Sample AOD cases for discussion

Case 1: Cassie

Themes: Ask, Assess, Advise, Brief intervention, higher risk group.

Cassie is a 19-year-old apprentice hairdresser. She is worried she may have a sexually transmitted infection and wants the 'full check-up' after a 'big night out.' Cassie's alcohol use is increasing. She has a previous binge drinking pattern on the weekends with friends and is now drinking one or two bottles of wine at night to help her relax and sleep. Cassie identifies as a lesbian and has had a recent relationship breakdown. Since the break-up Cassie has been thinking about the severe bullying she suffered in school. She is ruminating, having negative thoughts, and thinking about the previous abuse she suffered as a young child.

Supervisor notes:

- Cassie has presented for an STI check and escalating alcohol use.
- She has previously engaged in binge drinking and now drinks 1-2 bottles of wine per night.
- Cassie is suffering from low mood, possible depression and has a history of child abuse and bullying during her high school years.
- She is contemplative and would respond well to a HEEADSSS screen, motivational interviewing, and a brief intervention.

Discussion points:

- How to start a conversation about alcohol and drug (AOD) use. Normalize and ask permission to ask, link to presenting complaint or comorbidity. For example, "I ask all my patients about their use of alcohol and other drugs, is it ok if I ask you about this?"
- Consider patient's stage of change in AOD use and how to cater your advice.
- How to screen and assess volumes of AOD use:
    - AUDIT-C, ASSIST-lite.
    - Assess: last use, typical amount, dose, route, frequency, duration, effects, the patient's internal stage of change.
- Difference between hazardous or risky drinking versus dependent drinking.
- Motivational interviewing.
- Priority or higher risk groups who use AOD – LGBTQIA+, teens and younger people, those who have experienced trauma, emotional stress.
- Trauma informed care provision.
- HEEADSSS screen: Home, Education, Eating & Exercise, Activities, Drugs and alcohol, Sexuality & gender, Suicide-depression-self-harm, Safety.
- Brief interventions – what they are, how to conduct one using the FRAMES acronym.

Case-related resources available in the RACGP AOD GP Education Resource Library:

Access the RACGP AOD GP Education Resource Library ("The Library") pages on *AOD Screening* and *How to approach patients who don't want help* for more information. The *AOD Resource List* on the bottom of each page has collated resources on the topics of *trauma informed care*, *motivational interviewing*, *language and communication*, *screening tools*, *brief intervention*, and *alcohol*.

Case 2: Lahn

Themes: Harm minimisation – safe injecting practices, safe sex, recreational or party drug use.

Lahn is a 29-year-old accountant who has jaw pain. He has had left sided TMJ pain for the last few months. This is getting worse at night and with chewing. He has never had this before. He finds it worse on the weekends or after a night out. Lahn works for a big accounting firm in the city, is successful and lives by the motto 'work hard, play hard.' On questioning, Lahn admits to using 'uppers' such as ice and cocaine as well as GHB or ecstasy. He uses alcohol or diazepam to 'come down.' He cannot quantify volumes or drugs used. Last weekend an acquaintance injected him with ice during a 'party and play' session. He is worried about HIV and hepatitis and would like an STI check. He has never injected before and does not intend injecting again. Lahn's anxiety is quite high today, his MSE displays pressured speech and fidgeting. Lahn is single and identifies as bisexual.

Supervisor notes:

- Lahn has presented with TMJ dysfunction and for an STI check.
- Recreational illicit poly-drug use binges every second weekend (approx.).
- He is worried about HIV because he was injected with Ice during a recent party & play experience.
- He is pre-contemplative and does not respond well to paternalism.
- Lahn is open to harm minimisation advice on injecting practices, safer-sex, and self-care during polydrug use in the party setting.

Discussion points:

- Assessment of polydrug use in the party setting can be overwhelming. It can be helpful to discuss polydrug use in terms of the effect of each substance (stimulant, depressant, etc.) rather than getting bogged down in the specific substances and quantities.
- "Party & Play" is a term used to describe the consumption of AOD to enhance sexual experience. Risks increase with AOD use, intoxication and with multiple sexual partners.
- Precontemplation with party or recreational drug use is not uncommon. Respect a patient's stage of change and unwillingness to discuss change. If the patient is open to it, discuss harm minimisation, or build discrepancy in an open non-judgmental approach.
- Harm minimisation can include asking about what the patient knows about safe drug use:
    - Encourage Lahn to party with a person he trusts for the night. Discuss safe injecting practices - use new equipment, sharing increases risk of BBV/infection(bacterial/fungal), use alcohol swabs, filters (risk of particulate matter thromboembolism), use small amount of new drug prior to desired volume, avoid poly-drug use, arrange transport to and from event, pill testing not consistent/reliable. Eating well and drinking water - nutrition, hydration, every second drink, drink water.
    - HAV and HBV vaccination. Testing for HCV and treatment.
    - Safe sexual practices: e.g., three monthly testing, HIV, syphilis, Hep B and C serology; gonorrhoea, chlamydia in urine, anal and throat swabs - condoms as barrier against BBV as well as other STIs. Acknowledge the patient's anxiety and fear of contracting HIV, assures testing in a safe and confidential environment. Consider PREP (or PEP if appropriate).
    - Overdose prevention – naloxone IM and IN.

Case-related resources available in the RACGP AOD GP Education Resource Library:

Access the Library pages on *AOD Screening* and *How to approach patients who don't want help* for more information. The *AOD Resource List* has collated resources on the topics of *language and communication*, *harm minimisation*, *brief intervention*, and *other drugs*.

Case 3: Myra

Themes: Chronic pain, opioid use disorder and management.

Myra is a 22-year-old woman presenting to you today with a two-year history of oxycodone use. She was prescribed oxycodone immediate-release 5mg for migraine, after first-line treatments were not effective. Gradually her use of this medication increased from an 'as needed' to daily use. Her dose has increased to its current level of up to 2 boxes of 10 tablets daily (~20 tabs per day), which she obtains from various clinics and pharmacies. Myra has found it increasingly difficult to stop using oxycodone and stressful to maintain a regular supply as many clinics and pharmacies have now refused to see her. When Myra tries to reduce her use, she feels unwell, sweaty, agitated and in pain, with her migraines recurring. Myra is frustrated and 'over it' when discussing her increasing pain and the amount of time and energy going into sourcing the opioids. She does not know what to do next. On systems review, Myra has been trying to conceive for 18 months, has amenorrhoea, low libido, and constipation. She is wondering what her options are, or 'am I a lost cause?'

Supervisor notes:

- Myra is a 22-year-old with a two-year history of increasing use of prescription oxycodone, which is now daily.
- This started with treatment for migraine that she has had for years.
- She has been using up to 2 boxes of tablets daily (~20 tabs per day).
- She has come in for a follow up appointment to get the GP's advice on how to stop.
- She has previously had difficulty weaning her dose.

Discussion points:

- Myra is using oxycodone in a dependent fashion, review criteria for Opioid Use Disorder. She is having withdrawal symptoms, diaphoresis, agitation
- Opioid substitution therapy efficacy. Options include methadone and buprenorphine. The latter is safer, sublingual and can be given through longer-term injectable formats, giving patients more choice.
- Opioids are not recommended for chronic non-cancer pain. There is a risk of hyperalgesia and need for more opioids for pain relief over time.
- Myra's oxycodone dose is the morphine equivalent dose of 150mg and is high-risk of overdose. Discuss use of naloxone.
- Short term opioid-related side effects (sedation, confusion, respiratory depression), long term side effects (Hypothalamic-pituitary-adrenal axis suppression: low libido, infertility, low testosterone, estrogen, sexual dysfunction, osteoporosis. Hyperalgesia, OSA poor dentition, low mood).
- AOD service involvement - clinical advisory service numbers state by state.
- How AOD use impacts the childbearing years; Contraception, preconception counselling and stabilising of SUD/chronic diseases before conception, harm minimisation.

Case-related resources available in the RACGP AOD GP Education Resource Library:

Access the Library pages on *Complex cases and comorbidities, AOD Screening* and *AOD Clinical Advisory Service and S8 Prescribing in your State or Territory* for more information. The *AOD Resource List* has collated resources on the topics of *opioid pharmacotherapy*, *opioid deprescribing*, *care coordination and treatment planning*, *withdrawal management* and *patient resources*.

Case 4: Bill

Themes: Home-based alcohol withdrawal.

(This is a complex case and would suit GPs who are familiar with basic principles of supporting patients who use alcohol and other drugs. Find training on basic AOD skills on the *Access AOD Training* page of the Library).

You are a GP working in an isolated rural community. Bill is a 53-year-old farmer seeing you today to discuss his alcohol use. You have seen Bill a few times and have diagnosed him with a severe Alcohol Use Disorder (AUD). He wakes feeling sick and shaky. Bill also suffers from depression, which you are treating in parallel with his AUD. You have made a problem list for Bill, collated over four visits, including a mental health care plan. Bill's depression is responding well to an SSRI you have prescribed.

Today Bill is feeling defeated. He has reduced his intake to 4-6 full strength stubbies after work plus 1-2 whiskeys (half glass), but he feels physically unwell, and cravings are too severe to reduce further. Bill is upset as the drinking is impacting his work and relationships. He is trying to avoid the pub as much as he can. You discuss with Bill the pros and cons of slowly cutting back versus a planned withdrawal. You both agree a medicated at-home alcohol withdrawal is a good option. Cheryl, Bill's wife is supportive of this plan.

Bill tells you about Cheryl's cousin that would keep diazepam on hand when he needed to 'detox' or in the event he could not afford 'booze.' Bill asks if he can have a script for diazepam and just 'see how he goes.' He reassures you that "If I'm feeling sick or shaky, I'll take a pill." You open discussion on what an at home alcohol withdrawal program looks like.

Supervisor notes:

- Bill has presented to discuss home-based alcohol withdrawal (with completed assessment tools).
- He is currently drinking 6 x full strength stubbies and 2 whiskies per night (=10.4 standard drinks per night), waking feeling sick and shaky.
- He has recently started an SSRI for depression and anxiety.
- He is in the 'action' phase of the stages of change model.
- His wife and children who live with him are supportive of Bill's planned withdrawal.

Discussion points:

- Use the four-step process to plan an alcohol withdrawal; 'Who, Prepare, Withdrawal and Follow up.'
- Describe how to determine eligibility for home-based alcohol withdrawal. Consider the inclusion and exclusion criteria as well as assessment tools to assist you in this process.
- At the end of the consult, the patient asks if he can have a script for diazepam and just 'see how he goes.' Discuss how benzodiazepines work (cross tolerant with alcohol, effective symptom relief), risk of sedation and overdose with polydrug use, that they're only indicated during the withdrawal week, when to call the practice, when to attend the clinic and when to attend the emergency department.
- Thiamine is given at least 2-3 weeks prior to planned withdrawal and continued throughout in high dose supplementation.
- The withdrawal should occur over the course of a week. Discuss necessary tests and reviews as well as the importance of aftercare, to ensure a safe home-based withdrawal.
- Factors that would prompt you to refer Bill to an Alcohol and Other Drugs inpatient withdrawal unit include not having access to a support person and safe housing for the first few days, a history of withdrawal seizures or delirium, problematic poly-drug use, suicidality, serious concurrent illness.

Case-related resources available in the RACGP AOD GP Education Resource Library:

Access the Library pages on *Complex cases and comorbidities* and *AOD Clinical Advisory Service and S8 Prescribing in your State and Territory* for more information. The *AOD Resource List* has collated resources on the topics of *alcohol*, *care coordination and treatment planning*, *withdrawal management*, *patient resources* and *rural health*.