



SYDNEY NORTH
Primary Health Network



PREMISE
NHMRC CENTRE OF RESEARCH EXCELLENCE



Substance use in our community: Identifying commonly used substances and their effects

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A/Prof Katherine Mills

Before we get started...

Questions/comments "Q&A"

Technical support:

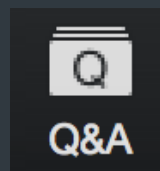
Call 1800 768 027, extension 2, quote webinar ID
100 112 088 when prompted

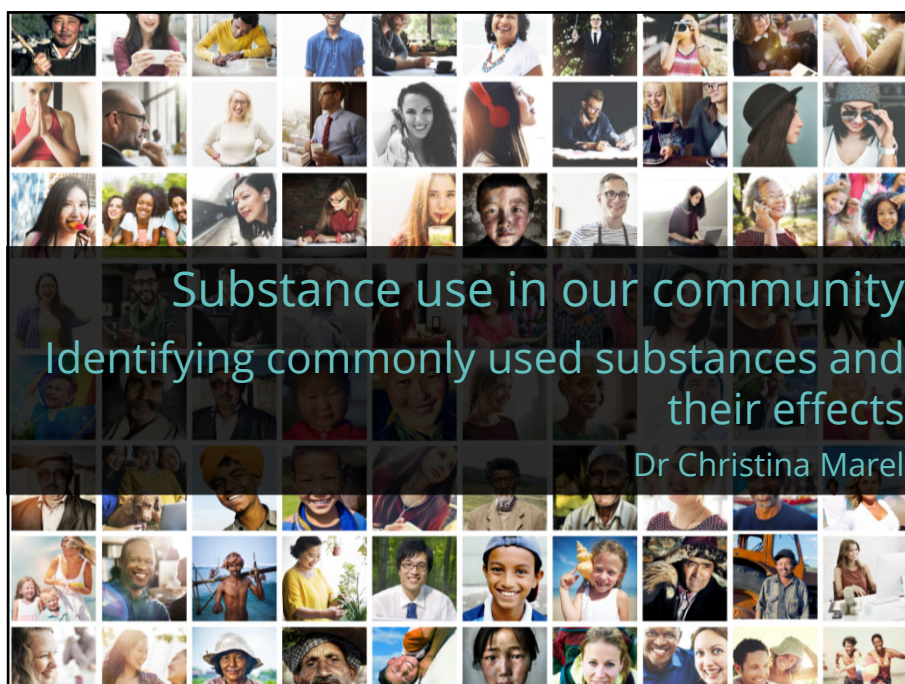
Visit <https://support.zoom.us/hc/en-us/categories/201146643-Meetings-Webinars>
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chat online with support staff

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of event:

<https://vimeo.com/comorbidity>

Remember: Complete CPD assessment at conclusion of
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Learning outcomes



- Improved understanding of commonly used substances, their effects, and what to do if use is suspected
- Improved understanding of how to identify substance use, and how to discuss with patients
- Improved awareness of where to access more information

Overview

- What are some of the commonly used substances in our community?
 - What are their effects
 - What to do if substance use is suspected
- How is substance use identified?
 - How to discuss with patients
- Where to access more information

A note on terms

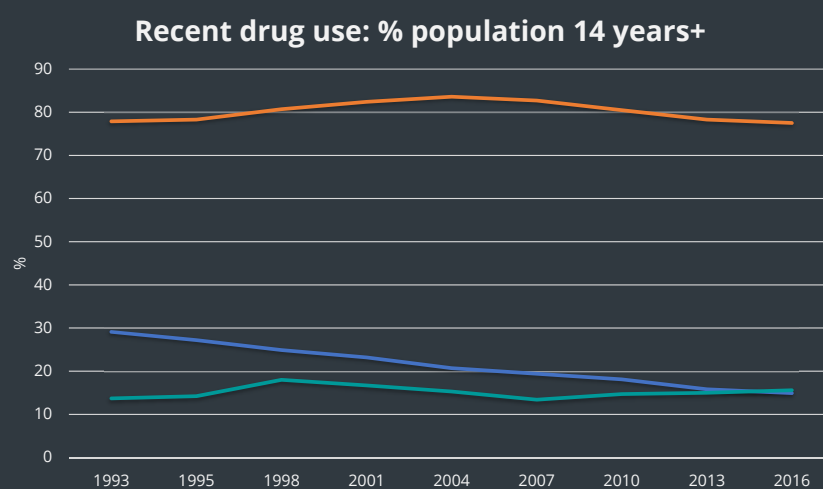
- Alcohol and other drug use (AOD)
- Substance use
- Illicit drug use
- Psychoactive substances
- 'Any substance which when taken into the body alters its function physically and/or psychologically, excluding food, water and oxygen' (World Health Organisation)



Overview

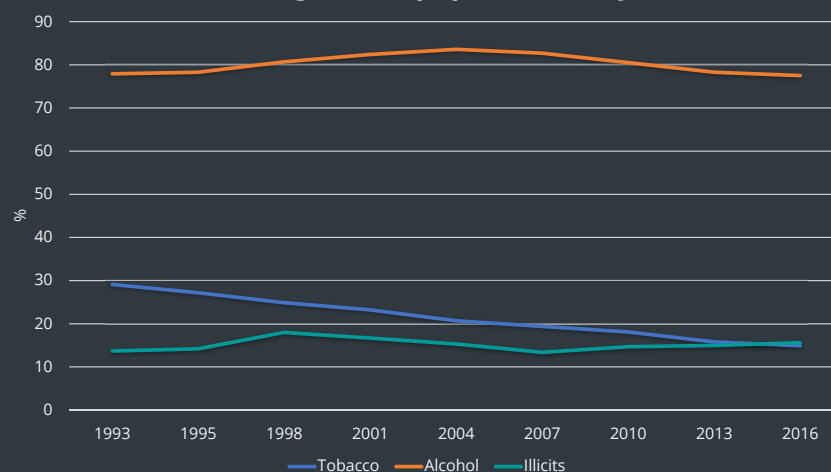
- What are some of the commonly used substances in our community?
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POLL 1: Prevalence of substance use



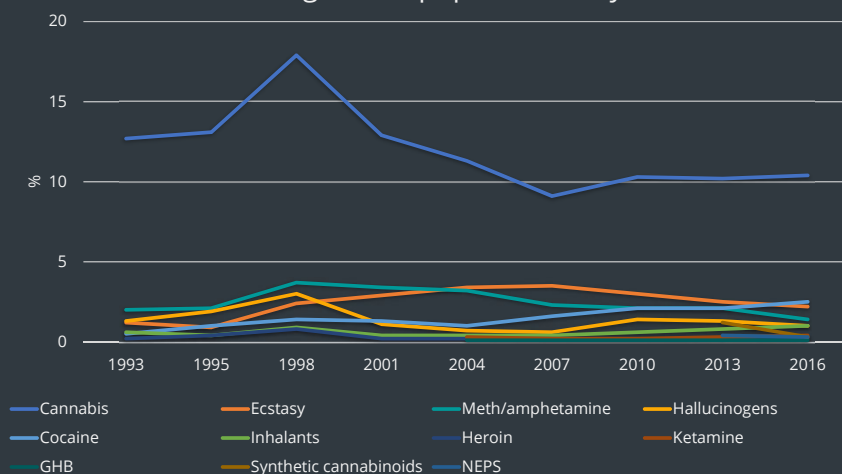
Prevalence of substance use: NDSHS 2016

Recent drug use: % population 14 years+



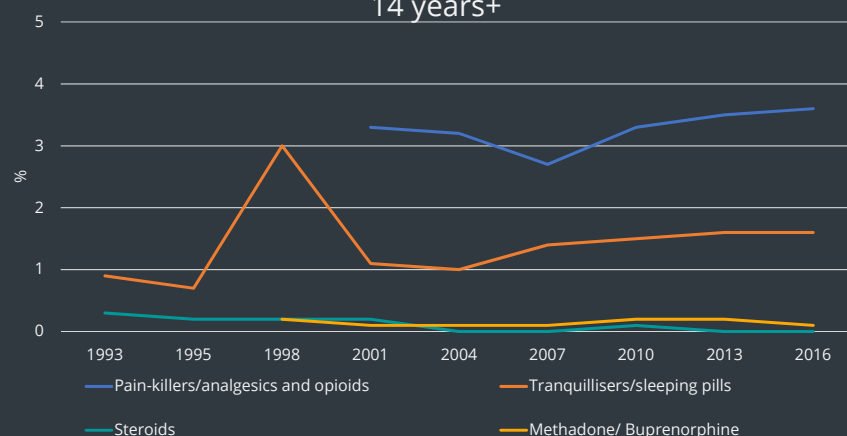
Prevalence of substance use: NDSHS 2016

Recent drug use: % population 14 years+



Prevalence of substance use: NDSHS 2016

Recent illicit pharmaceutical use: % populations
14 years+



Source: <https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-key-findings>

Not everyone who uses develops use disorder

When do we need to become concerned?

Use vs use disorder

Stimulant 50.4%



Opioid 46.6%



Sedative 39%



Alcohol 37.5%



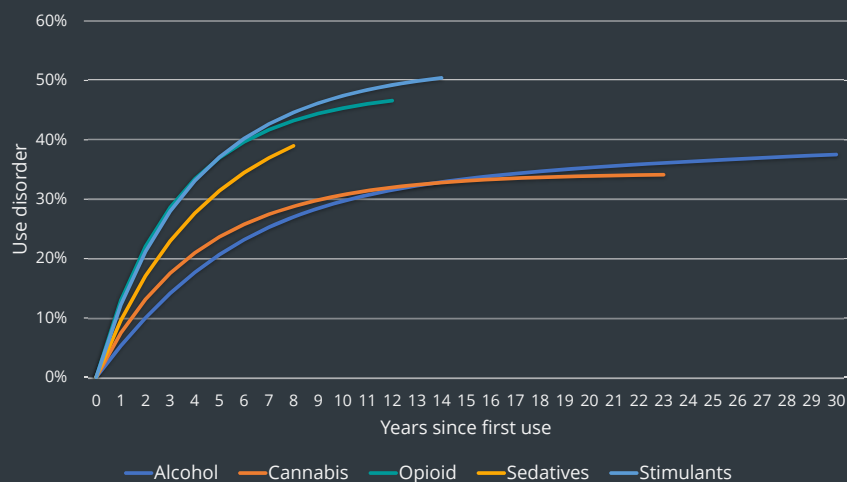
Cannabis 34.1%



Many people drink/use at high levels without meeting criteria for a disorder, they may be nonetheless be at risk of physical harm

Marel et al, (2018) Conditional probabilities of substance use disorders and associated risk factors, *Drug and Alcohol Dependence*

How long does it take?



Marel et al, (2018) Conditional probabilities of substance use disorders and associated risk factors, *Drug and Alcohol Dependence*





	What is it?	What forms are most common in Australia?	How is it usually administered?	How is it sold?
Cannabis	Sedative, hallucinogen, stimulant	- Marijuana (dried leaves, flowers) - Hashish (resin) - Hash oil	- Smoked - Smoked or eaten - Smoked	- Grams - Ounces
Ecstasy	Stimulant, hallucinogen	- Tablets	- Orally	- Tablets/pills, cut with other (unknown) substances
Cocaine	Stimulant	- Powder	- Snorted - Injected	- Points (0.1g) - Grams - Can be cut with other (unknown) substances
Hallucinogens	Hallucinogen	- Magic mushrooms - LSD	- Eaten raw or chewed - Added to food - Brewed in a tea - Swallowed	- LSD sold in perforated sheets
Meth-amphetamine	Stimulant	- Ice (translucent crystals/shards) - Base (white/ brown gummy substance) - Speed (white/off-white powder)	- Smoked (glass pipe), injected - Swallowed, injected - Snorted, swallowed, injected	- Points (0.1g) - Grams - Can be cut with other (unknown) substances

	What is it?	What forms are most common in Australia?	How is it usually administered?	How is it sold?
Inhalants:				
-Volatile solvents - Aerosols -Gases -Nitrites	- CNS depressant - Stimulant	Numerous (e.g.): - petrol, paint, glues - spray paint, deodorants - butane, nitrous oxide - amyl, butyl	- Inhaled	- Various
Heroin	CNS depressant	- Fine powder - Granules/rocks - White/off-white/brown	- Snorted - Smoked - Vapours inhaled - Injected	- Caps (small amount) - Grams
Ketamine	Dissociative general anaesthetic	- Liquid	- Powder snorted - Dissolved and swallowed - Injected	- Bumps (small amount of powder) - Grams
GHB	CNS depressant	- Liquid (clear), sometimes with blue colour added	- Orally	- Vials - Bottles - Fish-shaped soy sauce containers
Benzodiazepines	Sedative	- Tablets, capsules, pills	- Orally - Injected	- Tablets - Capsules



Heroin

- Usually injected, but can be smoked, snorted, or heated and the vapours inhaled ('chasing the dragon')
- Sold in 'caps' (small amount) or grams
- Can be sold cut with a range of unknown substances
- CNS depressant



Darke (2016) Heroin, NDARC Fact Sheet Series UNSW

Effects of heroin (3-5 hours)

- 'Rush'
- Small ('pinned') pupils
- Drowsy, slow, sluggish
- Feeling of warmth, relaxation, contentment, followed by feeling sedated
- Euphoria or 'high'
- Feeling detached
- Nausea or vomiting
- Dependence including withdrawal if use is stopped
- Coma
- Overdose (including death)



Darke (2016) Heroin, NDARC Fact Sheet Series UNSW

Risks of heroin use

- Physical health:
 - Blood-borne viral infections (e.g., Hepatitis B, HCV, HIV)
 - Lung infections, endocarditis
 - Overdose
- Long-term risks:
 - Dependence
 - Dental problems (dry mouth)
 - Higher risk of dying from suicide or trauma (accidents, assaults)
- Psychological health and social risks:
 - Family and relationship issues
 - Legal issues
 - Isolation from friends, family and community

Darke (2016) Heroin, NDARC Fact Sheet Series UNSW

Overdose

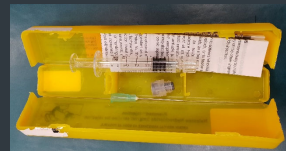
- CNS depressant
 - Accidental overdoses common
- Increased risk of overdose:
 - Use of other depressants (e.g., alcohol, benzodiazepines, other opioids), and some antidepressants (e.g., tricyclics), or stimulants (e.g., cocaine/methamphetamines)
 - After abstinence (e.g., release from prison or long-term treatment)
 - Previous overdoses
 - Use alone
- Signs of overdose:
 - Extreme drowsiness, can't be woken
 - Slowed breathing and HR
 - Cyanosis (lips/fingers)
 - Low BP
 - Hypothermia

Can be reversed with Naloxone if caught in time, but there are still risks of permanent health problems

Darke (2016) Heroin, NDARC Fact Sheet Series UNSW

What you can do

- Promote harm minimisation (for eg)
 - Never use alone
 - Smoke or snort rather than inject
 - Use clean injecting equipment, don't share
 - Don't mix substances
 - Carry naloxone and do brief training on how to use it
- Naloxone/Narcan available over the counter
- S3 medication (400mcg pre-filled syringe; 400mcg ampoule), also available on PBS as S4



Treatment for heroin dependence

- Opioid substitution treatment (methadone, buprenorphine, suboxone, naltrexone)
- Residential rehabilitation
 - Living in a drug-free residence following detoxification
 - Can be short (1 month) or longer (3-6 months)
- Counselling
- Withdrawal management
- Evidence supports **long-term, stable treatment**
- Detoxification as gateway into treatment (not treatment in itself)

Darke (2016) Heroin, NDARC Fact Sheet Series UNSW; Teesson et al, (2015) *Addiction*, 110; 986-993



Methamphetamine

- Synthetic stimulant manufactured from pseudoephedrine and other chemicals
- Amphetamine use was common in Australia until the late 1990s, when replaced with methamphetamine
- Crystalline form usually not cut with other substances, but can contain impurities from manufacturing process
- Powder form typically diluted

McKetin (2016) Methamphetamine, NDARC Fact Sheet Series UNSW

Effects of methamphetamine use

- Rapid if smoked or injected (minutes), slower if snorted or swallowed (within ~30mins)
- Dilated pupils
- Talkativeness
- Confidence
- Inability to sleep
- Reduced appetite
- Dehydration
- Rapid HR
- Restlessness, agitation
- Paranoia
- Hallucinations

McKetin (2016) Methamphetamine, NDARC Fact Sheet Series UNSW

Risks of methamphetamine use

- Physical health risks:
 - Weight loss, dehydration, malnutrition, exhaustion
 - "Meth mouth": dental cavities, cracked teeth and gum disease from poor dental hygiene, dry mouth and grinding teeth
 - Cardiovascular problems and stroke from elevated HR and BP
- Kidney problems, including kidney failure from dehydration
- Lung problems including pulmonary oedema
- Infective endocarditis, from dirty injections or abscesses
- Skin sores and abscesses from skin picking
- Risk of blood-borne viruses (Hepatitis C, B and HIV) from injecting

McKetin (2016) Methamphetamine, NDARC Fact Sheet Series UNSW

Risks of methamphetamine use

- Mental health risks:
 - Dependence, especially with smoking or injecting and with regular use
 - Episodes of paranoia and/or hallucinations
 - Depression, especially when coming off the drug
 - Anxiety and panic can be worsened by the stimulant effects
 - Agitation and irritability
- Longer term effects:
 - Impaired brain function, which can manifest as poor concentration and memory, ability to regulate emotions, movement problems
 - Unclear how long these persist after giving up
 - Some evidence of risk of heart failure and stroke

McKetin (2016) Methamphetamine, NDARC Fact Sheet Series UNSW

Treatment for methamphetamine

- Evidence indicates the best approaches for methamphetamine dependence are structured psychological and behavioural therapies (CBT and CM)
- Other treatment options include:
 - Detoxification (or withdrawal management)
 - Residential rehabilitation (or therapeutic communities)
 - Outpatient counselling
- Better outcomes for long-term treatment, beyond detoxification (relapse less likely)
- Dexamphetamine pharmacotherapy in the NSW Stimulant Treatment Program → no conclusive evidence

McKetin (2016) Methamphetamine, NDARC Fact Sheet Series UNSW



New and emerging psychoactive substances (NEPS)

- **New Psychoactive Substances (NPS):** Substances not controlled by 1961 Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances, but pose similar public health threat
- **Emerging Psychoactive Substances (EPS):** Relatively new to the market, as well as those which have a resurgence or increase in popularity
- Synthetic/designer drugs
- Legal/herbal highs
- Research chemicals
- Analogues
- Bath salts
- Synthetic cannabinoids, stimulant and psychedelic NEPS most common in Australia



Sutherland & Barratt (2016) NPS, NDARC Fact Sheet Series UNSW

Effects of NEPS

- Wide range of health risks depending on the chemical composition:
 - Agitation
 - Nausea
 - Hyperthermia
 - Cardiovascular problems
 - Tachycardia
 - Organ failure
 - Seizures
 - Psychiatric problems
 - Metabolic acidosis
 - Paraesthesia

Sutherland & Barratt (2016) NPS, NDARC Fact Sheet Series UNSW

Are NEPS legal to use in Australia?

- Complex issue
 - Most Australian jurisdictions (incl. Qld, NSW, SA, WA) have introduced legislation to ban possessing or selling any substance that has a psychoactive effect (excl. alcohol, tobacco or food)
 - Others play catch up, adding new NEPS regularly to the banned list
- Regardless of legality, high risk of harm

Sutherland & Barratt (2016) NPS, NDARC Fact Sheet Series UNSW

What to do if your patient is using NEPS

- Best way to avoid harm is to avoid using NEPS
- However, people will likely still use them: i) ease of access, ii) lack of screening for them, iii) being sold as traditional substances (i.e., cocaine, LSD, ketamine)
- Take a harm reduction approach:
 - Don't use alone
 - Try not to be the first in a group to try a new/unfamiliar product
 - Start with small dose, wait at least an hour before consuming intended dose/redosing
 - Use one drug at a time
 - Let someone know what you've used
 - Avoid NEPS when there are pre-existing cardiovascular conditions

Bright (2014) New drugs, old tricks, Treatment Guidelines for NEPS



Benzodiazepines

- Commonly prescribed for anxiety or insomnia
 - Anxiolytic, sedative, muscle-relaxing effect
 - Often referred to as 'benzos'
 - Most well known are Valium, Xanax
- Depressants
 - Cause feelings of relaxation, mild contentment, sedation
 - Take about half an hour to take effect

Nielsen (2016) Benzodiazepines, NDARC Fact Sheet Series UNSW

Effects of benzodiazepines

- | | |
|---|---|
| <ul style="list-style-type: none">● Immediate (~1/2 hour)<ul style="list-style-type: none">● Muscle relaxation● Decreased HR● Feeling of calmness● Drowsiness, sedation, dizziness● Shallow breathing● Slurred speech, blurred vision● Confusion● Loss of balance and coordination● 'Hangover' the next day● Blackouts | <ul style="list-style-type: none">● Long-term<ul style="list-style-type: none">● Dependence● Aggression or violence● Skin or vein problems if injected● Withdrawals (→ seizures and death if not well managed)● Blackouts● Overdose (added risk when combined with other depressants)● Sedation |
|---|---|

Nielsen (2016) Benzodiazepines, NDARC Fact Sheet Series UNSW

Risks associated with benzodiazepines

- Polysubstance use, particularly depressants (e.g., alcohol, antihistamines, opioids, tricyclics, gabapentinoids, antipsychotics)

→ Be aware of other depressants being used and/or prescribed

- Abrupt cessation can lead to withdrawal seizures

→ Follow RACGP Guideline recommendations for tapering withdrawal on an individual basis

<https://www.racgp.org.au/your-practice/guidelines/drugs-of-dependence-b/>



Cannabis

- Derived from cannabis plant
- Active ingredient is delta-9-tetrahydrocannabinol (THC) → potency varies between plants
- Smoked in hand-rolled cigarettes (joints), waterpipes (bongs), or eaten



NCPIC (2011) Cannabis, NDARC Fact Sheet Series UNSW

Effects of cannabis

- Short-term:
 - Feeling of well-being
 - Talkativeness
 - Drowsiness
 - Loss of inhibitions
 - Decreased nausea
 - Increased appetite
 - Loss of coordination
 - Dryness of eyes, mouth and throat
 - Anxiety and paranoia
- Long-term:
 - Increased risk of respiratory diseases
 - Decreased memory, concentration and learning abilities
 - Decreased motivation in study and work
 - Risk of mental health problems
 - Risk of dependence

NCPIC (2011) Cannabis, NDARC Fact Sheet Series UNSW

Treatment options for cannabis dependence

- Psychological:
 - Lack of good-quality research
 - In general, reduce frequency of use and severity of dependence
 - CBT with motivational-enhancement therapy
 - Abstinence-based incentives
- Pharmacological:
 - Lack of good-quality research
 - Some potential for preparations containing THC, but more research needed
 - Gabapentin, N-acetylcysteine promising, efficacy still unknown
 - Antidepressants, bupropion, buspirone, atomoxetine → little value

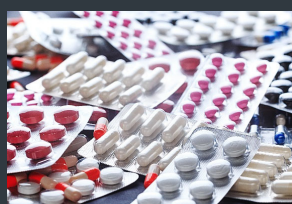
Gates et al, (2016) Psychosocial interventions for cannabis use disorder, Cochrane Database of Systematic Reviews, 5
 Marshall et al (2014) Pharmacotherapies for cannabis dependence, Cochrane Database of Systematic Reviews, 12



Pharmaceutical opioids

● Medications commonly used for pain

- Morphine
- Pethidine
- Codeine
- Oxycodone
- Methadone
- Propoxyphene
- Dextropropoxyphene
- Hydromorphone
- Hydrocodone
- Fentanyl
- Buprenorphine



Nielsen (2016) Pharmaceutical opioids, NDARC Fact Sheet Series, UNSW

Non-medical use of pharmaceutical opioids

- Occurs outside a doctor's prescription
- Includes taking orally outside doctor's instruction, snorting or injecting crushed dissolved tablets
- Can be obtained through:
 - Legitimate prescription from doctor
 - Purchase on illicit market or internet
 - Theft
 - Family or friends
 - Visiting several doctors ('doctor shopping')

Nielsen (2016) Pharmaceutical opioids, NDARC Fact Sheet Series, UNSW

Effects of pharmaceutical opioids

- Immediate effects:
 - Analgesia
 - Euphoria
 - Nausea, vomiting
 - Respiratory depression
 - Constipation
 - Drowsiness
 - Confusion
- High doses:
 - Respiratory depression
 - Circulatory failure
- Adverse effects more likely when taken outside Guidelines for safe and effective use
 - Overdose at higher doses, if injected, used in combination with other sedatives
 - Risks associated with injection

Nielsen (2016) Pharmaceutical opioids, NDARC Fact Sheet Series, UNSW

Treatment for pharmaceutical opioids

- As with heroin, methadone and buprenorphine (+/- naloxone) are effective for pharmaceutical opioid dependence
- Longer-term, stable treatment positive outcomes
- No difference in treatment retention or opioid use between methadone and buprenorphine
 - Patient preference, stigma issues, accessing treatment, potential drug interactions
- National Guidelines for the use of medication assisted treatment for opioid dependence:

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/ng-mat-op-dep>

Nielsen (2017) FAQs on opioid agonist treatment for pharmaceutical opioid dependence: An evidence summary, NDARC, UNSW



Alcohol

- Most widely used psychoactive substance in Australia
- Mistakenly thought to be a stimulant → CNS depressant, inhibits many brain functions
- After tobacco, alcohol is the leading cause of drug-related death and hospital admissions
- Alcohol effects vary: depend on gender, age, size, mood, medical conditions, and whether its consumed with other substances

Swift (2016) Alcohol, NDARC Fact Sheet Series UNSW

Effects of alcohol

● Immediate:

- Slower RR and HR
- Drowsiness
- Relaxation, loss of inhibitions
- Loss of coordination, confusion
- Impaired judgment
- Dehydration, nausea, vomiting
- Increased risk of experiencing violence
- Increased risk of STIs or unintended pregnancy
- Increased risk of accident/injury (accidents, falls, fires, drowning)
- Unconsciousness

● Long-term:

- Dependence
- Brain damage
- Cardiovascular problems
- Liver problems
- Cancer
- Increased risk of anxiety and depression
- Increased risk of diabetes and obesity
- Foetal alcohol syndrome

Swift (2016) Alcohol, NDARC Fact Sheet Series UNSW

Alcohol fact or myth?

Standard drinks

POLL: Alcohol standard drinks

www.alcohol.gov.au



Standard drinks

- In Australia, one "standard drink" is a drink containing 10g of pure alcohol
- More information:

<https://ndarc.med.unsw.edu.au/resource/alcohol-0>

<http://www.alcohol.gov.au/Internet/alcohol/publishing.nsf/Content/home>



NHMRC Alcohol Guidelines (2009)

- Informed by research looking at lifetime risk of alcohol consumption for acute injury and chronic disease:
 - 4 standard drinks on one occasion more than doubles risk of injury
 - Injury risk increases by 1.3 times for each additional drink
 - Drinking >2 standard drinks per day increases the lifetime risk of death from an alcohol-related disease >5-fold for men, >6-fold for women

Rehm et al, (2009) Method for moderation: measuring lifetime risk of alcohol-attributable mortality as a basis for drinking guidelines. *Int J Methods Psychiatr Res*; 17: 141-51; NHMRC Alcohol Guidelines 2009
<https://www.nhmrc.gov.au/health-topics/alcohol-guidelines>

NHMRC Alcohol Guidelines (2009)

- No more than 2 standard drinks a day for healthy men and women to reduce the lifetime risk of harm from alcohol-related disease or injury
- No more than 4 standard drinks on a single occasion for healthy men and women to reduce the risk of alcohol-related injury arising from that occasion
- Not drinking alcohol is the safest option for children and young people under 18 years of age
- Children under 15 years of age are at the greatest risk of harm from drinking. For this age group, not drinking alcohol is especially important. For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible
- There is no safe drinking level for women who are pregnant or planning a pregnancy, or for women who are breastfeeding. Pregnant and breastfeeding women are recommended to abstain completely from alcohol

<https://www.nhmrc.gov.au/health-topics/alcohol-guidelines>

Additional challenges



Images sourced from: www.abc.net.au; www.rte.ie; www.bandt.com.au; www.k-message.com; www.hawkesburygazette.com.au

What to do next

- Encourage breaking the cycle of regular drinking (e.g., Feb Fast, Dry July, Sober October, Hello Sunday Morning)
- Publicly available resources (i.e., online or telephone interventions) may be useful for mild disorders
- Specialist AOD services may be needed for more severe dysfunction
- Low GP uptake of long-term alcohol relapse prevention pharmacotherapeutic agents: naltrexone, acamprosate

Pennay et al (2014). Alcohol: Prevention, policy and primary care responses. *Australian Family Physician*; 43: 356-361; Hillgrove et al (2012). Evaluation of the impact of febfast participation: Final report. Melbourne: Victorian Health Promotion Foundation (VicHealth)

Key points

- Numerous types of substances with varying effects
- Can depend on method of administration and other (often unknown) substances cut with
- Be aware of different types of substance used in local area, harm reduction strategies
- Know where to access substance-specific information, management and treatment guidelines

Overview

- What are some of the commonly used substances in our community?
 - What are their effects
 - What to do if substance use is suspected
- How is substance use identified?
 - How to discuss with patients
- Where to access more information



How is substance use identified?

Strategies for discussing substance use with patients

Case study

Elizabeth

- 42-year old finance-manager
- Insomnia
- Practices relaxation techniques before bedtime
- Use to exercise regularly but since recent car accident, exercise reduced



Identifying substance use



Informal assessment



- Semi-structured interview
- Provide non-judgemental, empathetic, confidential environment
- Limits to confidentiality should be explained
- Mental state
- AOD use history
- Risk assessment
- Strengths and weaknesses
- Readiness to change

<https://comorbidityguidelines.org.au/guidelines/>

Mental state examination

- Should not consist of a series of direct questions
- Rather should be based on an overall evaluation of the client during the assessment(s)
- A record of the mental state examination should be completed after (rather than during) conversations with the patient

Page 229:

<https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf>

Mental state examination

- Consists of:

- Appearance
- Behaviour
- Speech and language
- Mood and affect
- Thought content
- Perception
- Cognition
- Insight and judgement

→ May all be affected by intoxication or withdrawal



Mental state examination

- Evidence of AOD use – intoxicated, flushed, dilated/pinpoint pupils, track marks
- Motor activity – immobile, pacing, restless, hyperventilating
- Speech: Rate – rapid, uninterruptible
- Expression: Derailment (unrelated, unconnected or loosely connected ideas, shifting from one subject to another)
- Emotional state: High/elevated – excessively happy or animated
- Heightened or dulled perception
- Attention: distracted, lack of concentration



AOD use history

- Range of substances used
- Quantity, frequency, duration, circumstances of use
- Previous AOD-related problems
- Risk behaviours related to use (e.g., injection as mode of administration)
- Previous treatment attempts (why successful or unsuccessful)
- Understanding of development of AOD use over time, including periods of abstinence, and how these were supported
- Also ask about use of NEPS

Addressing AOD use with patients

- Some clinicians reluctant to address AOD use among patients:
 - Belief that AOD use is normal or a developmental phase
 - Concerned about damaging rapport
 - Belief that patients are unwilling/not ready to change or address AOD use
 - Belief that patients won't be truthful
 - Belief that AOD use is self-inflicted
 - Unsure of what to do if AOD use is reported
 - Assumption that patients do not use AOD
 - Lack of recognition of signs/symptoms of AOD use
 - Sceptical about effectiveness of interventions, and pessimistic about long-term outcomes
 - Lack of time



Asking about AOD use

Ways to ask:

- Open-ended, non-judgmental

Can you tell me about your alcohol/drug use in the past month?

Can you describe a typical/normal day?

Ways **not** to ask:

- Judgemental

Don't you know the harm you're doing to yourself?

- Making assumptions

You don't use substances, do you?



Australian Drug Information Network (ADIN): <https://www.adin.com.au/>

Page 222:

<https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf>

Dos and Don'ts when asking about AOD use

DO:

- ✓ Ask open-ended questions
- ✓ Quantify the amount of AOD use
- ✓ Probe for more specific detail (e.g., beyond 'sometimes', 'not often')
- ✓ Ask about circumstances of use (i.e., risk behaviours, why they use)
- ✓ Be empathetic
- ✓ Be alert and considered

DON'T:

- ✗ Be afraid to ask questions
- ✗ Use stigmatising language (e.g., 'addict', 'junkie', 'user')
- ✗ Ask leading questions (e.g., 'you don't use, do you?')
- ✗ Express any judgement

Lapse \neq Relapse

Standardised screening and assessment



Standardised screening and assessment

- Should be completed upon entry into and exit from treatment, as well as at follow-up
- Provide useful clinical information (for both the patient and clinician) on the patient's case and an evaluation of how effective treatment has been



Standardised screening and assessment

- Provide the patient with the reasons for assessment and the purpose of each instrument
- Explain that it is a standard procedure
- Explain how standardised assessment can be useful in helping patients achieve their goals (e.g., by providing an objective measure)
- Provide appropriate and timely feedback of the results of the assessment

Standardised screening and assessment

- Standardised tools cover a range of areas which may be relevant to health services
- Some require specialist training, or else mislabelling, misinterpretation, or inappropriate use may occur
- Some are copyright protected and need to be purchased, and/or require specific qualifications
- Some are self-reporting (i.e., they may be self-completed by the patient), others need to be administered
- Dearly review of screening tools for use in AOD settings (2009):
 - Comprehensive review of all available screeners and assessment tools, including where to access, costs, validity and reliability
 - Report available for free download here:
http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf

Some useful AOD screening instruments

Instrument	What it assesses	How
CAGE Questionnaire	Problem drinking via 4 constructs (Cutdown, Annoyed, Guilty, Eye-opener)	4 items, Y/N
CAGE-AID	CAGE Adapted to Include Drugs	4 items, Y/N
Michigan Alcohol Screening Test (MAST)	Lifetime problems with alcohol use	24 items, Y/N
Drug Abuse Screening Tool (DAST)	Past 12-month drug abuse	28 items, Y/N
Alcohol Use Disorders Identification Test (AUDIT)	Past 12-months hazardous/harmful alcohol use	10 items, 0-4 scale
AUDIT-C	Brief version of AUDIT	3 items, 0-4 scale
Drug Use Disorders Identification Test (DUDIT)	Past-12 months drug use patterns and problems	11 items, 0-4 point scale

Elizabeth

- Elizabeth's clinician asked about the range of substances used:
 - Prescription opioids to help manage pain
 - Increasing alcohol to help with sleep and pain
- AOD use history
 - Cannabis use in teenage years
- Given AUDIT to complete
 - Scored 12, indicating hazardous or harmful drinking

→Need to ask detailed questions about AOD use

→Informal and standardised screening and assessment techniques can be used

Overview

- What are some of the commonly used substances in our community?
 - What are their effects
 - What to do if substance use is suspected
- How is substance use identified?
 - How to discuss with patients
- Where to access more information

Where to find additional resources and information

More information and resources

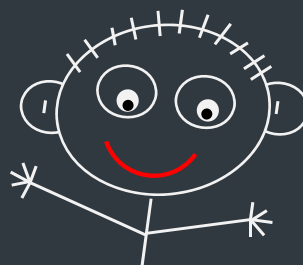
NDARC fact sheet series	https://ndarc.med.unsw.edu.au/RESOURCE-TYPE/FACT-SHEETS
RACGP Clinical Guidelines	https://www.racgp.org.au/your-practice/guidelines/
National Comorbidity Clinical Guidelines	https://comorbidityguidelines.org.au/guidelines/
Review of screening and assessment tools in AOD settings	https://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening%2C_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf
AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care (2 nd ed)	http://www.who.int/substance_abuse/publications/audit/en/
Assessing alcohol consumption in pregnancy with AUDIT-C	http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/wwtk-audit-c
AUDIT-C overview	https://www.integration.samhsa.gov/images/res/tool_aud_etc.pdf

More information and resources

DUDIT manual	https://www.paihdelinkki.fi/sites/default/files/duditmanual.pdf
Michigan Alcohol Screening Test	https://www.integration.samhsa.gov/clinical-practice/sbirt/Mast.pdf
Drug trends monitoring program	http://www.drugtrends.org.au/
Take home naloxone training	https://www.seslhd.health.nsw.gov.au/naloxone-training-supply
Your room – facts about alcohol and other drugs	https://yourroom.health.nsw.gov.au/Pages/home.aspx
Online Ice Toolkit, evidence-based info	https://cracksintheice.org.au/
Positive Choices – information for young people, parents and teachers	www.positivechoices.org.au
Language matters resource	https://nadaweb.azurewebsites.net/wp-content/uploads/2018/03/language_matters_online_final.pdf

In a nutshell

- AOD use is common
- Important that AOD use is identified so that can be managed and treated appropriately
- There is a lot you can do in primary care settings





Thanks for being part of the SNHN-CREMS Webinar Series



Thank you!

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Video recording and handouts of this webinar available at:

<https://vimeo.com/comorbidity>



12 Feb 2019

Substance use and physical health – register here:
https://zoom.us/webinar/register/WN_Dq99v9j9Q9ehOpuOh_CgZg



2019

More on substance use – stay tuned!

To complete CPD assessment (**available until 4 May 2019**):

<https://www.surveymonkey.com/r/M2MB7S6>

Any questions?