Alcohol and other drugs problems in primary care

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Introduction

The role of the general practitioner in identifying, helping and caring for those who have dependency or other problems with alcohol or drugs is an important one. In addressing the annual conference in Auckland last year my intention was to highlight some of the issues relating to alcohol and drug use in New Zealand and to pose some challenges and questions as to the role of the general practitioner and the primary care team in addressing these. This contribution derives from some 16 years of general practice experience in both an inner city and a rural context and seven years' work with the Auckland regional alcohol and drugs service (CADS).

This résumé of the conference workshop attempts to summarise my views and the issues raised relating to alcohol and the illicit use of prescription medicines.

Alcohol

Dealing with the inappropriate use of alcohol by our patients poses a significant challenge to the profession, which we often fail to meet. In our hospitals significant alcohol abuse and dependence goes unrecognised and, even when diagnosed, is often ignored or badly addressed. For some of our GP colleagues, asking a patient about their alcohol consumption seems an impossibly difficult task. The subsequent cost to patients, their family and friends and to society is very real in economic terms; the social and community harm is measured in unhappiness, unfulfilled lives, violence and crime.

Why do we have such collective difficulty in acknowledging our responsibility? In part this may be explained by the view that alcohol use is a choice of the individual and thus not a concern of the health service. In other words it is a 'moral issue' and so one that we can ignore. Many of us will remember the attitudes that prevailed when we did our stint in A&E and a 'drunk' was delivered to the doorstep. That alcohol misuse is a legitimate health concern is borne out by surveys that show between 20 and 50% of persons admitted to a general hospital have either hazardous or dependent use. A recent study within the medical unit at Auckland City Hospital demonstrated that 22% of all patients had significant alcohol misuse issues. The average age of these clients was 80+ years!

The figures are equally concerning for an 'average' general practice of 2000 patients:

- There will be100 alcohol dependent persons
- 400 patients will drink hazardously – their consumption will exceed the WHO recommendations of 14 standard drinks per week for women and 21 for men
- Binge drinking will be acceptable for the majority of adult patients.

So what responsibility do you have as a GP for the early detection of hazardous and dependent alcohol users? Doctors' intellectual and emotional preparedness to work with alcohol or drug affected patients is influenced by three factors:

- Role *legitimacy* – belief that substance use issues are a legitimate health area for the doctor to examine
- Role *adequacy* – belief that they have sufficient knowledge
- Role *support* – belief that appropriate advice and assistance is available when needed.

The first of these factors has already been alluded to. It is inexcusable in health services to adopt a moral stance over the use of alcohol and drugs by patients. These days no one would argue that nicotine dependence is not a legitimate concern for doctors; alcohol and drug use should be seen in the same light.

There is a knowledge gap for some doctors which results in their not feeling able to adequately address the

issues for patients. Despite a greater commitment in the undergraduate years to teaching in this area, the experience of most doctors within the hospital environment as house officers or registrars is that this area of medicine is afforded little importance. The use of diazepam as an 'aid' to assist patients to manage their alcohol dependence and reduce their intake is a frequent problem. In hospital the doses of diazepam used to manage withdrawals are often too little but, on occasions, can be excessive. The use of 120mg daily as administered to one patient over five days cannot be justified. In general practice similar confusion sometimes occurs. Recently we were referred a client who had been seen by her GP that afternoon. A prescription for 10mg diazepam tds was provided, a referral for admission to our unit was made and the patient sent home. The detoxification staff, on receipt of this referral, recognised that the combination of alcohol and diazepam was a potential problem and contacted the GP asking that he retrieve the script and thus obviate any risk of overdose leading to respiratory depression. Unfortunately this didn't happen; the patient continued to drink over the next six hours, consumed 300mg of diazepam and at 10pm that evening was admitted to the emergency department in a comatose state. Had she not been found she may well have died and the doctor's action would have been indefensible from a medico-legal viewpoint.

The combination of alcohol and benzos is a potentially lethal one and our recommendation to GPs who are confronted with an alcohol-dependent patient wanting to withdraw or in early withdrawal is that they should advise them to continue to use alcohol, make a referral to an A&D service and only prescribe diazepam to assist withdrawal management when the patient is in a supervised situation and the dispensing of the diazepam is controlled. I appreciate that the availability of A&D services in some parts of the country is less than ideal, but an attempt should be made to at least seek advice. Where the situation seems an acute one then referral to the A&E department of your nearest hospital is the best option. Advice to patients to continue using alcohol, while in the first instance a seemingly less than appropriate one, makes a lot of sense given that the patient has considerable experience in managing their withdrawal symptoms in this manner. The family often have difficulty accepting such advice but will do so more readily if they understand the reasons and if a plan is then put in place to achieve an assisted withdrawal.

Access to help and support is a very necessary requirement if a general practitioner is to be enabled to manage alcohol and drug affected patients in their practice. This level of support will vary around the country but practitioners should be seeking the support of their PHOs to develop better availability of both advice and services in their area. Current moves to implement a national medical advice hotline to support primary care workers by CADS in Hamilton will assist isolated practitioners.

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Early identification of hazardous and dependent alcohol users within your general practice population is a worthwhile project, which I would recommend to PHOs. The overall consumption of those who drink hazardously and are likely to progress to dependence or continue to cause harm to themselves or others can be reduced by up to 20% by simple, brief interventions offered by primary health workers. The postgraduate course in Health Lifestyle Management available as distant learning from the Goodfellow Unit of the School of Health Sciences, Auckland University provides instruction in this and other interventions that are relevant in general practice. (www.health.auckland.ac.nz/population-health/postgraduate).

Prescription drug abuse

While not as prevalent as alcohol dependence and misuse, prescription drug abuse and dependence is a considerable problem in New Zealand. Last year the International Narcotics Control Board warned that 'the abuse and trafficking of prescription drugs is set to exceed illicit drug use' internationally. This trend means that the rest of the world is beginning to catch up with New Zealand. We are unique in the western world in that the vast majority of opioid dependent persons (probably in excess of 95%) are abusing prescription drugs.

Clients cite general practitioners and specialist clinics as the principle source of supply. Thus we are an important aspect of the supply chain. A similar situation exists with respect to the abuse of benzodiazepines and hypnotics. Benzos are increasingly on the menu of persons who are multi-drug users as well as proving a problem with the alcohol dependent. The extent of dependence on benzos and hypnotics is difficult to determine, as little reliable data exists.

So what is the responsibility of primary care in relation to prescription drug abuse in New Zealand? The New Zealand Drug Strategy is based on the principle of harm minimisation. The aim of this approach is to improve social, economic and health outcomes for the individual, the community and the population at large. It does not condone harmful or illegal drug use and acknowledges that the most effective way to minimise harm from drugs is not to use them. However, where eliminating high risk behaviours is not possible, it is important to minimise the personal, social and economic costs associated with those behaviours.

Strategies to reduce drug-related harm can be characterised in one or more of the following ways:

- Supply control (regulation and law enforcement)
- Demand reduction (prevention through education)
- Problem limitation (e.g. methadone substitution, needle exchange).

It is clear that one of the principle contributions that the medical profession can make to limiting prescription drug abuse is to exercise increased rigour with respect to our prescribing and thus reduce supply. During my five years working in an inner city Auckland practice I maintained a simple rule – I would not prescribe drugs of dependence to any patient not known to my practice. In arriving at this decision I was aware that the need for prescribing opioids as tablets to strangers was extremely infrequent and thus the possibility of my denying a deserving patient of necessary medication was virtually nil. There were those who tried to obtain a prescription but a simple refusal was usually sufficient to resolve the matter. This was accompanied by an explanation of the risks of inappropriate prescribing and reference to the frequency with which GPs were approached by drug-seeking individuals. Another solution is to explain that it is now illegal to prescribe dependency forming drugs to anyone with a dependence without authorisation from an accredited drug treatment service.

On those occasions when an individual became persistent and difficult I offered to assist them with what seemed to be their real problem and offered a referral to the local drug clinic or gave them information about the drug helpline. Invariably they realised that I was not going to be an easy 'score' and they gave up and left. It has been claimed by some doctors in the past that they have been stood over by patients and, where such is the case, then the writing of a prescription is understandable but it should be followed by reporting of the incident to the police and notification of the patient's details to Medsafe.

Table 1. The cost of alcohol abuse/dependency in NZ

- Total annual cost between $1 and 4 billion
- Crime and related costs: $240 million
- Social welfare: $200 million
- Public health services: $655 million
- Despite public perception, alcohol causes the greatest harm of all drugs of abuse.

In my current role, clients tell me of their experiences in 'doctor shopping' and I continue to be surprised at the ease with which some colleagues comply with requests for specific drugs. Recently a client informed me she had successfully 'scored' from some 40 doctors over a period of three weeks. She readily admitted that any clear refusal or an offer of alternative therapies would quickly lead to her ending the consultation and a determination that she would not try it on again with that practice.

The inappropriate prescribing of benzodiazepines and hypnotics seems to be an increasing problem if our experience in Auckland is any indication. An increasing proportion of the clients we admit for withdrawal are benzodiazepine dependent. In common with stopping alcohol use, cessation of benzodiazepines can lead to withdrawal seizures and so the risk of death. The management of withdrawal from benzodiazpines is difficult and, depending on the extent of the dependence, can take many months. TRANX, a service dedicated to managing such withdrawals, state that a daily habit of 60mg may take between six and 12 months to treat.

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The old adage that prevention is the best cure surely holds in this instance. Benzos and hypnotics should be used with caution. The use of diazepam for a very short period (less than 10 days) may sometimes be appropriate; similarly, the prescription of sleeping tablets should be limited to a few days continuously or to intermittent use, say two or three nights per week, for a few weeks. This may seem self-evident but given that many of our clients testify to a situation where a significant number of doctors are still prescribing without appreciating the risk of producing iatrogenic dependence means the message is worth repeating.

A further word of warning. Having graduated in an era when diazepam was prescribed in copious quantities without appreciation of the risk of dependence, be cautious of drugs that are marketed for relief of pain, anxiety or insomnia which are claimed to be non-addictive. The drug companies are often wrong – witness Imovane and Tramadol.

Conclusion

I am aware that drug or alcohol dependent patients in general practice are often difficult to manage and can create problems for staff and other patients on occasions, but they are deserving of our care. Some planning and thought as to how you might better meet their needs and perhaps detect and intervene earlier in the development of their problem use is to be encouraged. Your resolve to not become part of the prescription drug supply chain by refusing to prescribe dependency forming drugs to anyone who is not a regular patient of your practice would also be a big help.

Competing interests

None declared.