Alcohol and Other Drugs Newsletter

Autumn 2021 Edition

Welcome to the Autumn edition of the Alcohol and Other Drugs (AOD) Newsletter. As always, we focus on content to assist GPs in improving care for patients and raising awareness of services for GPs and families.

I thank all contributors for collaborating so willingly and providing such enjoyable articles. If you have an article you would like to contribute, or topics to suggest, for the Spring or Summer editions, please contact Pat Simmonds at psimmonds@snhn.org.au.

In this issue

In April

New release from the Australian Institute of Health and Welfare

Wednesday, 14 April 2021

Alcohol and other drug treatment services in Australia: key findings

In 2019–20, 1,258 publicly funded alcohol and other drug (AOD) treatment agencies provided just over 237,500 treatment episodes to an estimated 139,000 clients. The four most common drugs that led clients to seek treatment for their own drug use were alcohol (34% of all treatment episodes), amphetamines (28%), cannabis (18%) and heroin (5.1%). Almost two-thirds (64%) of all clients receiving treatment were male, and the median age of clients was 35 years.

Articles

A GP's dilemma: Prescription opioids and chronic non-cancer pain

It's there every time I call. The sinking feeling that a hand will reach down through the phone and slap me when I call for PBS authority for opioid approval for my chronic non-cancer pain (CNCP) patient.

It's hard to ignore the facts. Every day in Australia, around 3 people die and nearly 150 are hospitalised due to opioids, including prescription ones, making it impossible for us to neglect their potential to inflict harm. But the options for de-prescribing opioids provided by experts who do not work in general practice are often glib, impractical and potentially dangerous. The reality: reducing and ceasing prescription opioids for those with chronic pain while finding suitable alternatives is challenging to say the least and does not necessarily decrease 'harm'.

Since the PBS changes to prescription opioids last year and the increased general focus on improving chronic pain management, there have been countless webinars to educate GPs on chronic pain management and opioid use. Many of us attend, looking for an elusive answer that will miraculously help us manage our CNCP patients without opioids and simultaneously help us safely and effectively de-prescribe. Of course, there is no such silver bullet; the solutions that GPs are presented with are often simplistic and untenable, and the rhetoric frustrating and at times condescending.

To recap, the TGA states that 'modified release opioids are not indicated to treat chronic non-cancer pain (other than in exceptional circumstances). 'Exceptional', as defined by the Faculty of Pain medicine (part of the College of Anaesthetists), is *'severe pain, for which other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management, and which has been shown to be opioid-responsive'.*

When faced with the pressure to deprescribe, we, as GPs, start by going through our CNCP 'checklist' based on best practice and evidence-based medicine. We attempt to transfer our patient to potentially less harmful medications such as tapentadol and pregabalin. We substitute short acting opioids for modified release ones. We decrease to the lowest dose possible (ideally less than 60mg oral morphine equivalent daily dose). We consider reducing the number of different types of opioids any one individual takes. We are cognisant of harm and have re-acquainted ourselves with the long list of opioid side effects. We switch opioid delivery systems. We try NSAIDS, inadvertently causing renal failure in the occasional elderly patient. We employ mental calisthenics to contemplate

whether a request for higher amounts is hyperalgesia, tolerance, uncontrolled pain, misuse or all four. We ask ourselves whether the patient's pain is in fact opioid responsive and question whether opioids are being used to manage insomnia or anxiety rather than pain. We consider the possibility of opioid use disorder.

As a last resort, we refer to pain clinics. While there is some evidence that this can reduce opioid use, in real life, the long waiting lists, geographic constraints, potential costs, impracticality of attending a multidisciplinary program, especially in the case of elderly patients, are significant barriers. And the bottom line? There is often little that the pain clinic can add to management. Knowing this truth, we sometimes experience referrer's guilt, aware we are passing the buck with this 'tick-box' approach, recognising that our patients will often have little to gain.

Currently, I have seven patients with CNCP for whom I regularly prescribe opioids. A couple of these I have initiated prescribing myself; the others have come from Elsewhere. In my over-zealous attempts to 'do better', I recently trialled a switch to transdermal patches for an elderly, relatively stable patient in an attempt to decrease her opioid risk and improve pain relief. As a result, she spent the next 2 weeks asleep on the couch, was close to falling on several occasions, and required more break-through pain medication than previous. A lose-lose situation.

When opioid reduction becomes our central aim, we risk losing sight of the imperative to do no harm and reduce suffering. I am not suggesting that opioids are not misused or don't possess a huge range of potential downsides, or that as GPs we shouldn't attempt to change our prescribing in favour of safer options. However, practically speaking, the imperative to reduce opioid prescribing is placed above the 'do no harm' maxim. Instead, our primary goal should be reducing harm and suffering which of course may lead to reducing opioids.

The elusive answer lies in individual risk management and harm minimisation. This may sound obvious and twee but we sometimes lose sight of this in primary care when faced with pressure from all directions.

Instead of making opioid reduction our mantra, we can have more open and honest discussions with our patients about opioid harm. We can speak collaboratively around goals and risks in a way that may lead to a 'next step' of dose reduction. We can steer away from our paternalistic models of care where we tell patients what they should and shouldn't be taking. We can address the stigma we often inadvertently use in our language which alienates our patients. We can use more compassion. Will thinking about prescribing in this way lead to reduced prescribing? I'm not sure it does, but if we aim towards doing no harm while simultaneously reducing suffering, we might feel like we are getting somewhere, even if the numbers might not show it.

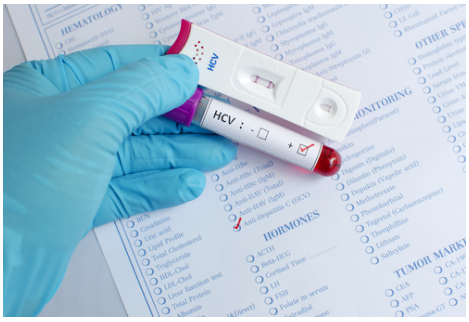
The sinking feeling is a sense of failure. Perhaps we just need to change our expectations?

Cut to the chase resources
Opioid tapering algorithm
Opioid conversion chart
Opioids: New and amended PBS listing
DSM Criteria for opioid use disorder

Further reading
Opioids, chronic pain and the bigger picture
Opioid prescribing: What do the 2020 PBS changes mean for GPs?
Opioid prescribing: strategies for GPs to optimise chronic (non-cancer) pain management and minimise harms

By Dr Nicole Gouda MBBS FRACGP, SNHN AOD Clinical Lead

Towards Hepatitis C eradication in the community



Clinicians who are new to the diagnosis and treatment of hepatitis C can access a remote consultation with the Hepatology Unit at Royal North Shore Hospital by fax or email **(call: 9463 2450 for advice).**

Other resources include the Hepatitis Australia website https://www.hepatitisaustralia.com/ and the website for the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine https://ashm.org.au/. **Further to this, advice is provided from your local hepatitis organisation through the helpline: 1800 437 222.**

See also HealthPathways – search term: Chronic Hepatitis C. Username: healthpathways Password: gateway

Hepatitis C is a curable blood borne viral infection of the liver. Many people in Australia are living with chronic hepatitis C. Over 130,000 cases were identified in 2018, with an unknown number not yet diagnosed. An estimated 585 deaths in 2016-17 were attributable to hepatitis C, while 66 liver transplants occurred in the same period for chronic hepatitis or liver cancer related to hepatitis C. Symptoms are often absent or are low-grade and wrongly attributed to ageing or unhealthy lifestyle choices. Diagnosis can only be made on a blood test.

Transmission of the virus occurs through blood to blood contact in contexts such as tattooing or surgical or dental procedures with unsterile equipment. Sharing intravenous injecting equipment is a high-risk activity for blood borne virus transmission. As a consequence of this, a higher than usual prevalence of Hepatitis C exists in the injecting drug-using community. This cohort is readily accessible through Drug & Alcohol Services (particularly, the Opioid Treatment Program) and through Needle & Syringe Programs.

At the Northern Beaches Opioid Treatment Program, serology has been conducted extensively (320 venepunctures over the past 2 years) to screen for hepatitis C. From this screening, 31 patients were diagnosed as positive for hepatitis C. Of these, 22 patients have been treated and confirmed cured. Several others have had treatment initiated here but have continued their treatment elsewhere.

Very few have been lost to follow-up with some still in treatment and others waiting for a confirmation-of-cure blood test (done 3 months after antiviral treatment).

The Opioid Treatment Program has been a participant in the REACH-C study for the past two years. REACH-C collects basic data on all initiations of direct-acting antivirals since they were subsidised in 2016. The project examines treatment provision in primary health and other more diverse models of care with aims to assess patterns of prescribing, response rates and rates of re-treatment. REACH-C study days have provided an opportunity to screen (with point-of-care serology and fibroscan) outliers to our service who have been externally referred, usually from the Needle & Syringe Program and Mental Health Services.

By Nicholas Miles, Nurse Practitioner, NSLHD Drug and Alcohol Service

Rescheduling of low-dose cannabidiol (CBD)

In December 2020, the Therapeutic Goods Administration (TGA) announced their decision to down-schedule certain low-dose CBD preparations from schedule 4 (prescription medicine) to schedule 3 (pharmacist only medicine), allowing for TGA approved low-dose CBD products (up to a maximum of 150mg/day/adult) to be supplied over the counter by a pharmacist.

This decision was made following a safety review of low dose CBD that indicated (while noting that there were only limited published studies available) that the known adverse effects of CBD at low doses were not serious. The impetus to reconsider scheduling was based on the notion that access was seen by many as too restrictive in comparison to access in other jurisdictions such as the UK and some parts of the US.

The TGA further stipulates that low dose CBD has not been widely used in clinical practice and the evidence for which conditions it is effective has not been thoroughly characterised or evaluated. Further, it remains important that the appropriate regulatory controls are maintained to ensure both safety and quality of products containing CBD.

For people using low dose CBD products for various conditions, this may seem a positive step, but it may be some time before these products are available over the counter. As to date, there are no currently approved TGA CBD products on the Australian Register of Therapeutic Goods (ARTG). Prior to approval, all products first need to go through rigorous TGA evaluation and testing before approval can be given. Presently, CBD, for practical purposes, remains a schedule 4 medication and can only be prescribed through the Special Access Scheme (SAS), Authorised prescriber scheme, or medical trial.

With respect to driving and the law, patients taking cannabidiol-only medicines can lawfully drive as long as they are not impaired. While cannabidiol can cause drowsiness and fatigue, these symptoms are observed more frequently at high doses and in combination with other medications.

Special Access scheme
Prescribed cannabis medications and fitness to drive
NSW cannabis medicines prescribing guidance (ACRE)

By Dr Nicole Gouda MBBS FRACGP, SNHN AOD Clinical Lead

NEW Australian Guidelines to reduce health risks from drinking alcohol

It's official. The *Australian Guidelines to reduce health risks from drinking alcohol* were released in December 2020, replacing the 2009 guidelines.

The new guidelines are simple and unambiguous, and have been reduced from 4 to 3 main recommendations:

- Adults: to reduce the risk from alcohol related disease or injury, healthy men and women should drink **no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.**
- Under 18s: to reduce the risk of injury and other harms to health, children and people under the age of 18 should **not drink alcohol.**
- Women who are pregnant, breastfeeding or planning a pregnancy: to prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should **not drink alcohol.** For women who are breastfeeding, not drinking is safest for their baby

Input for the guidelines came from trends in international recommendations, data on alcohol consumption and health indicators, mathematical modelling, input from working committees, and data from 42 systematic reviews of the effects of alcohol on health. The strength of these systematic reviews revealed varying levels of evidence quality; however, one area of relative strength was the evidence on the association between alcohol consumption and cancer risk. This link was perhaps the biggest factor contributing to the change to lower consumption level guidelines.

It should be noted that guideline 1 aims to keep the lifetime risk of dying from an alcohol related disease or injury to below 1 in 100 for the average healthy man or woman. The risk associated with alcohol can be further reduced (to below 1 in 100) by drinking at levels below the guidelines, and not drinking at all is the best way of reducing the risk of harm from alcohol.

There is no global consensus on the exact level of alcohol consumption recommended to keep the risk of alcohol-related harm low and alcohol guidelines vary substantially from country to country.

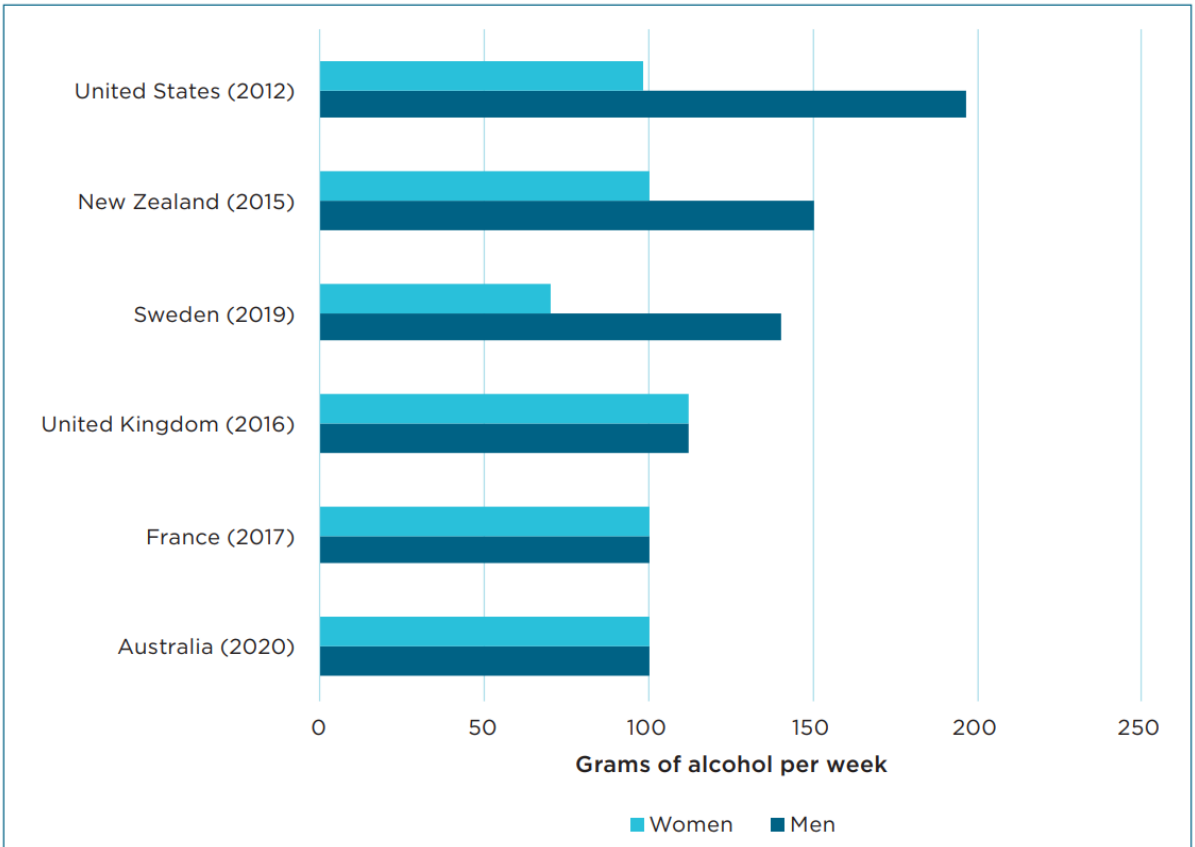


Figure 2.5. International comparison of recommendations on the upper limits of weekly alcohol consumption

Source: HealthLink BC, 2019 [21] and International Alliance for Responsible Drinking, 2019 [22].

Alcohol was responsible for 4.5% of the burden of disease and injury in Australia in 2015, making it the sixth highest risk factor contributing to total burden of disease.

In contrast to the previous guidelines, there is now one guideline for adults which does not distinguish between lifetime risk of harm and the risk of alcohol related injury arising from a drinking occasion. It also refers to alcohol consumed weekly rather than per day as was the case in the 2009 guidelines. Furthermore, the guidelines for children and young people refer to abstaining from alcohol till the age of 18 (rather than delaying initiation of drinking as long as possible).

By Dr Nicole Gouda MBBS FRACGP, SNHN AOD Clinical Lead

Alcohol use in the over 65s

Alcohol is the most common substance used by older people in Australia. People over 65 years of age are more likely than any other age group to drink daily and exceed guidelines for risky levels of consumption. They are more at risk of falls, injuries and chronic conditions and more likely to be taking medications that may interact with alcohol.

Ageing increases physical vulnerabilities such as decreased tolerance for alcohol due to slowing metabolism, decreased hepatic blood flow, inefficient liver enzymes and reduced renal clearance. Elderly brains are more sensitive to substances; in fact, alcohol dependent people are five times more likely to develop dementia than non-drinkers. Alcohol is an important risk factor for falls due to acute confusion, neuropathy and reduced bone density; falls are the most common reason for hospitalisation in the elderly.

Psychological and social issues increase in prevalence as people age. Loss, grief and isolation may become justification for continued drinking, or they may result from drinking. Finding a reason to NOT drink is hard sometimes.

Identifying alcohol use disorders in the elderly can be challenging due to memory problems, higher levels of denial, and embarrassment. Standard screening tools have limited application as they have thresholds which do not adjust for the increased sensitivity the elderly person has to alcohol. Australian guidelines for safe use of alcohol give no recommendation for those over 65, other than to consult their health professional. The current *4 standard drinks* benchmark of risky drinking for adults may floor a person who is frail, alone, and malnourished.

On the other hand older people are anecdotally more compliant with 'doctor's orders'. This gives agency to the clinician who can illicit protective factors, give clear recommendations on safe levels of alcohol (or even better, abstinence), and stress the importance of thiamine supplementation. Thiamine deficiency is often underdiagnosed and overlooked. One, or all, of the triad of Wernicke's encephalopathy - ataxia, confusion and nystagmus - is often present in older people who use alcohol; these people are also less likely to eat well or take vitamin supplements. Having a low threshold for diagnosis of thiamine deficiency ensures that priority is given to thiamine replacement - indefinitely.

Guidelines for administration of thiamine in the Northern Sydney Local Health District (NSLHD) is parenteral administration of up to 500mg three times a day for at least three days for people who have a history of falls, ataxia and alcohol use. This dosage can be challenging to replicate in an outpatient setting, though intra-muscular administration prior to commencement of high dose oral thiamine is appropriate.

First line anti-craving medications for alcohol use can be considered, however literature is divided on the appropriateness of Acamprosate in the elderly. Personal experience is that low dose Naltrexone

is more tolerable and efficacious in the longer term. Simple harm reductive suggestions such as eating before drinking, taking thiamine daily and using non-slip socks can reduce the risk of falls and ensure that any drinking older people do does not compromise their health and wellbeing.

NSLHD Older Persons Mental Health Services and Drug and Alcohol Services are working together in a group called DAMHAGE ie Drug, Alcohol, Mental Health And Gambling in the Elderly. DAMHAGE aims to improve liaison between services and raise awareness of increasing substance related problems in an ageing population. NSLHD Drug and Alcohol Services Medical and Nurse-Led Outpatients accepts referrals for people of all ages through the Centralised Intake number 1300 889 799 – option 1.

Referral to the Outpatient Alcohol Clinic at Brookvale Community Health Centre can be made by calling 0407896395.

By Melise Ammit, Clinical Nurse Specialist 2, CDAN. NSLHD Drug & Alcohol service

Drug trends in the COVID era

In December 2020, the findings from *Drug Trends*, an Australian Government funded program designed to identify emerging problems in substance use in Australia and provide impetus for policy response and intervention were released for the COVID era.

The data, collected between April 2020 till September 2020 comes from a variety of sources including annual interviews with people who regularly inject drugs and/or use other illicit substances, analyses of data such as drug-related mortality and hospitalisations, and monitoring for information on the availability of substances on online (dark-net) drug marketplaces.

Some relevant findings include:

- Intravenous drug users reported a decrease in perceived availability and an increase in the perceived price of both heroin and crystal methamphetamine as well as decreased purity of both substances since the March 2020 restrictions.
- Study of the intersection of change between alcohol, cannabis and ecstasy indicated there was an increase in cannabis use and a decrease in ecstasy and alcohol use compared with the previous year's reporting period.
- Illicit drug reporting system (IDRS) interviews reported drug service disruption for 49% of clients, but the level of satisfaction of care remained unchanged.
- Ecstasy and related drugs reporting system (EDRS) showed some decrease in demand for certain drugs such as ecstasy with COVID restrictions as drug use occurs typically within a social context that was absent during the pandemic.
- Amount that young people were drinking declined and a decrease in the frequency of consumption was noted.
- Some increase in quantity and frequency of consumption of alcohol in lower end drinkers but general decline in higher-level drinker.

For full reports and references:
NCARC Drug Trends

NDARC Drug Trends Key Findings
NDARC National Research Symposium: Substance use in the COVID era
IDRS National Infographic 2020
EDRS National Infographic 2020
By Dr Nicole Gouda MBBS FRACGP, SNHN AOD Clinical Lead

Recruiting patients for Topiramate Vs Naltrexone Trial

Double blind clinical trials for alcohol dependence.

As the Australian community begins to recover from the effects of COVID-19, it is important that individuals are aware of all treatment options for alcohol use disorder including clinical trials that are currently recruiting potential participants. The addiction specialists and researchers at Royal North Shore Hospital Drug and Alcohol Service are conducting a study of topiramate versus naltrexone for alcohol use disorder in alignment with recommended COVID safe practices to maintain patient safety. The main aims of the study are to evaluate the clinical effectiveness, tolerability and cost-effectiveness of topiramate compared to naltrexone. A genotyping sample is also obtained from patients to determine whether the GRIK1/OPRM1 allele moderates a patient's response to topiramate/naltrexone.

The treatment programme involves 3 months of free daily medication (either naltrexone 50mg or topiramate up to 200mg), weekly medical appointments with the addiction specialists, frequent blood tests to monitor liver function and the opportunity to participate in counselling. Follow up appointments are arranged with the treating clinician post-trial as a standard of care for all research patients. Through this trial we hope to create a more supportive environment for patients wishing to commence alcohol pharmacotherapy and encourage patients to either maintain abstinence or reduce their drinking.

Trial 1: Naltrexone and Topiramate

Most suitable for patients who need significant support in the community (weekly appointment attendance) and would like to commence an alcohol pharmacotherapy

Patients receive:

- 12 weeks medication (randomised to 200mg topiramate or 50mg naltrexone daily)
- Medical appointments, research appointments, medical management (brief medication adherence counselling)
- Optional counselling (free)

Inclusion Criteria:

- Alcohol dependence according to DSM-V criteria
- Willingness to provide written informed consent and blood sample for genotyping
- Age 18-70
- Average weekly alcohol consumption ≥ 25 stds for women and ≥ 30 stds for men

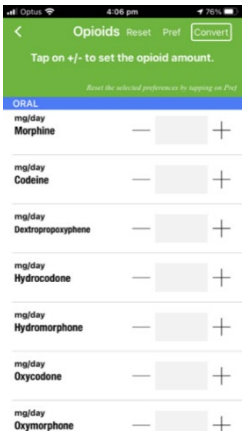
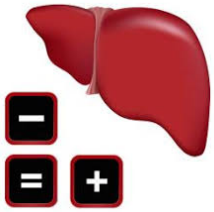
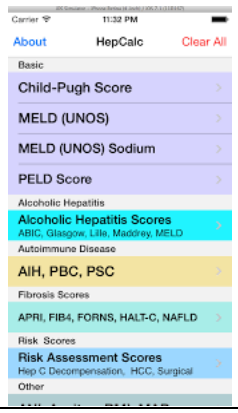
Exclusion Criteria:
Active major psychological disorder associated with significant risk of suicide, psychosis or signs of impaired cognitive functioning (*flexible- clinician assessed*)

- Pregnancy or lactation
- Current use of any psychotropic medication other than antidepressants
- Opioid abuse, opioid dependence or on opioid maintenance treatment
- Use of antiretroviral dolutegravir
- Any other substance dependence other than nicotine
- Clinically significant liver disease (AST, ALT levels > 3x upper normal limit)
- Recent history of nephrolithiasis
- History of glaucoma

For more information or to refer a patient please contact Ms Claire Adams on 0474 110 954, or email sydneyalcoholtreatmentgroup@gmail.com
Patients can also self-refer using the same number and email.

Support for GPs, Patients and Families

Support for GPs

Mobile AOD Apps on Parade	
Name	**Description**
Opioid calculator Apple App store	Easy conversion of opioid dose to oral morphine equivalent allowing conversion to other opioids when switch required OPIOID FPM ANZCA 
Liverpool HEP iChart Apple App store Google Play store	Allows search for potential drug-drug interactions between hepatitis drugs and other medications  
HepCalc Apple store Click here for website	A collection of liver related calculators, web links, resources and clinical notes to aid in management of hepatitis and other liver conditions  

Northern Sydney Drug and Alcohol Services

For health professional advice, contact 1300-889-788.

Drug and Alcohol Specialist Advisory Service (DASAS)

A free phone advice service for health professionals on the clinical diagnosis and management of patients with alcohol and other drug related problems.
For advice, contact the service via (02) 9361-8006.
For more information visit the website.

GP Psychiatry Support Line

The GP Psychiatry Support Line is a free service to GPs to help manage the care of mental health consumers.
Register here or phone 1800 16 17 18 for assistance. You will need your APHRA Registration Number and practice details.

Health Navigators Northern Sydney – Healthcare Hotline

Contact Health Navigators for assistance in finding services for older people in the Northern Sydney region. Ph 1800 271 212 Monday to Friday 8am to 6pm.

Social Work Service to Support GPs

Free social work services for general practice. Refer patients who could benefit from short-term care coordination. Visit the website

CCNB

Covering Willoughby, Lane cove, North Sydney, Manly, Warringah, Pittwater, Mosman

Patient eligibility
No age limit, people who the GP identifies as having one or more of the following:

- Alcohol or substance abuse dependency
- High and or complex care needs requiring support from a range of community care providers
- Carer stress or burnout - requiring support and assistance in their caring role
- Difficulty navigating and accessing support services e.g the NDIS or aged care service system
- Recent and or recurrent hospitalisations due to care needs
- Complex family situation including family and domestic violence
- Indicators of loneliness and isolation

Telephone 1300 002 262. Email referrals@ccnb.com.au. Website

PCCS Primary & Community Care Services

Covering Ryde, Hunters Hill, Hornsby, Ku-ring-gai LGAs.

Patient Eligibility – 2 or more of the following

- Chronic and/or complex health care conditions (not mental illness)
- Recent hospitalisations and at risk of representing without supports activated

- Experiencing difficulty navigating and accessing support services
- A carer who requires support and assistance

Telephone PCCS on 9477 8700.

Support for Patients and Families

Sydney Drug Education & Counselling Centre (SDECC)

A family inclusive service offering support for parents of affected young people.
To refer parent or carer to Chatswood phone 9977 0711
To refer parent or carer to Manly phone 9977 0711
Patients can self-refer on the numbers above.

Family Drug Support (FDS)

Evidence suggests that family support is a key element in successful treatment outcomes. FDS supports families and friends who have a loved one dependent on alcohol or other drugs and aims to assist and empower families to cope with the realisation of their situation and to survive it intact.

FDS offers:
Free support groups for families throughout Sydney.

Free Stepping Forward information sessions, covering 7 topics including Stages of Change, Boundary Setting and Effective Communication.

A Stepping Stones interactive and experiential weekend course which brings people together with similar challenges to work on finding new ways of coping. The goal is to turn crisis into coping and help families regain their own life.

1300 368 186 - 24/7 Telephone support line for those that need to talk things through

For more information contact Amy Steven, Family Project Officer, on 0457 260 079 or contact head office on 02 4782 9222.

Topiramate Vs Naltrexone Trial

For more information or to refer a patient contact Ms Claire Adams on 0474 110 954.
Patients can also self-refer using the same number or email
sydneyalcoholtreatmentgroup@gmail.com

Smart Family and Friends

SMART Family & Friends is intended to assist anyone affected by the addictive behaviour of someone close to them. It is first and foremost a self-management program. SMART Family & Friends aims to provide a practical toolkit for living in the present. Online Support Meetings

Al-Anon Family Groups Australia

Al-Anon's purpose is to help families and friends of people who misuse alcohol. It is not affiliated with Alcoholics Anonymous or any other organisation. Their program is adapted from Alcoholics Anonymous and is based on the Twelve Steps, Twelve Traditions, and Twelve Concepts of Service. Includes Alateen – Support for teenagers affected by problem drinking of a parent or other family member.
To find an Al-Anon or Alateen meeting phone 1300 252 666 or go to the webpage.

Drug, Alcohol, Mental Health and Gambling in the Elderly (DAMHAGE)

NSLHD Drug and Alcohol Services Medical and Nurse-Led Outpatients accepts referrals for people of all ages through the Centralised Intake number 1300 889 799 – option 1.

Outpatient Alcohol Clinic at Brookvale Community Health Centre

Phone 0407 896 395

Substance Use in Pregnancy and Parenting Service (SUPPS)

Provides:

- support and treatment for women who are using (or have used) alcohol and other drugs during their pregnancy.
- help for women to adjust to their role as parents.
- assistance to access other support services.
- support for family members to access drug and alcohol treatment services.
- Phone: 1300-889-788 (choose option 1)

Recorded Webinars, Education, and Opportunities

Prescribing buprenorphine in primary care.

Dr Hester Wilson, Dr Nicholas Lintzeris, Kim Nolan. Watch here

What lies behind the recent revival of therapeutic research on psychedelic drugs?

Professor Wayne Hall. Watch here

Home Alcohol Withdrawal and Relapse Prevention.

Dr John Smart and Dr Chester Omana. Watch here

Trends in cocaine and methamphetamine use, markets and harms in Australia.

Dr Amy Peacock. Watch here.

Use, safety and effectiveness of quit smoking medicines during pregnancy.

Dr Alys Havard. Watch here.

RACGP AOD GP Online Education Programs

- **Essential Skills**

This education takes approximately two hours with CPD points. For more information or to get started click here.

- **Treatment Skills**
  Course takes 6 hours to complete, CPD Accredited Activity, remuneration of $1200 on completion. For more information on eligibility or to apply click here.

- **AOD Connect: A Project ECHO Community of Practice for RACGP members**
  Discuss AOD cases with your peers every Thursday evening on Zoom, from 7.30pm - 8.30pm until 10 December. To register click here.

Drug and Alcohol Supervised Clinical Attachments with NSLHD Addiction Specialists

40 Category 1 CPD points (by self-notification) are available on completion of 10 hours of training with remuneration at $159 per hour. To learn more, click here.

Northern Sydney Community Drug Action Teams (CDAT)

Want to join a CDAT or get involved in a project or event? Contact Leanne Fuelling, Senior Community Development Officer at the Alcohol and Drug Foundation (ADF) on leanne.fuelling@adf.org.au or 0402 02 7601 to find out more about CDATs or what is happening with one of the CDATs in the Northern Sydney Region.

Community Drug Action Teams (CDATs) are groups of volunteers from the community and interested workers such as Police, LHD, PHN, youth workers, health and community workers, who are passionate about their area and want the best for their community particularly in relation to alcohol and other drug use. Some activities across Northern Sydney include a women and alcohol research project, advocacy against liquor licence applications and legislation changes, activities to support at risk youth, and parenting support.