Focus

Treating drug addiction in general practice

Ross McCormick is the director of the Goodfellow Unit, University of Auckland

Introduction

Today's drug seeking list according to the Ministry of Health's Auckland office is shown in the box. It is interesting to see tramadol enter the list.

Unwanted exposure to people suffering from drug dependency can colour our attitude to managing their problems in general practice. Some doctors adopt an antagonistic approach which prevents drug addicts from seeking help even when considering a change to their lifestyle; some attempt to help by prescribing drugs to treat the addict's dependency; and some work with local drug and alcohol treatment agencies to provide care.

It is illegal to treat opioid dependency under the Misuse of Drugs Act 1975 unless you are either a gazetted medical practitioner or a medical practitioner authorised by a gazetted doctor, or a gazetted service. In simple terms, without authority it is illegal to prescribe addictive drugs to a known drug addict in an attempt to treat their dependency.

Key points

- Drug dependence is a self-perpetuating, dominant behaviour with loss of flexibility in adapting to circumstances and a narrowing of interests
- General practice is often the first point of contact for an addict seeking or needing help
- Reflecting back personalised information about the patient's life and relationship with drugs is a crucial therapeutic activity
- The effectiveness of information provision can be increased by opportunistic and planned follow-up visits
- The aim of treatment is to provide greater autonomy, flexibility and normalisation of the lives of drug-dependent people as well as attending to biological and social factors, and maladaptive ways of coping

Features of drug dependence

Drug dependence is a pattern of behaviour characterised by the following features:

- drug use becomes increasingly stereotyped, taking place in a recurring pattern instead of a variable pattern that responds to social or emotional cues
- drug seeking dominates other activities
- a user experiences continued desire to use drugs despite persistent and

recurrent problems associated with their use

- there is subjective awareness of the compulsion to use the drug or "craving"
- there is repeated relapse after attempts to cease drug use
- there is use of drugs to prevent or relieve withdrawal symptoms
- neuroadaptation may develop, recognised by the presence of tolerance and withdrawal on cessation of drug use.

The loss of flexibility in adapting to circumstances and a narrowing of interests is central to drug dependence. Drug use becomes a self-perpetuating, dominant behaviour. Drug dependence is not an all-or-nothing phenomenon, but varies in severity. In any given individual the severity of dependence fluctuates over time.

First point of contact

General practice is often the first point of contact for an addict seeking or needing help. The addict may present as a drug seeker or with a health problem associated with drug use, or may be a general practice patient who had not previously disclosed his or her drug dependency. The GP's role in these situations is to work alongside the patient to facilitate agreement to seek appropriate help.

Drugs sought by addicts

Anorexiants including Umine and Duromine

Anticholinergics including Kemadrin and Cogentin

Benzodiazepines including Rivotril

Codeine

Dextropropoxyphene

Ephidrine and pseudoephidrine

Hemineurin

Imovane

Opioids

Ritalin

Tramadol

Information provision is the basis of "brief intervention" approaches to change behaviour. Taking a history about drug use and psychosocial functioning can both reveal important information and reflect it back to the patient. Reflecting back personalised information about the patient's life and relationship with drugs is a crucial therapeutic activity and is valuable where individuals seem unwilling or unable to see the impact of the behaviour on their lives. This process is a more powerful therapeutic tool than insight into why a patient is using drugs or discussing health risks in general.

The effectiveness of information provision can be increased by opportunistic and planned follow-up visits. These can reinforce the likelihood that a patient may eventually agree to seek appropriate treatment, particularly if the visits are accompanied by some form of negotiated monitoring of behaviour.

GPs should not expect a miracle to occur after one consultation. Patients are not always able to take advantage of the opportunity to change. It may take many visits before the patient is able to make a decision to change. It requires a process of negotiating the change via ongoing intervention between the doctor and patient.

A drug-using patient who continues to self inject and/or has relationships with those with self-inject should understand simple prevention strategies. Hygiene (eg, condoms, washing and drying hands after toiletting, using clean needles and not sharing needles) will reduce transmission of infections. Patients should be advised of

local needle exchange schemes.

What to do

GPs should screen for problems associated with drug addiction.

1. Compared with the general population, opioid-dependent individuals are approximately:
    - 24 times more likely to have antisocial personality disorder
    - 13 times more likely to have an alcohol dependence or abuse problem
    - nine times more likely to have schizophrenia
    - five times more likely to have a diagnosis of depression
    - three times more likely to have a diagnosis of anxiety.
2. Patients may overdose on drugs.
3. Patients may suffer consequences of non-sterile injection, including:
    - thrombophlebitis or cellulitis at the injection site
    - acute endocarditis; presentation is that of an acutely ill patient with fevers and sometimes the development of a new heart murmur
    - a "dirty hit" involving injection of pyrogenic material which can lead to an acute febrile reaction lasting 24-72 hours, sometimes associated with rigors and jaundice
    - transmission of HIV, hepatitis B, hepatitis C, and Delta hepatitis virus.
4. Some opioid-dependent patients may have been subjected to trauma, or may have untreated infections (such as sexually transmitted infections), socially inappropriate tattoos or poor teeth.
5. Power and control issues can be associated with access to illicit drug use. These issues are of particular significance for female patients who may be vulnerable to violence from a partner who supplies illicit drugs, and to the risks of prostitution.
6. Pregnancy in an opioid-dependent patient is a high risk situation for the baby.

Treatment options

The aim of treatment is to provide drug-dependent patients with greater autonomy, flexibility and normalisation of their lives. Treatment approaches vary between programmes. Some, such as methadone maintenance treatment, aim to reduce the harm associated with illicit opioid use. Residential and outpatient programmes may aim at abstinence from all drugs. Referral to the local drug and alcohol treatment agency once the patient is willing will identify which treatment option is best and whether the patient needs detoxification.

Whatever the approach, all effective treatments aim to attend to the multiple factors that contribute to the opioid-dependent patient's problems – biological and social factors and maladaptive ways of coping.

The patient

The label "manipulative" is often used in reference to drug users and may reflect the extent to which the health professional and patient have different goals. The clinical exchange can be used to clarify what the patient is seeking and what the health professional is willing or able to provide, and to avoid inappropriate perceptions of the patient as a result of these differences. The primary health care team should be concerned and caring, but not to the point of failing to recognise when a patient is making inappropriate demands.

The therapeutic relationship with opioid- dependent patients can be enhanced by an exchange and agreement between patient and health professional on:

- views of the cause and nature of the patient's problems
- expectations of one another
- expectations of how the patient's treatment goals may be met.

It is helpful for the health professional to outline his or her approach to drug dependency when beginning this discussion.

Many illicit opioid users have histories of invalidation, rejection and punishment, and this experience can entrench alienation and a sense of antagonism. A patient acceptance of treatment is an opportunity to provide a different experience, one of safety and containment.

Working with the methadone team

Some general practices with delegated authority to provide methadone to patients assign a practice nurse as case manager. The practice nurse will interact with the patient on a regular basis and when the patient presents an opportunity. The practice nurse has a key role in identifying and addressing life and health-related issues and in enabling patients to discuss these.

The pharmacist is key to the "methadone" patient's care. He/she sees the patient most often and, when working with the doctor, practice nurse and drug and alcohol agency, forms part of a collaborative team to monitor and assist the patient towards a successful outcome. The drug and alcohol agency is available for advice and assistance should a patient become destabilised.

The more overt and collaborative the approach, the more responsibility for treatment is shared between patient and health professional, the more effective methadone treatment is likely to be. Difficulties may still arise and should not be a cause for excessive recrimination. Often these arise where patients have adopted goals they are unlikely to reach. Realistic goals are key.

Future training

The Goodfellow Unit has a HFA contract to deliver training to GPs, practice nurses and pharmacists about providing methadone to stabilised patients within the primary health care team. GPs who attend one of our nationwide eight-hour courses will then be able to decide if they wish to contract with their local drug and treatment agency to be a delegated methadone prescriber.

Those doctors already contracted will be able to enhance the quality of the programme by sharing their experiences and advice with those considering adding this service to their practice. For information contact Annette Gohns, National Manager, Opioid Treatment Training Primary Health Care, Goodfellow Unit, University of Auckland. Email: a.gohns@auckland.ac.nz; Ph: 09 373 7599 ext 3029.

Acknowledgements: Thanks are due to Louise Kirkwood, who collated the Goodfellow Methadone Training Manual2 on which much of this article is based, and thanks also to Annette Gohns for her usual insightful comments.

References

1 *National Protocol for Methadone Treatment in New Zealand*. Ministry of Health, 1996.
2 *Methadone Treatment in Primary Care National Training Manual*. Goodfellow Unit, University of Auckland, 1999.