Addictions Consultation and Liaison

Treatment and Management of Patients with Substance Use Disorders within the General Hospital

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Part of AlfredHealth
Overview

- Addiction Psychiatry and CL.
- Opioid use disorders within the general hospital
- Amphetamine use disorders and limited contemplation of change
- Complicated alcohol withdrawal
Addictions Psychiatry

Addiction psychiatry is a medical subspecialty within psychiatry that focuses on the evaluation, diagnosis, and treatment of people who are suffering from one or more disorders related to addiction. This may include disorders involving legal and illegal drugs, gambling, sex, food, and other impulse control disorders.
Addictions CL

General Hospital and Mental Health support for management of patients with substance use disorders.

- Intoxication
- Withdrawal
- Maintenance
- Referral for ongoing treatment residential or community
Roles
Addictions CL

Assessment
History
Examination [withdrawal scales]
investigation

Treatment
Brief interventions
Detoxification
pharmacotherapy

Referral
Residential or community services
Case 1

36 year old man admitted to burns unit following ‘overdose heroin’
What do I want to know?
What are the issues?
Case 1

History
Using heroin on and off for years
Lately IV 2-3 times per day ‘a gram or two’
Prior ORT methadone 80mg per day off for 6 months
Last used day of admission [yesterday]
Pain ++++ burn to scalp fell unconscious infront of fire
Nausea, snuffles, diarrhoea
Wants to leave cravings for heroin and cigarette
Case 1

Issues
Medical/surgical
Pain
Withdrawal
Engagement/collaboration
Psychiatric
Case 1

Psychiatric Assessment
Pain / Withdrawal
NRT
Case 1

Pain
Withdrawal
NRT

Opiate what are options?
Short acting
• Oxycodone, morphine, hydromorphone.
Long acting
• Oxycontin, Targin
Opiate Replacement methadone buprenorphine
Case 1

Acute Pain service review

Commenced methadone 15mg bd
Breakthrough oxycodone 10-20mg 2/24 max 100mg / day
Regular review with methadone increased 10mg/d every 2 days
More settled

Skin grafts
Opiate Agonist Therapy (OAT)

**Buprenorphine**
Partial agonist long T1/2
Sublingual/parenteral/dermal
ORT dose 2-8mg daily
Precipitated withdrawal

**Methadone**
Synthetic opiate
Long T1/2
25-40mg dose
Missed dose lose tolerance if 4 days or more
Case 1

Day 3
Code grey
Wants to leave ward for cigarette but has IV in situ
Nurse calls team
Can’t leave ward unless IV out

What to do?
Case 1

Patient granted leave for cigarettes

Things going well

Graft healing
After smoke break RTW collapse

MET call What is cause?
Case 1

MET unresponsive low BP fever
OD?
Sepsis?
Case 1

Fever
Hypotensive
Murmur

Bloods anaemia, CRP+++ 

ID team think it may have IBE
Arrange blood cultures TOE
Case 1

Staph aureus IBE vegetation
Will need minimum 6 weeks IV AB

PIC line
Flucloxacillin 6/24

Complains of boredom
Graft healing
Increasing leave
Case 1

Fails to RTW after 5 hours

What to do?
Case 1

Returns to ward after 8 hours got caught up at home
Redirected to ED
Night in ED then back on different ward
Case 1

After another few days
PIC line in

Wants to go home for HITH care

What are the issues
Case 1

Risk
To self
To staff
PIC line
ORT
Case 1

HITH not willing to visit at home
Daily attendance to clinic
OT dispensed (cost saving to M)
Continues with treatment
Discharged after 6 weeks AB
Community prescriber recontacts
Referral to community AOD services
Harm Reduction
More than sterile injecting equipment
Case 2

• 42M admitted under plastics for treatment of cellulitis of his L) lower leg.

• Concern raised from Plastics that he is presenting as suspicious, agitated and difficult to engage around medical treatment.

• Unable to obtain any collateral from family or friends, as he continues to report that they are “all part of the problem”.

• No previous history of involvement with mental health services (CMI check).
• Restrained initially in ED due to level of agitation but settled quickly after 10mg of Droperidol.

• Request for ongoing CL Psychiatry given level of psychotic beliefs expressed whilst in ED and suspected crystal-methamphetamine use (although initially denied any substance use).

• Agitated and aggressive for the first 24 hours.
• Next 48 hours presented as drowsy, sedated and irritable.

What do you do next?
Case 2

- Crystal-Methamphetamine:
  - 4-5 points p/day.
  - Increased use over the past 6 months in response to relationship breakdown.
  - Previously used to smoke intermittently with friends and prefers to use speed, no longer able to source.
  - Switched to using intravenously just after his relationship broke down.
  - Attends a local pharmacy to collect fit packs.

- Denies all other substance use.

- No previous involvement with AOD services.
  - Not aware of what is available but also does not believe that he needs ongoing follow up.
  - Adamant that he is going to be able to abstain without support.
  - Stating that this is what he needed to “turn things around”.

- Review of injection: majority clustered around L) cubital fossa.
Case 2

- Now requesting to be discharged. The home team is unsure about this given his M/S and have contacted CL Psychiatry for further advice.
- No evidence of ongoing paranoid ideas and M/S appears to have improved significantly.
- No evidence of ongoing acute mental health changes.
- No evidence of significant physiological withdrawal.
- Continues to decline any support to access ongoing AOD treatment.
- No clear role for CL Addictions.
- Limited social supports.
- Living in OOH in St. Kilda.
- On New Start Allowance.
- Developmental Hx not explored, but the client has alluded to a disrupted upbringing and early drop out from high school.

What do you do?
What are your concerns?
Intravenous Substance Use

- High risk of relapse to use on d/c.
- High risk of further infections / DVT / complications associated with use given poor understanding of harm reduction strategies.
- High risk of further psychotic episodes if relapses to use.
- High risk of loss to follow up.

Interventions:
- Discuss changes to tolerance after abstinence whilst in hospital.
- Encourage test dosing after periods of abstinence or if going to a new dealer.
- Provide education around where to access local NSPs and what the NSP can offer vs. a pharmacy.
- Discuss filter utilisation, is he even using filters?
- Discuss importance of rotating sites of injection.
- Explain risk of future episodes of psychosis.
- Encourage discussion with local NSP about vein care, how to find veins and what to do if he is struggling to find veins.
- Ensure BBV testing is discussed.
- Encourage keeping one vein for emergencies.
- Short term anti-psychotics.
Approaches

**Supply reduction:** To disrupt the production and supply of illicit drugs.

**Demand Reduction:** To prevent uptake of harmful drug use.

**Harm Reduction:** Encourages those who are going to use drugs to do so as safely as possible.
General Principles

- Injecting
- Smoking
- Snorting
- Swallowing
Harm Reduction

Focus of the harms of the substance and how to promote safer use, rather than the legal status of the drug being used.

Alcohol is associated with the highest level of harm out of all substances, followed by tobacco then cocaine (Nutt, 2012).

“Drug treatment is far more cost-effective than prohibition” (Davies et al. 2009)
Needle Syringe Programs

- Developed as a result of the HIV/AIDS pandemic in the 1980s.
- First NSP in 1986 was illegal (Darlinghurst, NSW).
- Australia continues to expand NSPs due to recognition of the positive impacts with reducing transmission of blood borne disease.
- NSPs remain criminalised in some countries in favour of more punitive approaches.

- 2013-2017: Prevalence of HIV among PWID remains low (1.4-2.1%).

- By the end of 2000, NSPs had prevented an estimated 25,000 cases of HIV, 21,000 cases of Hepatitis C.
- By the end of 2010, 4,500 deaths associated with AIDS and 90 deaths associated with hepatitis C have been prevent due to NSPs (DHHS, 2018).
Needle Syringe Programs

- 584 NSPs listed with DHHS in Victoria.

Primary NSPs

• Provide a point of access to a range of health care services (e.g. social work, AOD counselling, legal support, general health care etc).

• Range of injecting equipment is provided based upon substances being used.
Dispensing Machines

- At least 22 operational dispensing machines across the state.
Medically Supervised Injecting Centres (MSIC)

- Originated in the 1980s in Europe.
- First safe injecting room was in Switzerland.
- Some of the first safe injection rooms in Canada and Europe have now been shut down due to the controversy created.

Sydney Medically MSIC 2001 - 2015:
- More than 965,000 supervised injections.
- Management of more than 5,925 overdoses without a single fatality.
- 70% of people attending have not accessed any local health care services prior to attending.
- Ambulance call outs to Kings Cross have reduce by 80% since opening.
- More than 12,000 referrals have been made to external health and social welfare services.

North Richmond MSIC:
- Opened 30/06/2018.
- Email msir@nrch.com.au for tours
- 07/2019 Phase 2 of building completed and expansion of the MSIC / NSP.
- Mon-Fri 0700-2100
- 04/2019: Average 200 visits p/day.
- 650 over doses successfully managed since opening.
- 2200 individuals have registered to use the facility.

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Take-Home Naloxone

- Not just for PWID.
- Recommended for anyone using in excess of 100mg OME.
Stigma

**Junkie:** A drug addict. A person with a compulsive habit or obsessive dependency on something, “power junkies”.

**Addict:** A person who is addicted to a particular substance, typically an illegal drug.

**Drug Seeking:** “A frequently used term that is poorly defined”
(McCaffery et al. 2005)
Alcohol related complications in withdrawal

Megan McKechnie
Addictions Clinical Nurse Consultant
Addictions CL Service
Case 3

- 60M admitted under general medicine after falling whilst acutely intoxicated.
- Small lac on forehead, otherwise no other clear injuries.
- Admission due to concern regarding odd behaviour and an inability to ambulate.

- Referral to CL Psychiatry due to increasing concerns about aggression and need for involuntary treatment.
- No formal CMI Hx.
- Multiple presentations to ED in the context of acute intoxication on alcohol.

- On arrival, the patient is trying to get out of bed and is not making sense.
- Diazepam 160mg last 24/24 in PRN.
- Commenced on Quetiapine 25mg BD PRN by Gen Med.

- Bilirubin 40
- ALT 1201
- AST 1764
- GGT 291
- ALP 155

- Platelets 107
- INR 1.9
- Lipase 10
- MCV 107
Case 3

- O/E: diaphoretic, flushed face, leaning against the wall, not able to ambulate independently, not making sense, perseverative, nystagmus, no evidence of flap, appears distracted.

- Scoring 13-20 on AWS.

What do you do next?
Wernicke’s Encephalopathy

- Occurs as the result of biochemical lesions of the central nervous system due to depletion of thiamine (vitamin B1).

- If left untreated, can progress to Wernicke-Korsakoff syndrome.

- Characterised by a triad of symptoms:
  - Ophthalmoplegia (most commonly lateral nystagmus)
  - Ataxia
  - Confusion

- Treatment is via assertive thiamine replacement.

- Intravenous / Intramuscular 200-300mg TDS for the first 3/7, then de-escalate based upon clinical response.

- High risk: 500mg IV TDS

- Diagnosis via MRI-B
Delirium Tremens

• Rapid onset; 24-72 hours post last drink of alcohol.

• Characterised by usual symptoms of severe alcohol withdrawal and acute confusion, disorientation, perceptual disturbances, fever, hypertension, tachycardia.

• Typically perceptual disturbances are associated with the individuals environment (e.g. patterns on the wall, seeing animals / insects).

• Assertive benzodiazepine treatment (may require >150mg Diazepam in 24/24, equivalent 900mg Oxazepam).

• Anti-psychotic; preference for Haloperidol
Case 3

• You return the following day.
• Ongoing fluctuations in presentation.

• GGT is getting worse, otherwise LFT is improving.
• Blood alcohol level is increasing
  • Had fallen to 0.00 during your review yesterday, now sitting at 0.174.

What do you do next?
Questions?

- Drug and Alcohol Clinical Advisory Service (VIC) 24/7: 1800 812 804
- Drug and Alcohol Clinical Advisory Service (SA) 0830-2200: (08) 7087 1742
- Drug and Alcohol Clinical Advisory Service (NT) 24/7: 1800 111 092
- Drug and Alcohol Clinical Advisory Service (Tas) 24/7: 1800 630 093
- Alcohol and Drug Clinical Advisory Service (QLD) 0800-2300: 1800 290 928
- Drug and Alcohol Specialist Advisory Service (NSW) 24/7: (02) 9361 8006
  1800 023 687
- Alcohol and Drug Service (ACT) 24/7: (02) 5124 9977
- Medicines Line (National Prescription Medication Advisory): 1300 MEDICINE