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Dr Saba Javed
Staff Specialist Psychiatrist, ACT Health, Pain Management Unit, Alcohol and Drug Service, Mental Health
BENZODIAZEPINES

Identification, Management and Effects on mental health

It is more difficult to withdraw people from benzodiazepines than it is from heroin.
Professor Malcolm H Lader
Institute of Psychiatry London 1999

The benzodiazepines are probably the most addictive drugs ever created and the vast army of enthusiastic doctors who prescribed these drugs by the tonne have created the world's largest drug addiction problem.

- Dr Vernon Coleman, 1992
HISTORY OF BENZODIAZEPINE USE IN AUSTRALIA

Benzodiazepines: 1960’s

- “safe”, “non-addictive”, “mother’s little helper”
- Increasing use over past 40 years
- > 3 million scripts in Australia / year
- Concerns re: abuse & ‘addiction’ emerged 1980’s
BENZODIAZEPINE USE

In general population:

▪ 2 of top 20 drugs prescribed in Australia
▪ 6-10% of US adults used a hypnotic for sleep in 2010
▪ Of those using benzodiazepines, ~25–76% use long term (>3/12)
▪ Prevalence long-term benzodiazepine use in Australia: 2 – 7.4%
▪ Estimates ‘high dose’ benzodiazepine dependence: 0.1-0.2%
In substance users (drinkers, heroin users, OTP)

- $\sim \frac{2}{3}$ report any benzodiazepine use past month
- $\frac{1}{3}$ report regular benzodiazepine use past month
- 10-20% report regular high dose benzodiazepine use
WHY IS BENZODIAZEPINE USE SO WIDESPREAD?

- High lifetime prevalence anxiety disorders
- High prevalence sleep disorders
- High prevalence dependence
- Relief of alcohol/opiate/amphetamine withdrawal
- Come down off stimulants (amphetamine, party drugs)
- For intoxication
- Inexpensive, widely available, legal, considered ‘safe’
<table>
<thead>
<tr>
<th>Anxiety disorders</th>
<th>Involuntary movement disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute anxiety</td>
<td>Restless leg syndrome</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>Akathisia associated with neuroleptic use</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Choreiform disorders</td>
</tr>
<tr>
<td>Phobias (social, simple)</td>
<td>Myoclonus</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>Detoxification from alcohol and other substances</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>Agitation or anxiety associated with other psychiatric conditions</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Acute mania</td>
</tr>
<tr>
<td>Anxiety associated with medical illness</td>
<td>Psychotic illness</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Anxiety associated with depression</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Impulse control disorders</td>
</tr>
<tr>
<td>Somatoform disorder</td>
<td>Catatonia or mutism</td>
</tr>
<tr>
<td>Convulsive disorders</td>
<td>Other adjunctive uses</td>
</tr>
<tr>
<td>Acute status epilepticus</td>
<td>Surgery</td>
</tr>
<tr>
<td>Neonatal seizures or febrile convulsions</td>
<td>Dentistry</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>Diagnostic studies, such as computed tomography, magnetic resonance imaging and endoscopy</td>
</tr>
<tr>
<td>Tetanus</td>
<td>Cardioversion</td>
</tr>
<tr>
<td>Adjunct to other anticonvulsants</td>
<td>Chemoxytherapy</td>
</tr>
<tr>
<td>Amnestic (before surgery or procedure)</td>
<td></td>
</tr>
<tr>
<td>Spastic disorders and other types of acute muscle spasm</td>
<td></td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Paraplegia secondary to spinal trauma</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1. PBS prescriptions for benzodiazepines 2002 and 2009

<table>
<thead>
<tr>
<th></th>
<th>Diazepam</th>
<th>Oxazepam</th>
<th>Temazepam</th>
<th>Alprazolam*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1 576 625</td>
<td>1 220 936</td>
<td>2 237 733</td>
<td>324 110</td>
<td>5 359 404</td>
</tr>
<tr>
<td>2009</td>
<td>1 639 952</td>
<td>1 015 080</td>
<td>1 840 222</td>
<td>413 526</td>
<td>4 908 780</td>
</tr>
<tr>
<td>% change</td>
<td>+4%</td>
<td>−17%</td>
<td>−18%</td>
<td>+28%</td>
<td>−8%</td>
</tr>
</tbody>
</table>

* Private prescriptions (non-PBS) for alprazolam comprised on average an additional 32% of prescriptions per year, based on estimates from the Australian Statistics on Medicines\[^10\]
DRUG RELATED HARMS

Intoxication

Dependence

Regular use
INTOXICATION-RELATED BENZODIAZEPINE HARMS

Impaired motor & cognitive performance, judgement, memory

- Poor performance (work, driving, parenting)
- Falls in elderly
- Aggression, criminality
- Needle sharing, poor injecting
- Paradoxical reactions to benzodiazepines, characterized by increased talkativeness, emotional release, excitement, and excessive movement

Overdose

- 40-80% of opioid-related deaths linked to benzodiazepines

Effects may be ‘acute’ & ‘residual’
HARMS ASSOCIATED WITH DEPENDENT BENZODIAZEPINE USE

Motor & cognitive performance, memory
- Do not develop complete tolerance

Sleep
- Hypnotics increase problems (sleep apnoea, prolong apnoeas or suppress respiratory drive) in some, mild improvement in others

Mood
- ‘Emotional numbness’
- Greater incidence of depression in benzodiazepine patients than placebo in RCTs (2.0% v 0.9%, p < 0.002, N=7,863) (Kripke 2007).

Mortality
COGNITIVE IMPAIRMENT OF MEDICATIONS FOR ANXIETY
HINDMARCH 2009 INT J CLIN PRACTICE

Table 2 | Proportional impairment ratios (PIR) for drugs used in the treatment of social anxiety disorder

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose ranges studied (mg)</th>
<th>No. of studies analyzed</th>
<th>No. of psychometrics impaired</th>
<th>Total no. of psychometric assessments</th>
<th>% Cognitive impairment</th>
<th>PIR for individual drugs</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>50–100</td>
<td>5</td>
<td>2</td>
<td>167</td>
<td>1.2</td>
<td>0.03</td>
<td>28,29,31,58,60</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>25–50</td>
<td>4</td>
<td>2</td>
<td>49</td>
<td>4.1</td>
<td>0.14</td>
<td>42,43,47,68</td>
</tr>
<tr>
<td>Citalopram</td>
<td>20–60</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>5.6</td>
<td>0.21</td>
<td>70</td>
</tr>
<tr>
<td>Sertraline</td>
<td>100–400</td>
<td>4</td>
<td>7</td>
<td>102</td>
<td>6.9</td>
<td>0.33</td>
<td>35,46,56,64</td>
</tr>
<tr>
<td>Trimiprazine</td>
<td>50–100</td>
<td>4</td>
<td>4</td>
<td>60</td>
<td>6.7</td>
<td>0.24</td>
<td>30,51,58,59</td>
</tr>
<tr>
<td>Buproprion</td>
<td>150–200</td>
<td>2</td>
<td>2</td>
<td>22</td>
<td>9.1</td>
<td>0.31</td>
<td>44,54</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>37.5–150</td>
<td>2</td>
<td>6</td>
<td>69</td>
<td>8.7</td>
<td>0.31</td>
<td>51,53</td>
</tr>
<tr>
<td>Buspirone</td>
<td>5–20</td>
<td>4</td>
<td>10</td>
<td>94</td>
<td>10.5</td>
<td>0.38</td>
<td>22,25,45,50</td>
</tr>
<tr>
<td>Pindolol</td>
<td>20–40</td>
<td>3</td>
<td>4</td>
<td>30</td>
<td>13.3</td>
<td>0.45</td>
<td>41,55,61</td>
</tr>
<tr>
<td>Prazepam</td>
<td>40–160</td>
<td>4</td>
<td>5</td>
<td>39</td>
<td>12.8</td>
<td>0.45</td>
<td>26,27,30,36</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2–2.5</td>
<td>2</td>
<td>2</td>
<td>183</td>
<td>15.8</td>
<td>0.53</td>
<td>40,56</td>
</tr>
<tr>
<td>Dilaudid (V)</td>
<td>50–150</td>
<td>3</td>
<td>10</td>
<td>54</td>
<td>18.5</td>
<td>0.66</td>
<td>30,43,55</td>
</tr>
<tr>
<td>Compazine</td>
<td>75–150</td>
<td>1</td>
<td>4</td>
<td>11</td>
<td>22.2</td>
<td>0.79</td>
<td>23</td>
</tr>
<tr>
<td>Preprodil</td>
<td>450</td>
<td>1</td>
<td>5</td>
<td>33</td>
<td>33.7</td>
<td>0.82</td>
<td>45</td>
</tr>
<tr>
<td>Imipramine</td>
<td>75–150</td>
<td>2</td>
<td>13</td>
<td>45</td>
<td>29.9</td>
<td>1.04</td>
<td>66,83</td>
</tr>
<tr>
<td>Diazepam (V)</td>
<td>5–15</td>
<td>4</td>
<td>18</td>
<td>60</td>
<td>30.0</td>
<td>1.07</td>
<td>22,28,35,48</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>0.5–3</td>
<td>2</td>
<td>8</td>
<td>26</td>
<td>30.8</td>
<td>1.11</td>
<td>34,63</td>
</tr>
<tr>
<td>Mitrazepine</td>
<td>15–45</td>
<td>3</td>
<td>23</td>
<td>65</td>
<td>35.4</td>
<td>1.25</td>
<td>46,57,69</td>
</tr>
<tr>
<td>Nefazadone</td>
<td>200–400</td>
<td>1</td>
<td>6</td>
<td>16</td>
<td>38.0</td>
<td>1.36</td>
<td>66</td>
</tr>
<tr>
<td>Bromazepam</td>
<td>2–18</td>
<td>2</td>
<td>16</td>
<td>36</td>
<td>44.4</td>
<td>1.57</td>
<td>25,62</td>
</tr>
<tr>
<td>Amikokyrofyn (V)</td>
<td>25–150</td>
<td>11</td>
<td>86</td>
<td>184</td>
<td>46.7</td>
<td>1.81</td>
<td>35,41,42,44,46,48,49,</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>0.5–3</td>
<td>7</td>
<td>88</td>
<td>175</td>
<td>50.3</td>
<td>1.92</td>
<td>23,32,37,41,52,63,66</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>3–10</td>
<td>2</td>
<td>8</td>
<td>57</td>
<td>54.4</td>
<td>2.60</td>
<td>24,49</td>
</tr>
<tr>
<td>Clonazepam (V)</td>
<td>15</td>
<td>2</td>
<td>13</td>
<td>22</td>
<td>59.1</td>
<td>2.11</td>
<td>30,31</td>
</tr>
<tr>
<td>Lorazepam (V)</td>
<td>1–2.5</td>
<td>0</td>
<td>60</td>
<td>58</td>
<td>61.2</td>
<td>2.35</td>
<td>33,36,40,49,47,</td>
</tr>
<tr>
<td>Mephen (V)</td>
<td>10–60</td>
<td>6</td>
<td>59</td>
<td>87</td>
<td>67.8</td>
<td>2.62</td>
<td>28,29,42,44,53,56</td>
</tr>
</tbody>
</table>

V = used as positive internal control, venet; PIR, proportional impairment ratio.
WITHDRAWAL SYNDROME

emergence of characteristic profile of symptoms that are different to original condition
20–100% of long-term benzodiazepines at therapeutic doses are physically dependent & experience withdrawal symptoms (Ashton 1997)
# Benzodiazepine Withdrawal

Table 1. Some common acute benzodiazepine withdrawal symptoms

<table>
<thead>
<tr>
<th>Symptoms common to all anxiety states</th>
<th>Symptoms less common in anxiety states: relatively specific to benzodiazepine withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, panic attacks, agoraphobia</td>
<td>Perceptual disturbances, sense of movement</td>
</tr>
<tr>
<td>Insomnia, nightmares</td>
<td>Depersonalisation, derealisation</td>
</tr>
<tr>
<td>Depression, dysphoria</td>
<td>Hallucinations (visual, auditory), misperceptions</td>
</tr>
<tr>
<td>Excitability, jumpiness, restlessness</td>
<td>Distortion of body image</td>
</tr>
<tr>
<td>Poor memory and concentration</td>
<td>Tingling, numbness, altered sensation</td>
</tr>
<tr>
<td>Dizziness, light-headedness</td>
<td>Formication</td>
</tr>
<tr>
<td>Weakness, &quot;jelly legs&quot;</td>
<td>Sensory hypersensitivity (light, sound, taste, smell)</td>
</tr>
<tr>
<td>Tremor</td>
<td>Muscle twitches, jerks, fasculation</td>
</tr>
<tr>
<td>Muscle pain, stiffness (limbs, back, neck, jaw, head)</td>
<td>Tinnitus</td>
</tr>
<tr>
<td>Sweating, night sweats</td>
<td>*Confusion, delirium</td>
</tr>
<tr>
<td>Palpitations</td>
<td>*Fits</td>
</tr>
<tr>
<td></td>
<td>*Psychotic symptoms</td>
</tr>
<tr>
<td></td>
<td>*Usually confined to rapid withdrawal from high doses of benzodiazepines</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Usual course</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Gradually diminishing over a year</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Gradually diminishing over 6 to 12 months</td>
</tr>
<tr>
<td>Depression</td>
<td>A few months: responds to antidepressants</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Gradually improving but may last a year or more and occasionally incomplete</td>
</tr>
<tr>
<td>Perceptual symptoms</td>
<td></td>
</tr>
<tr>
<td>Tinnitus</td>
<td>Gradually receding, but may last at least a year and occasionally persist indefinitely</td>
</tr>
<tr>
<td>Paraesthesia - tingling, numbness, pain</td>
<td>Usually in limbs, extremities</td>
</tr>
<tr>
<td>Motor symptoms</td>
<td>Gradually receding, but may last at least a year and occasionally persist indefinitely</td>
</tr>
<tr>
<td>Muscle pain, weakness, tension, painful tremor, shaking attacks, jerks, blepharospasm</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal symptoms</td>
<td>Gradually receding, but may last at least a year and occasionally persist indefinitely</td>
</tr>
</tbody>
</table>
Physiological dependence on benzodiazepines can occur following prolonged treatment with therapeutic doses, but it is not clear what proportion of patients are likely to experience a withdrawal syndrome.

unknown to what extent the risk of physiological dependence is dependent upon a minimum duration of exposure or dosage of these drugs.

Withdrawal phenomena more severe following withdrawal from high doses or short-acting benzodiazepines

Dependence on alcohol or other sedatives may increase the risk of benzodiazepine dependence
IS THERE A ROLE FOR THERAPEUTIC USE OF BENZODIAZEPINES AS ANXIOLYTICS/HYPNOTICS?

Concerns

- Onset of tolerance within weeks limits their utility
- Risks of abuse / addiction especially in high-risk groups

Consider alternative management strategies

- Sleep hygiene and relaxation techniques
- Address underlying anxiety/depression
- Address other substance use disorders

If going to prescribe:

- Limit duration <2 weeks
- Regular interval dispensing
- Avoid highly abused benzodiazepines
ARE SOME BENZODIAZEPINES SAFER THAN OTHERS?

Amount of cognitive impairment / intoxication

Onset & duration of action

- Slow onset & longer-acting drugs less abuse potential than fast onset & short acting drugs

Potential for misuse

- Preparations can impact upon misuse (e.g. temazepam capsules)
- Prescribing & dispensing practices
  
  (200x 2mg clonazepam + 5 repeats!!)
RESPONDING TO BENZODIAZEPINE ‘ABUSERS’

Avoid prescription of benzodiazepines altogether!

Offer alternative strategies for patients requesting assistance with anxiety, sleep, opiate withdrawal, coming off stimulants etc…

No role for ‘unconditional, never-ending benzodiazepine maintenance’
BENZODIAZEPINES

Effective short term treatment

Only a minority of patients benefit from long term treatment

Substance dependence is a relative contraindication as risk of developing benzodiazepine dependence is much higher

RANZCP recommendations

RANZCP guidelines for the use of benzodiazepines recommends their use “should be restricted to short terms periods only”.

Longer term use should only be considered in patients who do not respond to adequate trials of other evidence based pharmacological and psychological treatments”
ASSESSMENT

Through bio-psycho-social assessment

Do not rush in with a prescription

How much, how often, which types of benzodiazepines and how long for

Side effects of abstinence

Periods and symptoms of abstinence

Aberrant drug behaviours

Medical, psychiatric, social co-morbidity: treatment strategies

History, examination, collateral information, urinalysis
Diagnosis/formulation of pattern of benzodiazepine use

**Therapeutic use** – no regular benzodiazepine use. To Alleviate anxiety/sleep problems in response to a time-limited stressor

**Abuse**: Irregular use with associated harms. Often has tolerance but no significant withdrawal

**Dependence**: almost daily to daily use, tolerance, withdrawal, DSM IV criteria
**TREATMENT**

Treat concomitant anxiety/depression

Structured dose reduction

1. Minimum amount needed to prevent benzodiazepine withdrawal

2. Stabilise on long acting benzodiazepine (rarely need 60mg (usually < 40mg)

3. Structured dosing times
Compared to routine care (ie do nothing), brief intervention, gradual dose reduction and psychological treatment resulted in higher abstinence rates.

GDR = psychological. GDR alone (OR=1.82), CI-1.25-2.67; 7 studies, 454 patients

GDR + medications vs GDR alone (poor evidence) — paroxetine, trazodone, melatonin, valproate
Gradual reduction over weeks – months

Aim for 3-6 months tapers ie from 30mg diazepam 5mg every 2-4 weeks

Consider inpatient admission for stabilisation only with transfer to community for reduction as an outpatient

1. High dose benzodiazepines/ polydrug dependence
2. History of severe withdrawal: seizures, delirium
3. Co-morbid medical/psychiatric conditions
IF YOU ARE GOING TO PRESCRIBE BENZODIAZEPINES

Negotiate contract with patient re: treatment conditions

- benzodiazepine contingent upon not getting benzodiazepine from elsewhere, stable in treatment, attend appointments, not abusing other drugs

One doctor to manage all benzodiazepines & related medications

- Doctor shopping consent forms
- Consent to provide information to other health care providers
UNIVERSAL PRECAUTIONS

All psychoactive drugs have the potential to be misused (used badly) with associated morbidity & mortality.

All patients are at some risk of developing problems related to benzodiazepine use.

Identify & respond to ‘high risk’ patients.

Structure benzodiazepine prescribing with regular monitoring to minimise risks.
Limit access to benzodiazepines: daily/weekly dispensing

- Staged / Instalment dispensing scheme

Avoid benzodiazepines associated with high abuse rates

- (e.g. flunitrazepam, midazolam, alprazolam)

Agree upon how treatment will be assessed & monitored
MONITORING BENZODIAZEPINE TREATMENT

Regular reviews and monitoring Outcomes: The 4A’s

1. **Anxiety / Affect / sleep**: scales, diary
2. **Activities**: functional outcomes
3. **Adverse events**: side effects
4. **Aberrant behaviours**: UDS, intoxicated presentations

- Psychosocial supports – non medical clinician an essential part of treatment plan
- Exercise and diet
TREATMENT CONTINUED...

Risk contained

Contract – one prescriber, one dispenser

Frequent dispensing at limited intervals

Clear limits/boundaries – no early repeats, no replacement prescriptions

Have an exit plan

In the ACT – use a voluntary agreement
HTTP://WWW.HEALTH.ACT.GOV.AU/SITES/DEFAULT/FILES/VOLUNTARY%20UNDERTAKINGS%20APPLICATION%20FORM.PDF
If you're worried about taking so many tablets I could prescribe you some valium...
Morning Tea

Capital Health Network
ACT’s primary health network
Dr Anthony Sams
Medical Director, Drug and Alcohol Programs, Northside Greenwich and Northside Wentworthville Hospitals
Screening for Alcohol and Drug Dependency, and Preparing for Treatment

In General Practice
EPIDEMIOLOGY: ALCOHOL

• 2013: 80% of Australians aged 14 years or older had consumed alcohol in the past year
• Daily consumption is declining: 8% in 2007, 6.5% in 2013
• However, increasing alcohol related harm: increasing hospital admissions for Alcohol Use Disorder and alcoholic liver disease
EPIDEMIOLOGY: ALCOHOL

• 20% of Australians drink at levels that put them at risk of lifetime harm

• 45% of Australians drink at a level that place them at risk of injury, at least once per year
ACROSS THE YEARS

• Most people tend to reduce their drinking in their early to mid 20s

• Those with Alcohol Use Disorder (AUD) tend to escalate their drinking in the above period

• By age 70, a minority of patients still fulfill criteria for AUD: 50% will be dead, 1/3 abstinent, a small number will return to controlled drinking.
EPIDEMIOLOGY: DRUG USE

• 2011: Illicit drug use contributes to 1.8% of total burden of disease in Australia

• Proportion of illicit drug users relatively stable past 10 years: about 15% of adults, most commonly cannabis, ecstasy, methamphetamine (esp crystal) and cocaine

• 12% use illicits;

• 4.7% abuse pharmaceuticals (ie over a million people: increasing)
PRESENTATIONS?
ACUTE PRESENTATION
WERNICKE’S ENCEPHALOPATHY

- Life threatening presentation:
  - Confusion (80%)
  - Ataxia
  - Ophthalmoplegia
  - (UP TO 90% MAY NOT SHOW THE CLASSICAL TRIAD); may present with peripheral neuropathy, vestibular dysfunction and hypothermia

- Consequences:
  - 12% minor to no cognitive sequelae
  - 68% Korsakoffs syndrome: clear consciousness, anterograde and retrograde amnesia, +/- confabulation
  - 20% death (infection, cardiovascular collapse)
MOST COMMON PRESENTATION?
CASE NO. 1

• 23 y.o. female. Presented for detoxification, had been already commenced on lithium, olanzapine and valproate for ‘bipolar disorder’.
CASE NO. 2

• 48 year old male. Presented for eighth detoxification admission.

• Presented a letter stating he was suffering from a psychotic depression.
COMMON FEATURES OF MAJOR DEPRESSIVE DISORDER:

- Low, anxious or ‘numbed’ mood
- Increased need for sleep, or insomnia
- Loss of interest or pleasure in usual activities
- Disturbed energy levels
- Psychomotor agitation
- Impaired concentration or memory
- Increased or decreased appetite
- Social isolation
- Hopelessness, suicidal ideation
COMMON FEATURES OF SUBSTANCE ABUSE:

• Low, anxious or ‘numbed’ mood
• Increased need for sleep, or insomnia
• Loss of interest or pleasure in usual activities
• Disturbed energy levels
• Psychomotor agitation
• Impaired concentration or memory
• Increased or decreased appetite
• Social isolation
• Hopelessness, suicidal ideation
DIRECTIONS OF EFFECT?

• Depression can increase risk of developing SUD

• SUD can worsen pre-existing mood symptoms

• Symptoms of depression may reflect a SUD
BIPOLAR PATIENTS

- Alcohol problems more common in bipolar I
- Drug problems commoner in bipolar II and rapid cycling groups (7-25%)
- 60% comorbidity overall (3x unipolar depression)
- Stabilizing mood DOES diminish substance abuse
HOW TO ASSESS?
ASSESSMENT: CONUNDRUMS

- Usual screening instruments for mood symptoms have not been validated for patients abusing D&A

- Screening instruments for substance abuse do remain reliable
ASSESSMENT: CONUNDRUMS

• Expression of psychological distress does not always indicate an Axis 1 diagnosis, nor immediate commencement of antidepressants.

• Psychological distress increases with increasing levels of substance dependence.

• Psychological distress decreases more quickly in comorbid patients when substance use treated vs ‘pure depression’.
CLUES TO D&A INFLUENCE

• Older age at onset of psychiatric symptoms

• Abrupt onset of psychiatric symptoms

• Absence of family history of psychiatric disorder
CLUES TO D&A INFLUENCE

• Unusual presentations in a known patient

• Resolution of symptoms quickly

• Physiological signs (e.g., pupils, sweats, tremor; difficult to control hypertension)

• LFTs, MCV, UDS

• CDT
RULE OF THUMB

• You cannot make any psychiatric diagnosis (except ‘substance induced….) with confidence, nor expect psychototropic medications or psychological therapy to work properly (or perhaps at all) in a patient who is abusing alcohol or drugs.
WITH THE PATIENT THERE..

• Check your own resolve, avoid the ‘manic defence’.

• Motivational Interview?

• Consider abstinence as a PRECONDITION to treating mood symptoms, rather than the goal of treating mood symptoms (hard to score when the goalpost keeps moving…)
PRAGMATIC APPROACH?

- SSRIs have been shown to reduce depressive and alcohol dependence symptoms in comorbid patients
- SSRIs of no benefit for alcohol dependence alone
- Compliance will always be uncertain
- Partial response good enough?
SCREENING...

• Take a history: frequency, amounts (then double it??)

• D&A History as part of routine ‘organic workup’ for any patient presenting with mood symptoms

• Empathic, nonjudgemental approach
CAGE FOR ALCOHOL/DRUG USE DISORDER

1. Have you ever felt you should Cut down your drinking/drug use?
2. Have people Annoyed you by criticizing your drinking/drug use?
3. Have you ever felt bad or Guilty about your drinking/drug use?
4. Have you ever used alcohol or drugs in the morning to steady your nerves / get rid of a hangover? (Eye opener)?

Yes to ONE question: ‘widen the net’ (2 or more = likely problem)
CAGE

• 1. CUT DOWN
• 2. ANNOYED
• 3. GUILTY
• 4. EYE OPENER
MANAGEMENT?

• CLARIFY THE DIAGNOSIS:

• Substance abuser?

• Or Substance dependent?
HEALTH PATHWAYS?
1. Screen all patients aged ≥15 years, as per RACGP guidelines, using the AUDIT C questionnaire. If AUDIT C consumption score is < 5, screen every 2 to 4 years.

Audit C Questionnaire

CAGE questions
1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticising your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (#eye-opener)?

Scoring:
Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.
See also, US Preventative Services Task Force - CAGE Questionnaire® (pdf).
Alcohol Dependence: Management

Clinical Resources

- NHMRC - Australian Guidelines to Reduce Health Risks from Drinking Alcohol
- RACGP:
  - SNAP Guidelines
  - Early Detection of Problem Drinking
  - Problem Drinking - Management in General Practice
  - Motivational Interviewing Techniques
- The University of Mexico Department of Psychology and Center on Alcoholism, Substance Abuse, and Addictions (CASAA) - Motivational Enhancement Therapy with Drug Abusers
- US Preventative Services Task Force - CAGE Questionnaire

Education

Education and Resource Centre (HIV, Hepatitis, STIs), The Alfred Hospital Fairfield House, Moubray Street, Prahran, VIC 3181 (courses on MET)
- phone (03) 9076-6993
- email erced@alfred.org.au

Patient Information

- Alcoholics Anonymous (phone 1300-22-22-22)
- Department of Veteran Affairs - The Night Mix
- NHMRC - Frequently Asked Questions: 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol
Opioid Dependence
how to find the pathway

Look through the table of contents...

…or use the search function
Drug seeking behaviour

- Patient (especially new to a practice) that may raise suspicion:
  - Arrives after regular hours or wants an appointment towards the end of office hours.
  - States that they are travelling through, visiting friends or relatives.
  - Exaggerates or feigns medical problems.
  - Provides a convincing, textbook-like description of symptoms but vague medical history.
  - Provides an aged clinical report and/or X-ray (often from interstate) in support of their request.
  - Declines a physical examination or permission to obtain past records or undergo diagnostic tests.
  - Unwilling or unable to provide the name of their regular doctor, or states that the doctor is unavailable.
  - Claims to have lost a prescription, forgotten to pack medication, or says medication was stolen or damaged.
  - Shows unusual knowledge about opioid medications.
  - States that specific non-opioid medications do not work, or that they are allergic to them.
  - Adds pressure by eliciting sympathy or guilt, or by direct threats.

- Identify known doctor shoppers through the
  Prescription Shopping Information Service (PSIS).
Opioid Dependence: Management

Clinical Resources

- ACT Health - Pharmaceutical Services - Controlled Medicines
- Department of Health - National Drugs Campaign
- Drug and Alcohol Specialist Advisory Service (DASAS) - a service for rural and regional health professionals in NSW.
- NSW Health - Mental Health and Drug and Alcohol
- Prescription Shopping Information Service, phone 1800-631-161

Patient Information

- ADIS (24 hours per day)
  - NSW (rural) - phone 1800-422-599
  - Sydney - phone (02) 9361-8000
  - ACT - phone (02) 6207-9977
- Australian Drug Foundation - Fact Sheet: Heroin
- Drug Info - Help and Support
- NSW Health:
  - Heroin - Drug Facts
  - Methadone
NEUROADAPTED? NEEDS DETOX

• ‘Elective’ procedure
• Comfortable and safe: removes a barrier to addressing alcohol / drug problem
• Goal is to prevent a withdrawal syndrome, or minimize it’s symptoms

• Severity of withdrawals affected by:
  • - older age
  • - concurrent sedative abuse
  • - greater duration and amount of alcohol use
  • - malnourishment, dehydration, sepsis, electrolyte disturbance
HOME DETOX?

• Mild to moderate alcohol dependence
• Daily medical review, easy access to doctor/nurse
• Supervision at home (not alone)
• Quiet environment
• Low complications risk
• No polysubstance abuse
• No significant medical or psychiatric comorbidity
• Not vomiting or malnourished

• Check baseline bloods, correct electrolyte abnormalities
# ALCOHOL WITHDRAWAL SCALE

## Alcohol Withdrawal Scale (AWS)

### Perspiration
0 – No abnormal sweating  
1 – Moist skin  
2 – Localized beads of sweat (such as on face, chest)  
3 – Whole body wet from perspiration  
4 – Profuse sweating (such as clothes, linens are wet)

### Tremor
0 – No tremor  
1 – Slight intentional tremor  
2 – Constant slight tremor of upper extremities  
3 – Constant marked tremor of extremities

### Anxiety
0 – No apprehension or anxiety  
1 – Slight apprehension  
2 – Apprehension or understandable fear  
3 – Anxiety occasionally accentuated to a state of panic  
4 – Constant panic-like anxiety

### Agitation
0 – Rests normally during day, no signs of agitation  
1 – Slight restlessness, cannot sit or lie still, awake when others sleep.  
2 – Moves constantly, looks tense, wants to get out of bed but obeys requests to stay on bed.  
3 – Constantly restless, gets out of the bed for no obvious reason; returns to bed if taken.  
4 – Maximally restless, aggressive, ignores request to stay in bed.

### Armpit Temperature
0 – Temperature of 37 °C or less  
1 – Temperature of 37.1 °C to 37.5 °C  
2 – Temperature of 37.6 °C to 38.0 °C  
3 – Temperature of 38.1 °C to 38.5 °C  
4 – Temperature above 38.5 °C

### Hallucinations
0 – No evidence of hallucination  
1 – Distortion of real objects. Aware that they are not real.  
2 – Appearance of totally new objects or perceptions. Aware that they are not real.  
3 – Believes the hallucination but oriented to place and person.  
4 – Believes self to be in totally non-existent environment, preoccupied and cannot be diverted or reassured.

### Orientation
0 – The patient is fully oriented in time, place and person.  
1 – The patient is oriented in person but is not sure about place and time.  
2 – The patient is oriented in person but disoriented in time and place.  
3 – Doubtful personal orientation, short periods of lucidity can be noticed.  
4 – Disoriented in time, place and person. No meaningful contact can be obtained.
HOME DETOXIFICATION PROTOCOL

• Daily review by nurse or doctor
• AWS should remain below 5

• Diazepam: supervised, daily dispensing
  • Day 1&2: 10mg q6h
  • Day 3&4: 5mg q6h
  • Day 5&6: 5mg bd
  • Day 7: 5mg at night
  • Day 8: Cease

• Thiamine: 100mg tds PO for a month, multivitamin daily
HOME DETOXIFICATION

- Caution re benzodiazepine effects: sedation, ataxia, not to drive
- Withold diazepam if sedated
- Cease if resumes drinking (breathalyse if in doubt)
- Short term benzodiazepines due to risk of dependence

- TRANSFER TO HOSPITAL IF:
- Rapid rise in AWS, or unable to maintain score <5
- Withdrawal seizures
- Agitation difficult to control
- Hallucinations
INPATIENT DETOXIFICATION

• Moderate to severe alcohol withdrawals
• Physical or psychiatric comorbidity
• Safer
• Offers an entry point to ongoing addiction treatment; no easy access to alcohol/drugs

• Low stimulus environment
• AWS, sliding scale diazepam dosing, regular nursing and medical review. Start dosing when symptomatic and BAL <0.1
• Thiamine, multivitamins
ONGOING MANAGEMENT

• Australian data: on average, an 18 year delay before AUD patients access treatment

• Dealing with stigma

• There is NO evidence that detoxification alone reduces risk of relapse to drinking

• Assess physical comorbidity (liver, pancreas, neurological, anaemia, thrombocytopenia, nutritional)

• Pharmacotherapies
‘REHAB’

• Australian data: on average, an 18 year delay before AUD patients access treatment

• Dealing with stigma

• There is NO evidence that detoxification alone reduces risk of relapse to drinking

• Assess physical comorbidity (liver, pancreas, neurological, anaemia, thrombocytopenia, nutritional)
‘REHAB’

• Initial medicated detoxification

• Group therapy at least 4hrs daily, psychologist run: CBT, Mindfulness, 12 Step Facilitation

• Nutritionist
• Exercise physiologist/gym

• AA/NA at least 4x per week, encouraged to do more of own volition
AFTER REHAB...

• - Day patient group weekly

• ‘90/90’ 12 step meetings

• Individual therapy as indicated
Thank you for your time..
Chris Gough
Manager, Canberra Alliance for Harm Minimisation and Advocacy
Dr Alfiya Mutlu
Consultant Psychiatrist, Gungahlin Community Mental Health team
ADULT COMMUNITY MENTAL HEALTH SERVICES (ACMHS)

PROPOSED MODEL OF CARE (MoC)
Today's presentation:

- ACMHS MoC Update
- ACMHS MoC impact on management of mental health consumers with Substance Use disorders
New MoC - Why?

- 4th National MH Plan and draft 5th National MH Plan
- *Mental Health Act 2015*
- MH sector change ie NDIS, CHN, population growth, workforce shortages
- 2015/16 budget for expansion of community mental health
- ACT Health Reform agenda
- Increased standardisation of procedures, processes and practices to promote more internal consistency in service delivery and best practice interventions
- Clarification and delineation of the roles and service functions to reduce duplication and inefficiencies, reduced administrative burden on staff and promote more direct clinical contact
- provide optimal treatment for people in their homes and community as effective hospital diversion.
- Faster access to effective care.
Proposed MoC – Scope

Redesign of existing ACT Health services of:

- Crisis Assessment & Treatment Team (CATT),
- Mobile Intensive treatment Team (MITT),
- Community Mental Health Teams of City, Woden, Belconnen, Tuggeranong and Gungahlin

The MoC is not proposing changes to mental health services in inpatient, child and adolescent, forensic, rehabilitation, primary health care, private sector or community agency settings.
Proposed MoC - Main Changes?

- **Focus of Care** regarding priority group of people requiring ACMHS
- **Principles of Care** for all aspects of service delivery
- **Components of Care** or service functions
- **Sustainability** enablers for the ACMHS MoC implementation
- **Evaluation** of the expected benefits
Proposed MoC – Key Access Criteria

- Adults.
- Experiencing mental illness or mental disorder.
- Significant psychosocial functional impairment and/or
- High risk of harm to self or others or misadventure; and have
- Complex needs and intervention requirements.
Proposed MoC - Components of Care

<table>
<thead>
<tr>
<th>Access Assessment and Triage</th>
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<tbody>
<tr>
<td>A distinct access, assessment and triage team to promote greater access and consistency in service responses to access requests</td>
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</tbody>
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<tr>
<th>Acute Response and Intensive Home Treatment</th>
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<tbody>
<tr>
<td>An acute response and intensive in-home treatment team which provides an alternative to inpatient admission, inpatient access functions and in-reach into hospital settings to facilitate discharges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Recovery Service</th>
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<tbody>
<tr>
<td>Clinical Case management and care coordination with a focus on a strengths-based approaches to Recovery</td>
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</table>

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<tr>
<th>Assertive Community Outreach Service</th>
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<tr>
<td>An assertive community outreach service to engage more actively with people with complex needs</td>
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</table>

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<tr>
<th>Individual Therapies</th>
</tr>
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<tr>
<td>Psychological therapies, psychosocial and other specialty interventions to more specifically target individual requirements</td>
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</tbody>
</table>
What does the MoC say about partnerships with General Practice?

- We look to GPs as the experts in holistic medical care to provide regular appointments and ongoing care for people with mental illness, even if they are also receiving care through specialist mental health services.

- Most people will not receive life-long care through specialist mental health services. Rather that they will ‘step up’ to specialist mental health services when needed and ‘step down’ to primary care when a specialist service is no longer required.

- Ease of referral – one number.

- Clarity about who should be referred.

- Consistency in our response to referrals.

- A responsive service.

- A targeted service providing care to those who are most in need.

- Access to advice via a dedicated GP line.
What does the MoC say about Comorbidity?

ACMHS works with individuals to address both areas of mental health and substance use as both conditions are:

- typically not mutually exclusive
- and interact with each other.
What does the MoC say about Comorbidity?

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
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</thead>
<tbody>
<tr>
<td><strong>AOD Problem</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Joint treating team of Specialist MH and Specialist ADS</td>
<td>ADS treating team MH consult liaison</td>
<td>ADS treating team</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>MH treating team ADS consult liaison</td>
<td>MH treating team ADS consult liaison OR ADS treating team MH consult liaison</td>
<td>ADS treating team</td>
</tr>
<tr>
<td><strong>Mild</strong></td>
<td>MH treating team</td>
<td>MH treating team</td>
<td>Assessment, information, support</td>
</tr>
</tbody>
</table>
For example:

- use of de-stigmatising, evidence-based and integrated pathways to appropriate care and treatment.
- enhance motivation and engagement;
- identify risk factors;
- develop relapse-prevention strategies
- more complex issues are addressed through consultation and collaborative work with other alcohol and drug services to ensure access to specialist intervention when required and the integration of treatment efforts.
- improve referrals, care pathways and coordination between services to facilitate earlier detection and treatment of people with or at risk of developing comorbidities.
- Focus on what services and interventions are needed at any point in time to best support individuals rather than identifying which diagnosis takes precedence.
- Promote the use of screening tools, and staff development to ensure best practice assessment, treatment and care to appropriately respond to people with comorbidity.
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Summary
Thank You!