# GP LINK Lunches | Dr Jennifer James

**Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.**

Dr Jennifer James

Dr Ken McCroary

Ken McCroary - Dr Jenny James is a GP VMO in the general practice drug and alcohol advice and support service of South Western Sydney Local Health District who contacted Sydney South West GP Link earlier this year as part of our advocacy for local GPs in regards to opioid treatment and accreditation course she was running for GPs and other prescribers in Liverpool.

The drug and alcohol services continue to be an important part of dealing with the ongoing issues of drug and alcohol addiction. These are foremost issues for primary health care and can sometimes be quite a complex area to manoeuvre through for both the doctor, patient, family, and support networks. I thought it would be a great opportunity to spend time with Jenny to explore a bit more about what she and the service do and what they can offer for support of the local GPs and general practices in South Western Sydney.

Drug and Alcohol issues have not escaped the ravages of the COVID pandemic and associated mental health sequelae of the infection, so, I really appreciate the opportunity to discuss drug and alcohol services in the region with you today Jenny and thank you for the work you are doing.

Jenny has enjoyed working as a general practitioner for many years and works with the General Practice Drug and Alcohol Support Service at South West Sydney Local Health District. She previously worked at the Mt Druitt Aboriginal Medical Service for 23 years and coordinated the activities of the Substance Misuse Program within the Aboriginal Medical Service. She has a Master's degree in Psychological Medicine and has been a GP supervisor for many years. Her interests include mental health and addictions, teaching and mentoring fellow GPs, continued life-long learning, and program planning to encourage integration of physical, mental and drug health care.

In 2018 Jenny's life changed dramatically when her beloved son Aidan died from a sudden unexplained cardiac arrhythmia. This unfathomable loss fueled a drive to find the ways forward that allow people to continue living with deep purpose and love after grief and trauma. Though this is an interest that all of us would rather not have to have, Jenny is nonetheless keen to share coping strategies with GPs who are building skills in patient care in this area, or indeed, GPs who have experienced adversity in their own lives.

Ongoing long term commitment to GP wellbeing is one of the special commitments of GP Link and hearing from someone with lived experience dealing with such extreme tragedy I think is a great opportunity for us to reflect on our own wellbeing and functional coping strategies.

**Ken McCroary - Jenny can you explain the GP drug and alcohol advice service please?**

**Jenny James -** Yes sure, well I am a GP and I started working for South Western Sydney Drug Health Services at the end of 2017 it was a new project that was funded by South Western Sydney Primary Health Network. When we started I was funded to take the position as a GP within drug health services to lead the direction of a project that would assist GPs working in this area.

When we commenced we also had a clinical nurse consultant as part of that team and also offered a part time position for a GP registrar. And since we have started we have extended the team a bit and we have also got a second CNC working as part of that team. So basically the underlying philosophy that really drives me forward with this is to always ask that question what can we do to assist GPs in their quest to provide best possible care to their patients who have got drug and alcohol issues?

That is the prime driving philosophy. It is about assisting GPs to do the job that GPs really want to do and to provide that assistance in the most hands-on and practical way, and in fact for the shape of that, what that assistance is to be kind of largely driven by the feedback that we get from GPs with GPs telling us what they find is helpful and not helpful.

So when we started we started one component as a district-wide helpline so that is a phone that one of the CNCs carry with them all the time and it is available for any GP or Practice Nurse to call Monday to Friday excluding public holidays between 9.30am and 5pm and the CNC will answer that call straight away and our service has sort of been driven a lot by the kinds of calls that we initially got from that so what we found when we started is that I didn't know what kinds of things GPs might ring about. But very quickly it became apparent that what GPs wanted was they would often have just completed a consult or they might have been part way through a consult with someone with pretty complex set of clinical issues and substance issues were part of that and quite often there were other sort of co-morbid things going on so often major mental health issues, often sort of physical co-morbidities and the nature of the drug and alcohol issues is usually pretty complex so GPs would be ringing saying 'I am in this situation now I am really just not sure what to do so can you give me immediate advice of this'.

So what we often found was you could give the quick advice to sort of move things along but pretty much what is often needed is we need to come in and offer to do a really comprehensive drug and alcohol assessment so what our nurse often does is she will collect as much information as she can from the GP and with patients' permission might say look 'I would like to call that patient back and we can chat over the phone' and she might spend an hour talking to the patient over the phone doing a really comprehensive history and getting down to a lot of the nitty gritty and then we will come back and talk as a team and decide on what that next step is.

Now sometimes it might lead to us needing to link that patient up with some internal drug health services that we offer at the specialist health service and one of the most common might be and what the patient wants and what the best way forward might be admission into the withdrawal unit but often the next thing that might be needed is actually a discussion back with the patient and the GP about possible options and what we do next.

So we will offer case conferencing, so that means the patient goes back to see their GP and then that GP will call myself and the CNC and we will link up in a Medicare style case conference we do with that GP and discuss what we are going to do next and quite often there will be sort of motivational interviewing going on, information about harm minimisation, supportive counselling so we will be moving into that treatment and finding away forward for the patient.

So that is what happens with the helpline. A lot it ends up being a vehicle to kind of allow us to come in and I guess keep the GP in the drivers seat and bring the patient and the GP and ourself together it is a bit different to that traditional outpatient model where you might refer someone to an outpatient services and they get a review and they come back so this is actually us doing it together and we have found that patients often love it.

GPs often love it because they are often picking up sort of new skills as well. So we have been able to work with things like if a GP has wanted to assist a patient an ambulatory withdrawal from alcohol, so if a patient is on that more kind of lower risk end of dependence and they are suitable for withdrawal in the general practice setting and the GP is keen to do it and the patient says yes that sound great. We can offer that really hands on assistance that involves the GP we are sort of working alongside with them side by side to sort of see that patient through that treatment. And then GPs often love it to because they feel that they have gained another skill and they have been able to add that to their tool kit of things that they feel a little bit more confident about. So that is the kind of helpline, case conferencing model we use and those separate comprehensive drug and alcohol assessments and we also offer a GP Registrar term that we offer with us we are keen to get people to sort of spend some time with us and take those skills back into a general practice setting and get ourselves involved in supporting local education events for GPs in that drug and alcohol space as well.

**Ken McCroary - I will come back to this later but whilst it is fresh what is the phone number?**

**Jenny James -** Yes sure, good one let me just grab it for you **0455 079 436.**

**Ken McCroary - Great, thank you**

**Jenny James -** Yes, so really what I want to emphasize it doesn't matter how big or how small the issue is, how simple or how complex, if it needs a bit of short immediate advice or if it is looking as if it actually pretty messy and needing a huge amount of support and it doesn't matter what substance we are very keen to be involved.

**Ken McCroary - Yes, I really like hearing about these collaborative approaches and the case conferencing and how everyone is included in working together to get the best outcome for the patient that sounds impressive. We also chatted earlier about the opioid treatment accreditation that you guys were introducing in South West Sydney a little while back can you tell me a bit about that program as well?**

**Jenny James -** Yes, the vast majority of GPs probably have little experience working in that space and then there is this kind of really small group of GPs who have done the accreditation course run by Sydney University and NSW Health and that is called the OTAC accreditation course. It basically involves one day of training and that can be face-to-face or sometimes it is in a virtual interface. Then there is a 3-4 hour clinical placement where a GP, and it is not just for GPs you often get psychiatrists or nurse practitioners or you even get nephrologists doing the course, and they spend just half a day at a drug health service with a staff specialist basically it is often see one ,do one, teach one model so they have been observed doing consults with patients who are on methadone and buprenorphine. We did recently co-facilitate with Richard Hallinan one of the staff specialists and Drug Health Services and we run one locally at Liverpool and did attract a few more local GPs which was great.

So where we did most of our work was actually with GPs who are not interested they don't want to do the OTAC course and become accredited they don't really want to be taking on 50 patients at their practice and prescribing methadone and buprenorphine but what they do want often is to be able to look after their own patient so they might have been seeing a patient for a long time they find that their patient has got opioid dependence and they like the idea of them being involved in that persons care and they might have two or three patients like that.

We work in that space a lot so with GPs who are not going to go through that accreditation course but definitely are under NSW guidelines able to prescribe to up to 20 patients on buprenorphine and 10 patients who are on very, very stable methadone treatment. So we have been working in the buprenorphine space so quite often the way it works is a GP is seeing a patient with a really complex prescription opioid problem and they are not sure whether the patient is opioid dependent or not as a complexity of issues not quite sure exactly how to call that and make that diagnosis so we will come in with a comprehensive substance assessment and feed that back to the GP and we will discuss what the best way forward is and if that patient is opioid dependant we will discuss that with the patient and see what they would like to do and you know obviously opioid treatment has got loads and loads of research evidence behind it being excellent treatment for opioid dependence and buprenorphine in particular I think is suitable for GPs with not necessarily a background in this area to prescribe.

So then we will discuss with that GP whether they would like to prescribe that treatment for the patient and then we will also discuss with them whether they would like us to assist them with commencing that treatment at their general practice which is possible we have done that with some GPs who have never done it before. Or the other thing we can do is we will commence treatment at our drug health services and stabilise the patient on treatment and that usually doesn't take long, usually 2-3 weeks to get them on that right dose of buprenorphine and sometimes they go onto in injectable, and at that stage we can transition the patient back to GP care when they are on their stable monthly injection of buvidal . We will set up a case conference with that GP where the patient goes back to see their GP in their rooms and we will do all the liaising with the pharmacy we will do the liaising with the pharmaceutical regulatory unit because it is a little bit of paperwork around it which I know is just kind of messy if you know you are not used to what you have got to do.

We will do a long consultation in a case conference where the GP is hearing all about buprenorphine so I will discuss all around how it is given, what are the dosing arrangements, how it works with the pharmacy, what the drug interactions are, what the potential side effects are. Patients will be asking how long I should stay in treatment.

We will talk about all of those sorts of things and so we are kind of driving that consult along but the GP is going side by side. Doctors learn fast and so they are kind of into that space quite quickly and the patients often love it to because they are given all of these details about treatment in a fair bit of detail and they will often say 'oh this is great', 'oh I didn't know that', 'oh that is good to hear how that works'. So, it is a sort of a win win all around and we will stay involved with that GP for as long as they want.

So, if say for example started giving buprenorphine to one of their patients and we have done the case conference they might say at that point ok thanks I am right to go now and I have got your helpline number so I know I can ring you if I need to. Or they might say oh look would you mind, could we have you along for the next couple of consults as well and that is absolutely fine, so it is completely the GPs call in terms of how much assistance they might or might not want. So, we are working with that group of GPs as I say who are not necessarily are not wanting to take on a huge load of patients, but they do want to be able to work in that space with their own patients and that has been very fruitful working with that group of GPs.

**Ken McCroary - Yes, and the way you guys involve the patients so much in the decision making is really important as well. As you know we are a local organisation and I was wondering if you could give us a run down on a bit of information regarding addiction in South Western Sydney?**

**Jenny James -** Yes, sure so I guess in terms of treatment services available?

**Ken McCroary - Or do we have issues with certain drugs, certain health problems in our region compared to others or is it pretty standard across the country?**

**Jenny James -** We follow a bit of a national trend, so certainly with the data we collect absolutely pretty much overwhelmingly the number one substance we get calls about is alcohol and that is at all ends of the spectrum. But we also get the calls at the more severe end of the spectrum and people are really, really struggling often when there is a dependence problem. We did find during the pandemic period the calls around alcohol use increased as a percentage of what were doing there was a bit of a shift around and there were more and more calls about alcohol. So that did happen, and I think that there was a trend happening about that nationally as well.

I would say the second most common calls we get from GPs is around prescription opioids and again, I think we are following national data trends there. So we know the opioids that used to be behind the majority of overdose deaths and the majority of opioid dependence when we go back to the 1990s, we certainly knew heroin was driving a lot of that, and that there were a lot of opioid treatment clinics that were funded and opened around that time.

But as we hit around the mid to late 1990s, the pharmaceutical companies were very active in this space, and they started bringing out lots and lots of different formulations of opioids and promoted them as god's treatment for chronic pain and we know now that that is not the case but that is how they were promoted and there was a massive increase in the amount of opioids that were prescribed. Drugs like oxycontin for example, and those trends went up and up and when we looked at the overdose data and drug death data that comes out every year there is a report called the Pennington Report which gives us all of that overdose data.

We could see that switch around from heroin and moving into prescription opioids happening and we saw how problematic prescription opioids were becoming and that essentially has continued until quite recently.

There has just in the last couple of years been a bit of a flattening out and a little bit of a downturn in that but I think with increasing knowledge and all of this information coming out about the detrimental effects and the lack of treatment efficacy that these drugs have had in that space. Which is also not to say that you never use them because they do have a place with chronic pain but it is just for some patients as part of a multi-disciplinary program but that would be our certainly second most common types of calls but then I think after that we get quite a lot of calls about benzodiazepine use as well. And some of the other prescription drugs as well so we see pregabalin for example that certainly in the last year we get GPs ringing about that and what is going on.

**Ken McCroary - It's quite confronting isn't it that most of the issues with drug and alcohol abuse locally and throughout the rest of the country are legal drugs and prescribed drugs or easy access which is a shame. What about the support networks available for patients and the services that are available for GPs. Do you sort of sometimes work as a sort of conduit liaison between those services and general practice and if so what sort of services are around?**

**Jenny James -** Yes sure, well we are positioned inside the district drug health services so first of all our district drug health services offer a number of services, so they are the one most GPs are familiar with is the withdrawal unit and that is located at Fairfield on the grounds of Fairfield Hospital. So that is often known, and a lot of people know it as Corella. Now the drug health services also operate opioid treatment program services what I probably need to say about them is they area over subscribed so they are full to the brim and they have a waiting list in terms of trying to access the district opioid treatment program so nationally we have an enormous problem with not being able to provide enough treatment services for people with opioid dependence.,

We also have counselling services, and they are zero cost and they operate within the different LGAs and all during the COVID period that was all being delivered via telephone and now people are asked to come in preferably but sometimes combination between telephone and face to face can be arranged. They also do have a little bit of a wait list, but they are not closed for business in that sense.

They are probably the main ones for GPs because we do other things of course were we are supporting the hospital and accident and emergency that sort of stuff then there are a lot of NGO services that offer things in the space and we also liaise with them and link GP patients up with them so some examples of them would be Odyssey House which is an NGO and they actually run their own withdrawal and residential rehab but they also have the contract to run a lot of the smart recovery services and smart recoveries are a great thing for GPs to know about so it is basically a CBT based service that offers treatment for people who are using any substance at all at any stage of their use of that substance be it early or being heavily dependent and they often do things in group programs they do in person they also offer them in virtual space where you can join meetings from your home and it is using all of those sort of cognitive behavioural principles and as such they are sort of very accept the fact that many people who are joining are not necessarily looking for abstinence. They may or may not be, but it doesn't matter just join us and we will see what we can do to help you. So those services are zero cost, so we often link GPs patients up with smart recovery services as well that is a really important one to know about.

**Ken McCroary - Yes, and it certainly keeps with the Primary Health Network's commissioned services for drug and alcohol support as well. Now I was also going to ask you about COVID, it has had an impact on all of us and you sort of touched on it a little bit ago as well how did you guys survive, and did you have that significant deterioration and are you having post COVID sequelae now with drug and alcohol particularly the alcohol stuff that you mentioned?**

Yes, we saw more calls come in with alcohol that was the main thing that happened and of course then everything was telehealth, and it was actually amazing to see how the OTP services had to cope with that. And I have to say they coped with that brilliantly because of calls people were worried about people milling around places. There is nothing like a place where you go to get dosed for methadone where there is a lot of milling around so there were strategies that had to be put very quickly into place and that involved provision of reassessing peoples suitability for take away doses of opioid treatment and NSW Health guided all of this and they basically loosened their guidelines and said we are really concerned about how this might go for vulnerable patients with drug and alcohol problems so here are you new guidelines and it was a kind of, the patients quite liked it because they were actually able to access more take aways during that period we followed all of that up and that certainly resulted in no harm, there was no increased harm from that change in guidelines.

Patients were also often moved out to more community pharmacies, so rather than coming into the OTP unit itself to dose more patients were moved to community pharmacies that were seen to be lower risk for coming into contact with groups of people and essentially, we have had to, obviously people have stayed at community pharmacies that was quite successful and the take away guidelines have reversed back to how they were. But that was very sudden changes that the drug health services had to cope with, and I must say they coped with them amazingly well and we did not have terrible disasters happening in terms of COVID cases with the population of people that were coming into our clinic. So, I think it was managed pretty well.

**Ken McCroary - Yes I think that reflects on the work and all of the nimble changes that go into the services the LHD, the region, the GPs and the rest of community health and primary health. The changes we had to go through so quickly were all integrated rapidly and have been quite successful and have been quite positive. Now you mention also your experience with Aboriginal and Torres Strait Islander populations, and I was just wondering about any special issues facing that group in our community?**

**Jenny James -** My background was for about close to 25 years I worked in the Aboriginal Community Controlled Service which was in western Sydney actually. And the reason I got really, really interested in the drug and alcohol space was because we had a couple of our GPs who were working in justice health as well as at the AMS and they would be seeing patients there who were coming due for release from prison and who were on say methadone programs within prison.

These Aboriginal men would say that's great you are at the AMS to so when I am out can I come and see you, you can be my GP. And the GPs who were in justice health as well would say yes, yes sure great come. And then of course the patient would say, and you will prescribe my methadone to won't you? And when none of us knew anything about it or were doing it and so we thought oh my god in terms of vulnerability we know and again we have got all of the information about what a high-risk time it is for people in that first six months coming out of prison there is increased rates of morbidity and mortality and overdose is part of that story. So, there we were feeling like we were actually backing out at the very time that we wanted to be really supporting people. That is what drove us all into it.

It seemed like a no brainer we had to get those skills and put them in our tool kit. So, I guess, I think what I am leading up to saying is it really is I think about the importance of really holistic care isn't it?

So it is bringing all of those arms of treatment together and being able to I think as GPs provide a lot of the not just physical healthcare but the mental healthcare the drug and healthcare and bringing it all under that one roof, all being part of the same cube which also helps to de-stigmatise a lot of those treatments as well so I think that it a really I think it is a really powerful thing to do especially when you are working with Aboriginal and Torres Straight Islander populations of people. I think many of the AMSs do have GPs where they are running in house primary healthcare drug and alcohol programs that are a part of that armoury of treatment that we all are in and stand side by side with the diabetes treatment and vascular stuff it is all just together and equally important.

**Ken McCroary - Yes, just part of the never ending conglobulation of complex co-morbidities that horrible risk associated with that group unfortunately. Speaking of horribleness, you were also kind enough to share some personal tragedy about yourself previously about your son Aiden and I just feel that is such a horrible thing to potentially experience and I am just thinking with drug and alcohol obviously people get driven for different reasons and are you able to talk a bit more about coping strategies for patients and us as GPs as well with everything that we get faced with in life, like we get exposed to the traumas and griefs that everyone else does as well. Are you able to give us some input into that if you don't mind?**

**Jenny James -** Yes sure, our beautiful first born son Aiden died completely unexpectedly in 2018 and it was presumed to be a cardiac arrythmia and I think any parent who has lost a son or daughter will tell you there is a place called hell and we certainly felt that our lives were absolutely shattered at that point.

I think that at the time I certainly didn't feel I needed people to describe what grief was like or tell me things like that because we were living it, but I do recall very early on wanting to know what I can do about this. I came across, actually a lot of work that is being done at the New Zealand Institute of Resilience and Wellbeing, where one of the directors there had been interested in that whole area of resilience and was doing a PHD in that area and then thought she had found her calling when the Christchurch earthquake came and then her daughter was suddenly killed in a car accident and it catapulted work they were doing looking at any of those kinds of strategies around resilience being applied to bereavement and grief so I did set upon reading everything I could get my hands on.

I mean it is such a huge area and I think one thing that is probably good for everyone to know is that it is quoted so often is those blasted five stages of grief and it is to say I think they need to be put away and then in fact that work came out of interviews with people not who were bereaved but interviews with people who were dealing with their own mortality. So, it was a very different group of people and really there are no five stages of grief.

There was no empirical evidence that was behind any of that work and I think the potentially can feel there is something wrong if they are not going through those stages experiencing them in a certain way which is of course total rubbish and grief as individual as your fingerprint and it is a very model of such passivity that you sit there and you have just got to wait for these five stages to come and get you.

That is what it is all about and I think you know one of the things that happens around traumatic grief is that feeling of just loss of control and anything we can do I suppose to put ourselves back in the drivers seat and just bit by bit get a sense of a bit of control back over our world is often just gently without it being a pressure thing a good thing to do.

So those kinds of models that are very passive, that are about this passive process that is going to come and get you and there is nothing that you can do about this, I think that is not, I think that is a really poor model so we want to put that to bed and encourage people depending on where people are at with things I think that initially it is permission for people to really do and say what ever they want in those terrible early stages of terrible shock and anxiety and then as time goes on to just start to look at the strategies of tools that you can use to deal with some of those things.

**Ken McCroary - Yes you are completely true, Kubler Ross she talked about people who were dying not an overall pattern of grief for everyone that somehow has got mixed up with every day and you don't pass through and get over grief you just hopefully eventually cope better as life continues to happen around us but the stuff is still there and yes I really applaud your ability to talk about that with us today, probably whilst I have got you on this sort of topic. Have you got any concluding words to say about general health and GP wellbeing overall as a way to wrap it up?**

**Jenny James -** Yeah, I have become very interested in that myself and over the last few years that has been as you would be aware Ken there has been increasing and and it has been good to see more focus on it. And also a lot of doctors coming out with there own personal stories and it is so, basically been I think a really good thing and I am just so grateful to a lot of those people who have just sort of come out and some of them are in sort of you know, sort of, was it the president of the ONG college I think he was one of them wasn't he and there is an amazing, amazing story of when he was a medical student and there it was all through I think it was Australian Doctor Weekly and there was something like 200 and something posts after it and you know might if someone is interested in an article you might get 3 or 4 but that was like 200.

I looked at this with amazement and saw the power of what we can do as a group and seeing when you hear about your peers coming out and talking about what has happened to them you are actually faced with this role model that same person who is standing in front of you and is not only ok but is you know, you know the good they have gone on to do in the world.

So seeing those kinds of stories and people being more open about the fact that doctors are not god and doctors have problems to just like everyone else has been a really good thing to do and I think the support we can give each other and that is not to say that we don't need other support, but that intra GP support anything that we can do no matter where we are working even if it is just in our own practices that we have some kind of system meeting, something that we set up and that we are aware of those issues of wellbeing and however that looks and in whatever form it takes place but just allowing peers to get together and have that space where it is ok to just say you know I feel like shit lately actually. Because I think hearing that from our peers and still seeing that actually we are still coping and being able to learn what coping strategies we have with each other is a really powerful thing.

**Ken McCroary - Yes, just being able to talk to each other and be kind to each other and be around for each other it is certainly has changed for the better hasn't it. I have been doing this for a long time and you have been around for a while as well and yes, it is good to see but we still have a long way to go. So, I would really like to thank you for your input today the DNA stuff was really enlightening but the comments about wellbeing and stuff that is you sharing stuff which is really great, so I really appreciate your time today and thanks for all of your help that are doing out there in the local community as well.**

**Jenny James -** Thank you so much for the opportunity to talk to you Ken and also link in with all of the other wonderful GPs out there.

**Ken McCroary - Great so I will just sum up again that the phone number for the Drug and Alcohol service is 0455 079 436.**

**Remember if you're not a member of GP Link already or you would like to learn more log onto our website at https://sswgp.link/.**