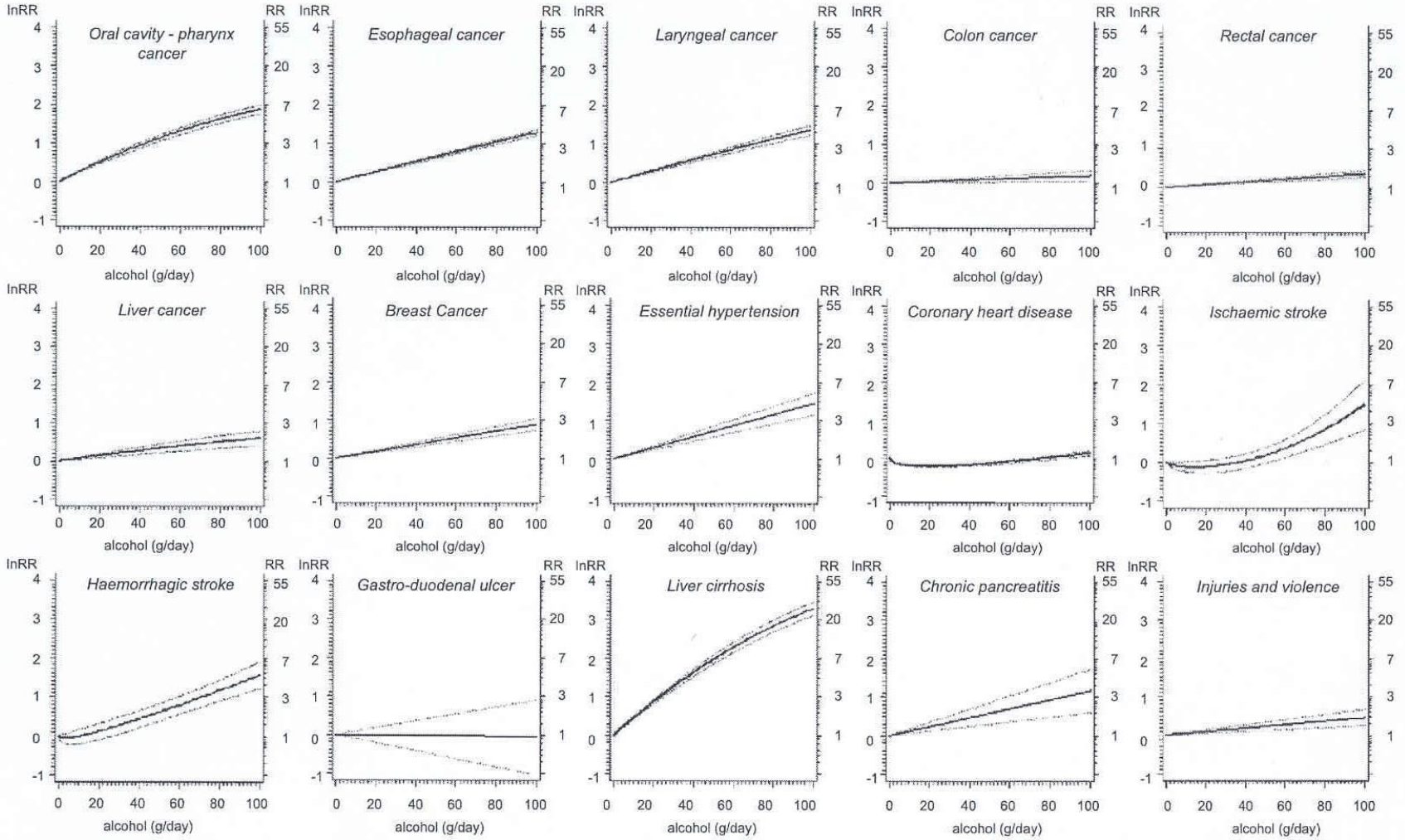


Fig. 1. Relative risk functions and corresponding 95% confidence intervals describing the dose-response relationship between alcohol consumption and the risk of 15 alcohol-related conditions obtained by fitting meta-regression models.

A meta-analysis of alcohol consumption and risk of 15 diseases, Corrao et al, Preventive Medicine, 2004, 38, 613-619

Domains

Risky or Hazardous Alcohol Use

Dependence Symptoms

High-Risk or Harmful Alcohol Use

AUDIT – Alcohol Use Disorders Identification Test = Gold Standard

Full 10 - question AUDIT

	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
In the last 6 months, how often have you had more than 6 units on any one occasion if female, or more than 8 units if male?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7=lower risk drinking, 8-15 = increasing risk drinking, 16-19 = higher risk drinking and 20+ = possible dependence

My Single Screening Question

'I would like to ask you about alcohol, how many drinks do you have in the average 7 day week?'

If men say 6 or less and women say 4 or less = safe drinker.

If more than that, ask more questions, eg those in AUDIT.

Screening for other drug use

- Do you use non-prescription or recreational drugs?
- Do you ever feel the need to cut down on their use?
- In the last year have you ever used them more than you meant to?
- Do you want help with your drug use?

[F Goodyear-Smith et al, BJGP, 2008]

- **'Are you having problems with any other drug use?'**
- **Or, 'Do you use cannabis or other drugs?'**

Other screening tools

BPAC tools in your PMS: CHAT, PHQ-9, GAD-7, AUDIT, Kessler-10

Remember the strong association between substance use disorders and mental illness, so ask about both

Substance misuse are experienced by over 25% of Maori in their lifetime. Best Practice Journal, June 2010


KIA AUAHI KORE • QUIT CARD
Subsidised Nicotine Patches, Gum or Lozenges
Pharmacy name/claimant number:
Client name and address:
Tel:
Issued by:
Product and Dose:
1154399

Brief interventions

Professional approach

- Non-judgemental, 'maintain high standard of human rights'
- Empathic

<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.

Withdrawal Sx

In general withdrawal effects are the OPPOSITE of the effects of substance of dependence

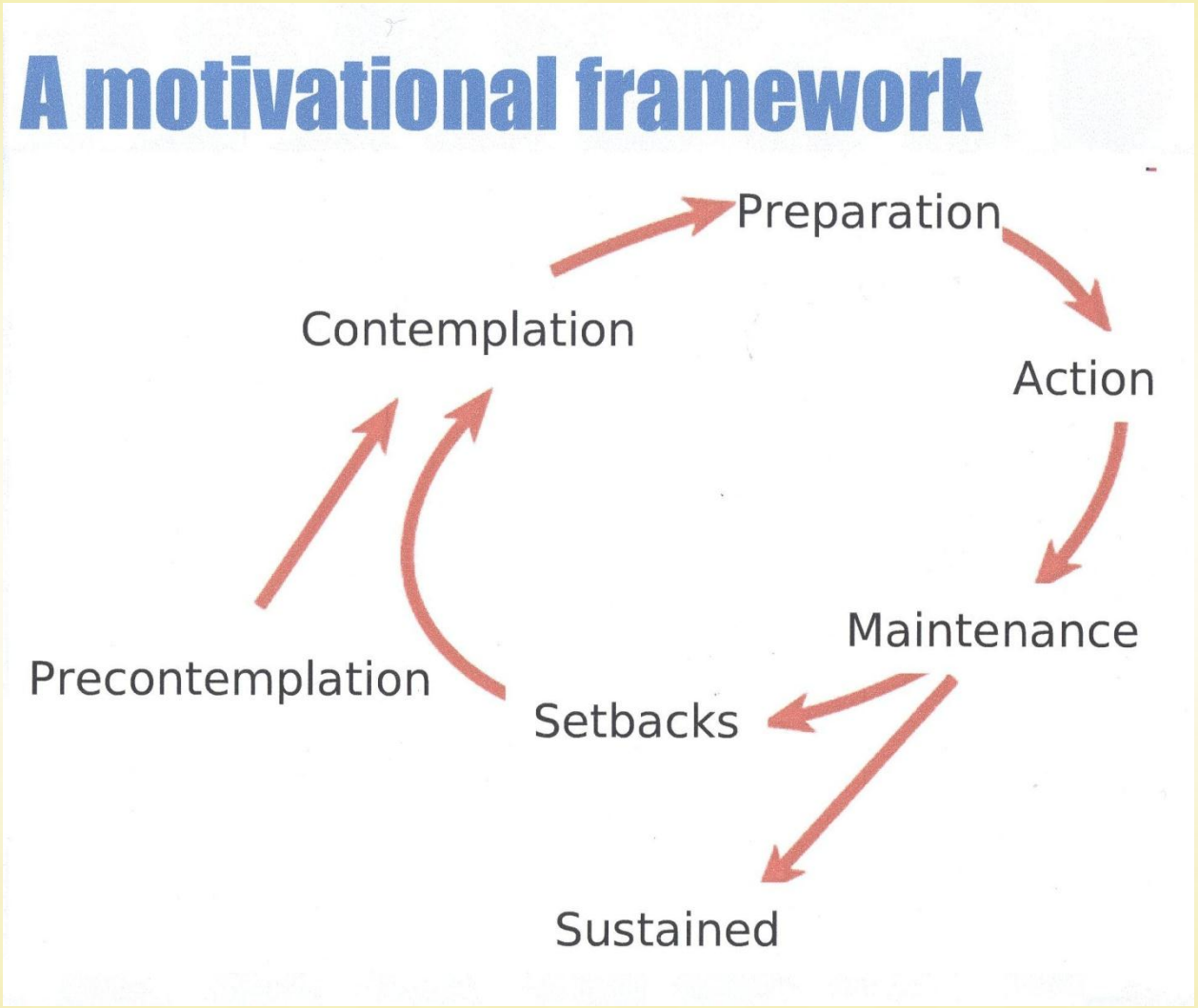
- Sedatives→ CNS and autonomic arousal
- Stimulants→ CNS and autonomic depression

The greater the tolerance, the greater the severity of withdrawal effects

NNT Alcohol

For every 7 interventions, 1 patient will reduce drinking to safer levels

A motivational framework



Brief interventions e.g. FLAGS

- **F**eedback on the risks of continuing use, linking in to presenting problems
- **L**isten to any concerns, and for any readiness to change
- **A**dvise change in order to limit bio-psycho-social consequences of ongoing use
- **G**oals: explore reducing or abstaining, what is realistic
- **S**trategies for achieving goals, eg identify the first step needed or Relapse Prevention

- FOLLOW UP

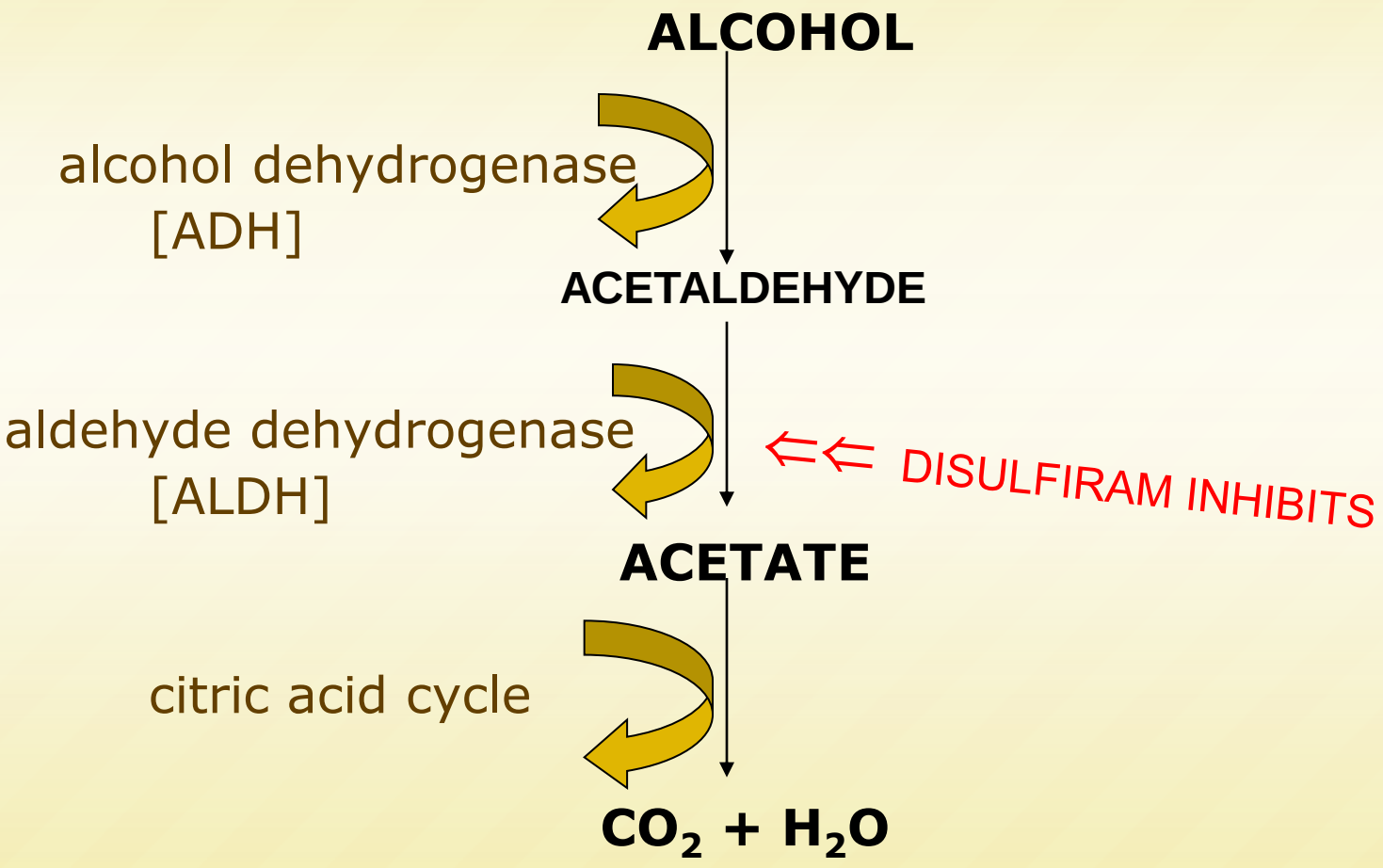
4 Take Home Points:

1. 1 in 6 of our adult patients are risky drinkers
2. Brief Interventions are effective, but require patience: 'for every 7 interventions, 1 patient will reduce drinking to safer levels'
3. So.... RECORD A SMOKING, DRUG & ALCOHOL HISTORY ON EVERY TEEN & ADULT PATIENT!
4. Non-Judgemental approach

Thank You

Medication

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)

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

Section 24 – The Rules

The Misuse of Drugs Act 1975)

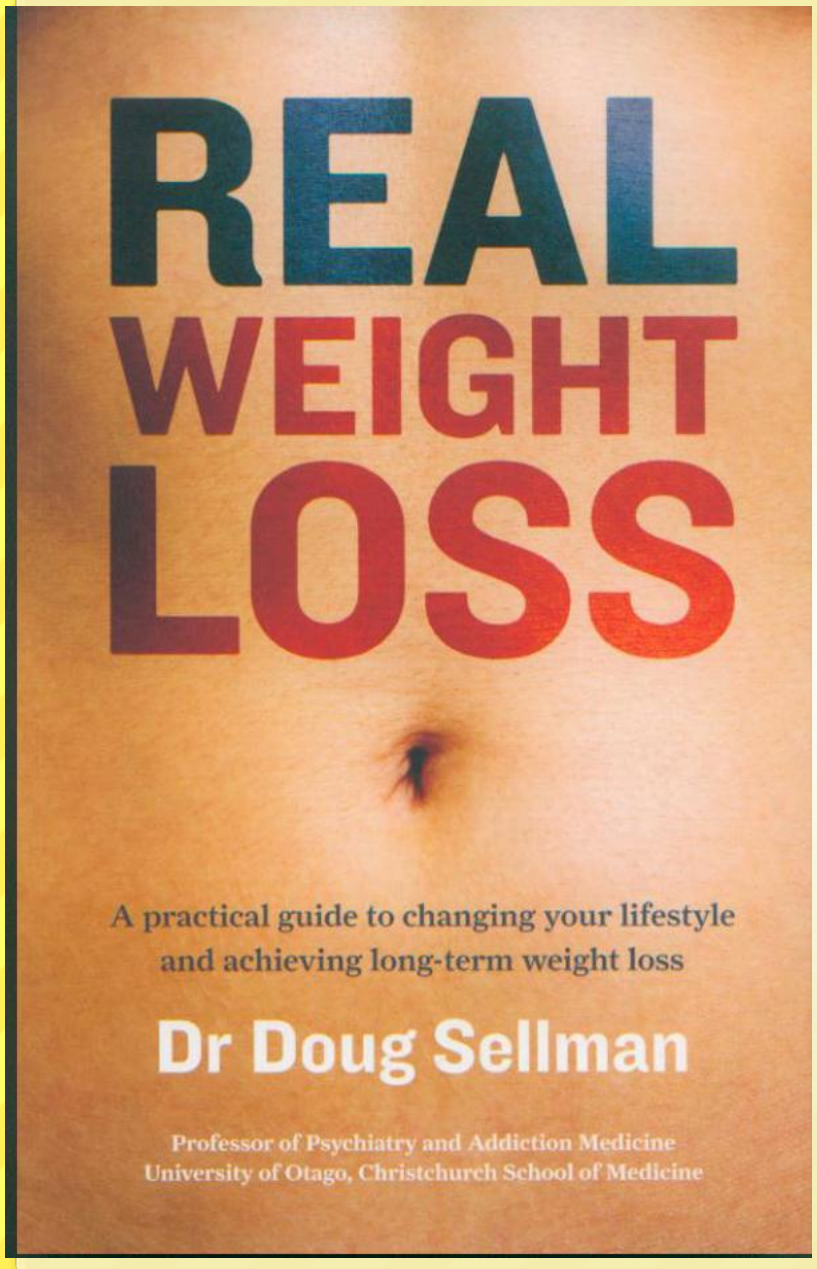
Section 24(1) states that "...every medical practitioner commits an offence against this Act….who prescribes, administers or supplies any controlled drug for or to any person, whom the practitioner has reason to believe is dependent (on that or any other controlled drug) in the course, or for the purpose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

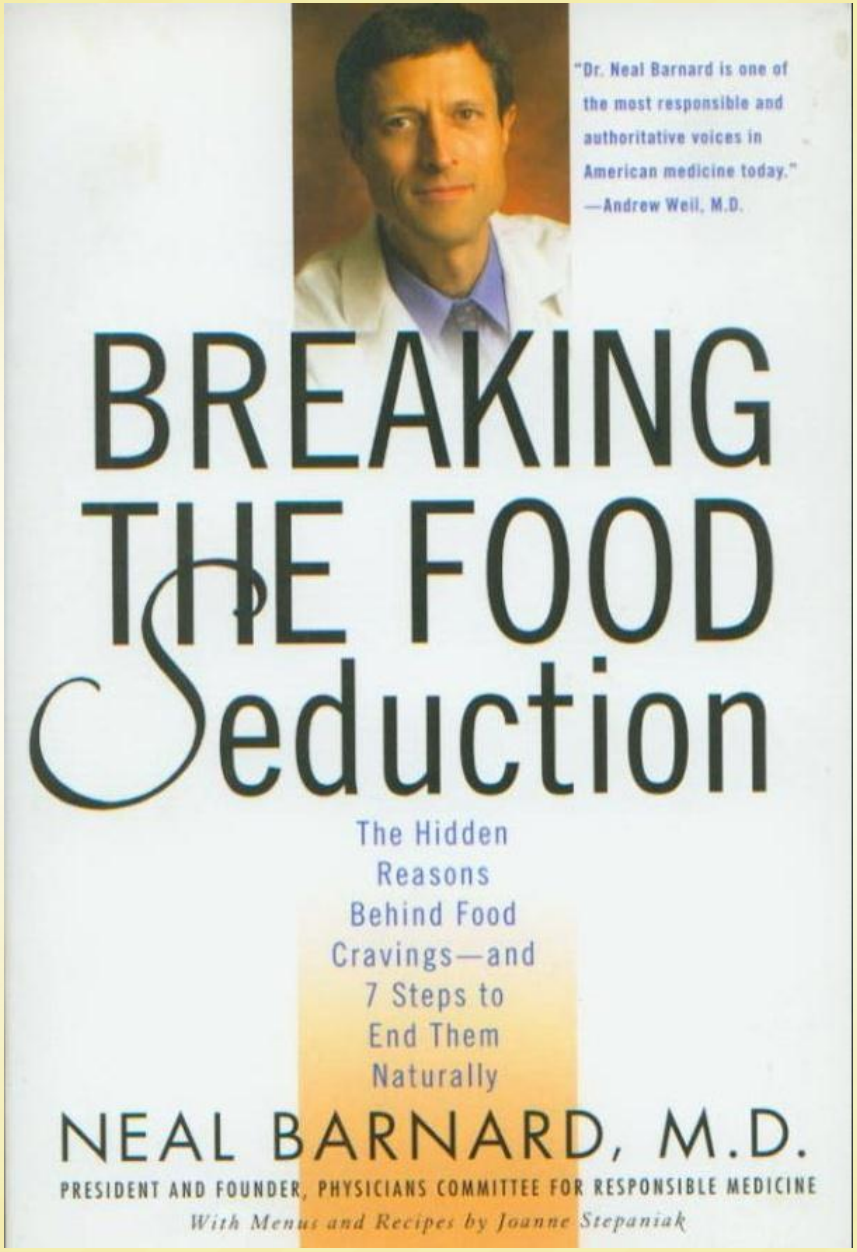
....**except** if the medical practitioner is acting with the permission in writing, given in relation to that particular person by an authorised medical practitioner." S24(2)(d).

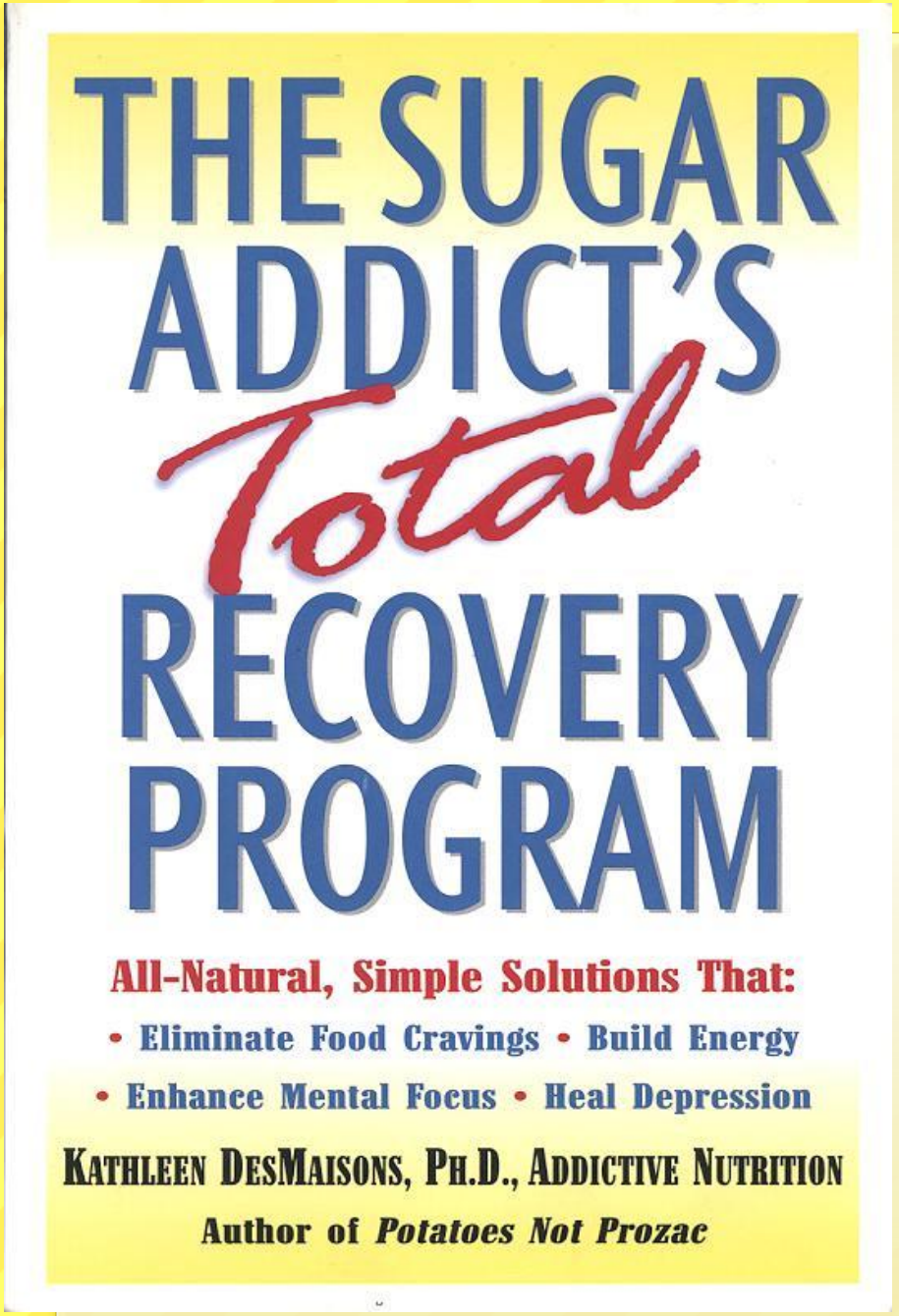
Only gazetted specialist services (e.g. Alcohol & Drug Services), gazetted GP's and Authorised GP's can prescribe for people dependent on controlled drugs. See S24(2)(a)(b)(c)

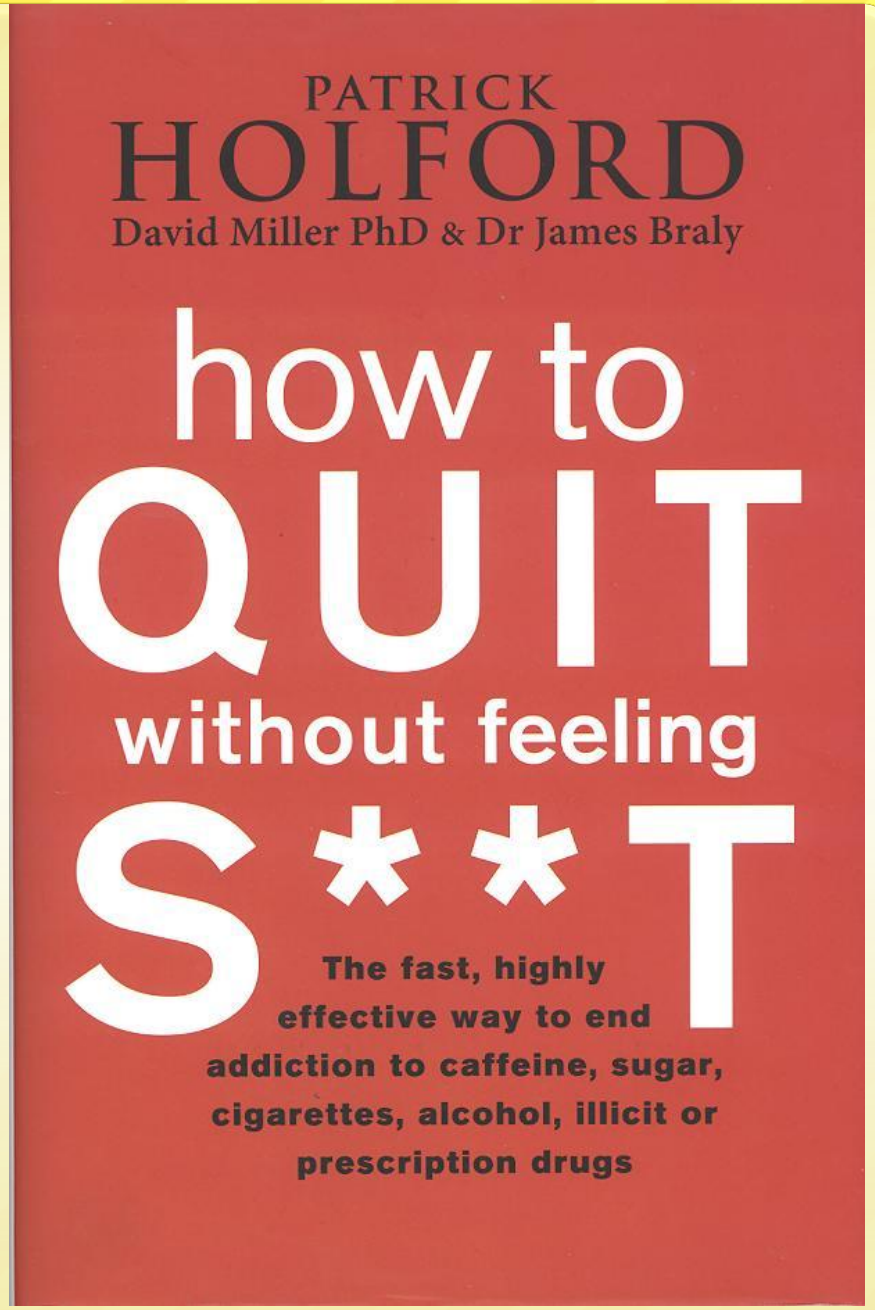
What's Your Favourite Food?

Food Addiction....


REAL
WEIGHT
LOSS
A practical guide to changing your lifestyle
and achieving long-term weight loss
Dr Doug Sellman
Professor of Psychiatry and Addiction Medicine
University of Otago, Christchurch School of Medicine


"Dr. Neal Barnard is one of the most responsible and authoritative voices in American medicine today."
—Andrew Weil, M.D.
BREAKING
THE FOOD
Seduction
The Hidden Reasons Behind Food Cravings—and 7 Steps to End Them Naturally
NEAL BARNARD, M.D.
PRESIDENT AND FOUNDER, PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE
With Menus and Recipes by Joanne Stepaniak


THE SUGAR ADDICT'S Total RECOVERY PROGRAM
All-Natural, Simple Solutions That:
• Eliminate Food Cravings • Build Energy
• Enhance Mental Focus • Heal Depression
KATHLEEN DESMAISONS, PH.D., ADDICTIVE NUTRITION
Author of Potatoes Not Prozac


PATRICK
HOLFORD
David Miller PhD & Dr James Braly
how to
QUIT
without feeling
S**T
The fast, highly effective way to end addiction to caffeine, sugar, cigarettes, alcohol, illicit or prescription drugs

Parallels

- Pleasure, comfort eating
- Harmful consequences
- Screening questions: caffeinated drinks, sugar, narrow palate
- Parallels with successful drug withdrawal: gradual reduction, ‘long and slow...to quietly establish a long-term change in lifestyle’.

Nutrition supporting abstention

- Growing evidence for supplementation
- Replace depleted neurotransmitters with 5HTP, tyrosine
- Replace depleted biochemical co-factors: Zn, Mg, Fe, B vitamins, vitamin C
- Address neuroinflammation with fishoils [EPA & DHA], cysteine & vitamin C
- Maximise neuronal metabolism & repair with CoQ10, L- Carnitine, lipoic

Acknowledgements

- CADS Auckland colleagues
- Prof Ross McCormick, Uni of Ak
- University of Auckland School of Pharmacy
- *Addiction Medicine* – Oxford Specialist
- Handbooks, 2009
- Internet