GP LINK Lunches | Dr nni r

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.