Addictions Update – engaging and retaining patients in treatment

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OVERVIEW OF PRESENTATION

- Effective treatment
- Retention in treatment
- Drug use statistics
- Patients with alcohol related problems
- Engaging these patients in treatment
- Managing injecting drug users
- Retaining patients in treatment

Features of effective treatment

- **Strength of the therapeutic alliance** between clinician and patient. **This is the most powerful asset to engage patient in treatment**
- **Length of time in treatment**
- Inclusion of relapse prevention in program
- Careful monitoring of progress by
  - Clinician
  - Patient
  - supporter

You in the "hot" seat – not the patient

- RESEARCH into patient/clinician alliance indicates that:-
- You and

  your ability to retain your patient in treatment are
- The best predictors of

  A GOOD PATIENT OUTCOME

Management of alcohol and drug problems

- WHO NEEDS TO BE RETAINED IN TREATMENT?

EVERYONE

Well almost everyone

Treatment options where retention is needed

- Brief interventions
- Shared care with the GP being the major carer supported by specialist services
- Stepped care – the specialist services take over during times of significant illness/relapse and when stable patients return mainly to the care of the GP
- Integrated care – a team approach that is able to care for all the needs of the patient (an ideal)

Retention in treatment - Maybe!

- Some individuals respond to a brief intervention and the situation rapidly comes under control – is retention necessary?
- Even with resolution of the harmful drinking most individuals will still need to visit a GP for prevention and/or treatment of concurrent health care needs.

Drug use in Australia

Some Relevant facts

Drug use - Australia

- 35% of Australians drink at “risky levels for short term harm”, 10% at “risky levels for long term harm”
- 6% of Australians have alcohol dependence
- Alcohol is responsible for
  - 10 premature deaths per day
  - 1/3 of fatal road crashes
- Illicit drug use is responsible for
  - 1 premature death per day
  - Young people (20-29yrs) use in last 12 months
    - 13% cannabis, 10% amphetamines

Statistics on drug use in Australia 2006 AIHW April 2007

Global Burden of disease

- Mortality
  - Tobacco 8.8%
  - Alcohol 3.2 %
  - Illicit drugs 0.4%
- Disability (DALYs)
  - Tobacco 8.0
  - Alcohol 2.0
  - Illicit drugs 2.0

ALCOHOL

Where are these drinkers who need your help?

- Every GP has “risky drinkers” among his patients – some recognised, some not
- I hope to convince you that

there is a large potential pool of patients that you can help and

are able to help

Drinking habits of patients in your consulting room may be …..

- Non drinkers (15% population)
- Drinking at low risk levels. (50%)
- Drinking at "risky levels" (10-35%) this includes
  - Risky drinkers with mild dependence and some harms
  - Dependent drinkers (moderate to severe) with significant consequences (6%)

Case 1

Case 1 – A young male drinker

- A male patient age 29
- Insurance examination
- Drinks 9 standard drinks daily (a 6 pack)
- Physical health
  - Hypertension
  - GE reflux
- How would you approach the management of his drinking?

Young male drinker

- He is drinking at risky levels
- This might have been quantified by screening with the AUDIT questionnaire
- Further assessment is required
- He is likely to be ideal for a brief intervention

Assessment – Questions

- Does the patient consume at risky levels?
  - Frequency/quantity/pattern
- If yes how severe is the problem
  - Physical, social and psychological harms
  - Dependence (addiction)
- Is there co-morbidity – especially mental illness?
- What is the patient's motivation to change?
  - Stages of change
- Are the physical exam and investigations consistent?
- Can I manage this patient alone or is referral needed

Motivation to Change

- Is not a static entity
- Is not available on prescription
- Can be assessed.
- Can be enhanced
- Needs to be maintained
- Is essential if an intervention is to succeed

What are the Stages of change?

- Pre-contemplation-"I have no good reason to change"
- Contemplation-"I am uncertain" ambivalence
- Determination – "I must change"
- Preparation – **if missed, failure is likely**
- Action – I am ready to alter my lifestyle. This includes behaviour change
- Maintenance – avoiding relapse

Pre- contemplators – “the not ready”

- Are happy users
- They usually come to a GP for other reasons
- Confronting them with their harmful drinking is usually counter-productive
- You need to stay with them until they make a commitment
- This is easier if you have a consequence (eg. HT or reflux) that is the reason for follow up
- Linking their drinking and their problems is a key

Contemplators - “the uncertain”

- They are concerned but -------
- They are uncertain about need to change and ability to achieve change
- Ambivalence is universal
- The dissonance between their thinking and their behaviour is the key
- You help them to explore and weigh up their understanding and options

Determination – “they are ready”

- A individual who has decided to change can be assisted with an intervention
- A brief intervention for the risky drinker who has not developed significant dependence
- Withdrawal support and rehab for the dependent drinker
- All need to prepare for change and learn relapse prevention to maintain change

Motivational interviewing

- This is a method of working with individuals who are uncertain about change (contemplators).
- This approach helps people to explore and do something about their present or potential problems. It is intended to resolve ambivalence and to get them moving along the path to change*.
- Counselors listen for “change talk” that culminates in “I must change”. However along the way it is often sandwiched between doubt BUT …

*Miller and Rollnick 2002

You have motivated your patient to change – deliver a brief intervention!

- **F**eedback - personalised
- **R**esponsibility
- **A**dvice on how to change
- **M**enu – presenting alternatives (choices)
- **E**mpathy
- **S**elf efficacy often illustrated by setting goals that are realistic, achievable – coping skills, improving self esteem

Case 2

Case 2 – An injecting drug user

- This man presents with an 8 year history of injecting heroin. Over the last year his use has escalated. He currently injects 2-4 times daily and cost $100-200. he is in financial strife and his girlfriend is threatening to leave
- While pleasant, he appears depressed and still affected by his use that morning
- What can you do for him?

Managing this injecting drug user

- A detailed assessment – physical, psychological and laboratory are needed.
- He has some potential motivators to change but this will need to be assessed
- The initial treatment most likely to maintain him in treatment is to commence him on opioid substitution therapy to prevent withdrawal and "break his habit"
- While this is a good relapse prevention medication, there is much more to do

Managing patients with drug and alcohol problems

Assessing motivation to change – where in the spectrum is your patient?

- Be aware that most individuals who have tried something believe they are in the action phase, BUT mentally they are often ambivalent
- Commencing a motivational approach with a discussion of the pros and cons of change will usually bring out ambivalence if present.
- If in the determination phase you are ready to start an intervention.

What is needed to adequately manage these patients - attitudes

- Unhelpful attitudes
  - “You have a self inflicted condition”
  - GOMER – “get out of my ------ (House of God)
  - “Just say no” – zero tolerance to all drugs
- More helpful attitudes
  - “Am I getting the whole picture” (good crap detector)
  - “Coaches don’t kick goals” but can guide strategy
- Essential attitudes
  - Boundary setting while maintaining a positive regard

Treatment – what are our expectations?

- Treatment can only make a **time-limited contribution** to the lives of those who receive it.
- As with other chronic relapsing disorders
  - The clinician acts as a facilitator/guide/coach
  - The patient needs
    - to undergo a lifestyle (behaviour) change and
    - be actively involved in his/her treatment

What treatment outcomes?

- There are no program or treatment settings that have been shown to be superior to all others.
- Desirable outcomes.
  - Life long abstinence
  - Reduction in drug use
  - Improved physical health
  - Improved mental health
  - Reduced risk to others – crime, BBVs
- Factors contributing to outcomes
  - The strength of the therapeutic alliance
  - Retention in treatment
  - Nature and severity of drug related problems
  - Psychological and social characteristics of the individual

Relapse prevention medications

- Cannot be expected to work in an individual not motivated to change and continuing to use/consume
- Pharmacotherapy works best when accompanied by
  - Behaviour change. This may require counseling from a professional skilled in delivery of such programs

Evidence based treatments for relapse prevention

Medications to reduce relapse

- Substitution agonist treatment
  - Nicotine and opioid replacement (methadone, buprenorphine, buprenorphine+naloxone)
- Opioid antagonist treatment
  - Naltrexone
- Alcohol “anti-craving” medication
  - Naltrexone, acamprosate
- Aversion medication
  - Disulfirum (if supervised)

Self Help groups – AA,NA etc

- Social support groups most attractive to those who have alienated family and friends
  - They assist one another by working together to maintain abstinence
- Research although limited suggests that

  -participation in these groups predicts more positive long term outcomes for many
- These groups are considered a useful **adjunct** to treatment programs

Resources you should know.

- DACAS - Drug and Alcohol Clinical Advisory Service
- Specialists – Addiction Medicine Specialists including psychiatrists with interest and expertise in dual diagnosis co-morbidity
- Drug treatment services – residential withdrawal, counseling
- DHS – drugs and poisons unit
- Liver/ Hepatitis clinics
- Pain management services
- Medical indemnity organisations, (GP)

Summary – management of drug and alcohol problems especially by GPs

- Drug use does not occur in isolation. It needs to be viewed in context – mental health, family, community, culture, employment
- GPs are at the forefront of treatment and can do a great deal particularly if they retain the patient and supported by specialist services
- Advances in neuroscience are likely to improve our understanding of addictions and may lead to new treatments BUT…..