Addiction:

Yet another chronic disease for primary care?

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ABSTRACT

Addiction is a common, chronic relapsing disorder suitable for management in primary care settings, but one where first impressions can be formative.

Addiction can be difficult to understand for those of us without personal experience, but personal experience is not necessary to help patients with addiction – just the desire to understand and develop empathy, as for any other chronic disease. The key requirements for GP management are:

- An interest in the condition
- Skills in brief intervention and assessment of motivation to change
- A working understanding of principles of harm reduction, and
- Good clinical documentation.

A well-supported practice nurse can provide primary care screening and management for a patient with addiction. Information for continuing education is readily available.

Health professionals bring their own personal perspective when dealing with complex chronic difficult disorders such as addiction. Practitioner self-care is important.

People with addictions are often either fiscally disadvantaged, or motivated to prioritise their money on things other than health care, or both. GPs should therefore consider accessing chronic disease funding, as well as mental health shared care schemes, to fund primary care management of patients with addiction. In addition, patients may also personally qualify for disability allowances and/or sickness benefit whilst requiring active treatment. A business case could be made to the local PHO to facilitate change towards better support for the management of addiction problems in primary care.

Key words

Addiction management, primary care, chronic disease, difficult patients, motivation to change, brief intervention, practitioner self-care, health service delivery.

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There is always a first time

First time experiences are most impressionable: my early foray into smoking certainly was. My cousin and I were schoolchildren when we first experimented. I recall the thrill of illicit activity (*'Dad'll have a fit when he finds out!'*) as we selected from a pack of cigarettes 'misplaced' by an older relative, fumbled to light up, in-drew with anticipation, and then coughed and sneezed and retched and asked ourselves why on earth the adults did this? Little did we know how formative this early experience was to become. On that day neither of us intended to ever pick up a cigarette again.

My cousin became a life-long nicotine dependant, but the lasting effect was altogether different for me: triggering, from a healthy distance, a curiosity and questioning which was the start of long-standing academic interest. Why were the two of us affected so differently, although closely related? What would make anyone persevere through the unpleasantness long enough to become addicted? What is this phenomenon of addiction that can drive an intended experimental user beyond self control? Why does recovery from the substance abuse not also cure addiction? What drives relapse? What can be done?

Likewise my first drink was formative. I didn't take to that distinctive smell and taste of warm flagon beer,

but there were options. Despite an inauspicious introduction to the cheaper end of the wine market I persevered with drinking, after all I intended to become a medical student where alcohol was a norm. But nature had conspired against me: I realised quite quickly that with deficient alleles I would not easily drink in a hazardous or heavy manner. Again the experience ended in puzzlement and more questions. How could anyone drink enough to become alcoholic? Why is alcoholism so prevalent? What could possibly be the adaptive advantage to humans of having efficient aldehyde dehydrogenases? What is it about humans that some seek stimulated highs, others distorted reality experiences, but many can be happy without all that? Why, does double espresso generate a caffeine-driven high for some but nothing for others? Could neurobiochemistry really hold the answers to addiction and recovery? So many fascinating questions... Curiosity was to shape a career-long academic interest in alcohol, drugs and addiction.

There will also always be a formative first time consultation with a patient with addiction: and a bad experience may be adversive to both parties. By luck an enthusiastic undergraduate tutor or dedicated postgraduate supervisor may be on hand to facilitate our understanding of a trying encounter. If not, how can we prepare ourselves to ever want to deal with another patient with addiction again, after a discouraging start?

Just as for any other chronic disease, it is not necessary to have personal experience in order to understand or develop empathy and help those with addiction problems, but it pays to be well informed

Getting a grip on it

Addiction is a difficult phenomenon for those of us without personal experience to understand. Looking in from the outside, addictive behaviour appears irrational and maladaptive: self-centred and self-destructive; others are harmed along the way; denial is characteristic. Such patients can present a real challenge to health professionals as they try to engage in a therapeutic manner.

Just as for any other chronic disease, it is not necessary to have personal experience in order to understand or develop empathy and help those with addiction problems, but it pays to be well informed. Health professionals can learn a lot from patients in recovery from an addiction. People who have personally been through addiction experiences are often very willing to share wisdom with those who will listen. The power of such personal testimony can be seen in the enduring successes of self-help groups such as AA and NA. Many are particularly motivated during recovery to help health professionals to gain insight and to understand what they have been through, in order to help others. They are also keen to pass on insights from their prior health service interactions, especially to explain what was not helpful from professionals during the full grip of an addiction.

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Yes, there are difficult patients

Not surprisingly, people who are still actively caught up in the throes of their addiction are amongst those patients regarded as difficult, frustrating or unpopular with doctors.[1] 'Difficult' patients may present a challenge to the doctor's assumptions about how illnesses 'should' progress, or how patients 'should' behave.[2] It is easy for practitioners to slip into this pitfall with their patients with addiction. Addiction is a chronic relapsing disorder. It is to be expected that the underlying condition will remain despite treatment and might progress, just as other chronic diseases: diabetes or coronary artery disease, obesity or high blood pressure will progress, especially with management non-compliance. Whether a patient is labelled as 'difficult' or not also depends on the perception of the doctor involved; we bring our own personal perspective and understanding when dealing with patients with addiction.

To add to the difficulty, patients with addiction problems often come with an extensive co-morbidity, and this also complicates management. Co-morbidities might be psychological such as interpersonal difficulties, which may be both cause and consequence of addiction, or psychiatric such as dual diagnoses of anxiety, depression, personality disorders and psychotic disorders. Patients will often have medical problems as well. Most people with substance abuse will not present that fact to their doctor as the primary complaint, but will hide the bigger picture behind a miscellany of medical symptoms. Health practitioners (of every discipline) must be willing to look beyond the initial presentation and be ready to assess motivation to change and make an offer of advice and help. In a user pays primary care health system patients who are not motivated to prioritise spending money on health care do not go down well. Addiction patients often exhibit this particular 'difficult patient' characteristic.

Requirements for successful GP management

A common-sense approach to patients with addiction has served me well in primary care (Table 1).

Motivation to change

This is a key concept in the management of addiction and a skill that every health practitioner should strive to master. The Di Clemente and Procheska model[3] applies to any other chronic disease as well as to addiction. In *Pre-Contemplation* mode the person does not recognise the existence of a problem. Someone in *Contemplation* is willing to do something but hasn't started yet. The *Action*, *Maintenance* and *Relapse* stages are self-explanatory. An individual can hover from one stage to another, particularly influenced by what significant others do and say. Health professionals play an important part in that network to support patients to move in the desired direction.

Table 1. Addiction management in primary care

1. Assess patient motivation to change (at every opportunity)
2. Save time: Use brief intervention techniques
3. Target the messages: Adjust your intervention to the patient's level of motivation
4. Set clear boundaries: Stay within them
5. Be a team player: Share the management load with another professional
6. Do not expect instant successes
7. Remember harm reduction: Use these principles wherever possible
8. Always keep good documentation
9. Get supervision: Share your feelings with another professional
10. Reduce financial barriers: Join a mental health shared care or chronic disease management funding scheme

Brief intervention

This very useful technique takes very little time, yet has been shown to be just as therapeutic as some more time-consuming interventions.[4] For this reason brief intervention is ideally suited for general practice. Recommendations made to patients for change will not immediately take seed and flourish. It may be necessary to re-sow seeds of change many times before they fall on fertile ground and in an environment that is conducive to making the change. The only downside is that brief intervention is recommended for mild to moderate dependency only.

Clear boundaries

It is important to set professional boundaries and work within them in the management of any chronic disease. Health professionals should not try to hold the addicted person's hand or lead him (or her) personally through the changes. There is a high risk of co-dependency with many of these patients and/or manipulation beyond safe boundaries. Complaints occasionally arise that the doctor knew all about the drinking or drugging all along but ignored it, intervened unhelpfully, or even encouraged their continuing use.

Good documentation

Good clinical documentation is good insurance. Wise GPs will document the current level of motivation to change as well as stated drug or alcohol intake. This does not take long – one question or two will suffice. Knowledge of motivation helps a practitioner to appropriately customise the message to the level of the patient.

Reliance on miracles of modern medicine must be tempered by pragmatic reality, as addiction is not only chronic but also relapsing

No magic cures

Do not expect instant successes. The rule of thumb is 'there are no magic cures in addiction medicine'. Recovery from addiction requires a spiritual conversion in the widest possible sense: patients must truly want to change their lifestyle and have the determination not only to make it happen but also to keep it that way. To do this they must come to strongly believe that their old ways were wrong and seek to convert in whatever way works for them. Doctors and their medicines can certainly help a lot but a medical approach may also hinder. A quick fix pharmacological solution might divert attention from the underlying malcontent of spirit that also needs attending to. Good things take time, as the cheese advert says. Reliance on miracles of modern medicine must be tempered by pragmatic reality, as addiction is not only chronic but also relapsing.

Harm reduction

The guiding principle of harm reduction is to advise on how damage can be minimised for a person who will continue drinking or drug-taking.[5] It is a paramount consideration in addiction. Encouragement of injecting drug users to use clean needles and dispose of used ones safely is perhaps the best known example of harm reduction. There are more common examples: filtered cigarettes; designated smoking areas; low alcohol beer; guidelines for low-risk drinking (http://www.alcohol.org.nz/LowRiskDrinking.aspx).

Self-care

Practitioner self-care is the last, but most important item in successful management of patients with addiction. The primary care workforce is a very precious resource; we cannot afford professional burn out. Professional supervision is a worthy investment, as it allows the emotional load

to be shared.[6] Working within a team also helps by task distribution and sharing the case management load. With encouragement, practice nurses will not only provide practical support but can also take the lead in primary care screening and case management of patients with addiction.

Is addiction management really a primary care role?

Addiction is chronic, relapsing, with challenging multiple co-morbidities and a fair share of difficult patients, and that sounds exactly like the sort of condition that GPs deal with every day!

In the previous paper, Ian Scott has mentioned three factors that strongly influence service provision: role adequacy (*'do I have the knowledge?'*), role legitimacy (*'is it really my job to do this?'*) and role support (*'how much help will I need, where will I get it from, and can I be sure the assistance will be there when I need it?'*).

Role adequacy

Addiction knowledge and decision support is available to GPs in many formats. Free online resources (for alcohol) include the helpful ALAC site www.alcohol.org.nz with an interactive CME tool. The Ministry of Health has produced many relevant publications on both drug and alcohol topics (www.moh.govt.nz). There are other (mainly international) practice guidelines designed to put the GP in the picture for managing addiction. One example is the US National Institute on Alcohol Abuse and Alcoholism clinician guide with support materials: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

GPs who seek a formal qualification can tackle postgraduate papers in addiction topics offered by both the University of Otago and Auckland University. Most papers are also open to practice nurses and the wider health team.

Role legitimacy

That general practice will do chronic disease management, previously the domain of hospital specialists, is increasingly taken for granted: hospitals no longer have the clinic time, the staff or the funding, so this role must fall to GPs. Patients with problems of addiction prefer to see their GP[7] and GPs are interested in seeing patients with addiction and enjoy sharing their skills and insights with those still in training.[8]

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GPs not only see a different spectrum of addiction to hospital specialists but also perceive addiction differently. In the psychiatric domain, addiction is both defined and constrained by diagnostic criteria such as DSMIV.[9] The seven criteria DSMIV include:

- uncontrolled dosing (using more, or over longer periods than initially intended)
- unsuccessful attempts to cut down
- time prioritisation (spends increasing amounts of time on activities, such as recovery and looking for more)
- salience issues (giving up other life activities as a result)
- tolerance
- withdrawal; and
- use despite knowledge of and or experience of adverse consequences. One or more of the criteria must apply, leading to significant impairment or distress, to diagnose substance abuse. For dependence three or more of the seven criteria must apply.

Most GPs do not use the DSMIV to diagnose abuse and dependence: it is cumbersome; the seven criteria are subjective and overlapping; it does not satisfy the disease spectrum seen in primary care. GPs know that sensitivity and specificity characteristics of tools will miscalculate risk in low prevalence populations. Diagnostic tools such as DSMIV are also inflexible to socio-cultural and other factors and simply put a label on a problem. You first need to know that there is a problem.

Screening tools can be helpful in general practice settings[10] but even the

Table 2. Suggested practice audit topics

Management of smoking
For what percentage of your adult and adolescent patients is their current nicotine smoking status documented?
For what percentage of your adult and adolescent patients is their current cannabis smoking status documented?
How often do you ask your patients (smokers and non-smokers) about changes to their previously documented smoking status?
Management of alcohol issues
For what percentage of your adult and adolescent patients is their current alcohol intake status documented?
How often do you ask your patients about changes to their previously documented alcohol intake?
Drug use screening
For what percentage of your adult and/or adolescent patients is their other drug use status documented?

new generation screening tests may be underutilised. CAGE, MAST, CAST and AUDIT screen for alcohol. The latter more recent WHO tool produces a gradated score that can detect changes in drinking in general practice patients. Screening tools are also available for nicotine and opiates and there has been encouraging work to develop screening for other drugs, especially in the youth health area.

Role support

Every day each practising GP comes into contact with at least one person with a problem caused by addiction, be it a patient personally afflicted or by proxy (because of an affected close family member or friend). If primary care is to tackle the task, the system needs to be capable of supporting GPs to do their job well. No chronic disease can be managed satisfactorily within a single 15 minute appointment. The ethos of patient-funded primary care still exists, in the main, in New Zealand, although the user pays philosophy does not apply well to addiction or any other chronic disease state. Despite recent subsidy increases, few general practices can afford to waive patient co-payments: but it is not just about funding. Patients needing active management have access to the sickness benefit and/or disability allowances for their addiction treatment.

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GPs need access to timely and appropriate specialist consultation. In the step-up model of health service delivery the GP refers problems on to specialty care. This seems wrong for the management of addiction. It is in the nature of addiction that affected persons will be hard to reach, non-attenders, uncomfortable with institutions and authority figures. Long waiting lists for the next level of care only prolong the agony for both patients and service providers. Sometimes when the referral assistance comes it falls short of initial expectations. Historically primary care and specialist units worked independently: one mainly as a small business and the other as part of the public service. There is still some misunderstanding of respective roles, and residual mistrust. Equality in the professional partnership is hard to achieve, even in shared care contracts. A workforce development tension exists between the drive to upskill primary care providers and to increase specialist numbers. Addiction workforce redistribution could bring existing services closer to where they are most needed, while fostering cooperation within the existing workforce could see professionals playing to their strengths.

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Primary care management of chronic conditions is now facilitated by primary care multidisciplinary initiatives such as Care Plus http://www.moh.govt.nz/moh.nsf/wpg_Index/-Primary+Health+Care+Care+Plus). This nurse-led shared care concept in primary care could be extended to include the management of addiction, complementing psychiatric shared care agreements.

The PHO is now the first port of call for GP role support, and has become the place to make a business case to facilitate change in primary care. Data is required for a business case but some CME audit activities (Table 2) could double as baseline data to lobby for better support for the management of addiction patients in the practice.

Competing interests

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References

1. Hawken S. Strategies for dealing with the difficult patient. Postgrad Med J 1995; 71: 653–7.4. http://www.health.auckland.ac.nz/psych-ed/staff/sue's%20papers/Hawken_Aug_05.pdf
2. Wilson H. Reflecting on the 'difficult' patient. NZ Med J 2005; 118 (1212) http://www.nzma.org.nz/journal/118-1212/ 1384/J
3. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology 1983; 51(3): 390–395.
4. WHO Brief intervention study group A cross-national trial of brief interventions with heavy drinkers. WHO Brief Intervention Study Group. Am J Public Health 1996; 86(7): 948-955.
5. Ritter A, Cameron J. A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. Drug and alcohol review 2006; 25(6): 611-624.
6. Wilson H. Self-care for GPs: The role of supervision. http://www.rnzcgp.org.nz/news/nzfp/Oct2000/wilson.htm
7. Hindler C, Nazareth I, King M, Cohen J, Farmer R, Gerada C. Drug user' views on general practitioners. BMJ 1995; 310: 302.
8. Moriarty H, Wynn-Thomas S. 'Alcohol and drug teaching – can primary care practitioners do this?' Focus on Health Professional Education 2001; 3: 59-68.
9. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Fourth edition, text revision. Washington, DC: American Psychiatric Association, 2000.
10. Goodyear-Smith F, Arroll B, Sullivan S, Elley R, Docherty B, Janes R. Lifestyle screening: development of an acceptable multi-item general practice tool. NZ Med J 2004; 117 (1205). http://www.nzma.org.nz/journal/117-1205/1146/