Community-based opioid detoxification – future roles for GPs?

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Abstract

This discussion paper considers community or home opioid detox as another service possibly deliverable in primary care, rather than by hospital services. Some GPs already provide all the elements of community-based detox.

The methadone detox protocol of the Wellington Alcohol and Drug Dual Diagnosis and Detoxification Service (Addox) is outlined. A recent audit of outpatient community detox at this service illustrates the profile of patients who seek such services, and likely success rates. Those attaining abstinence by the end of a methadone countdown had shorter duration of opiate use, fewer prior withdrawal attempts, and lower poly-substance use. GPs could use this information to select suitable patients for community-based detox.

The theoretical basis of detox treatment is discussed. Reduction of opiate use may be a more appropriate end point than abstinence for some patients, as more than half of the audit sample did not return after completion of their countdown. Long-term abstinence rates could not be obtained from the hospital audit data but GPs with their pivotal position can keep in touch with patients, monitor for relapse after detox and encourage them to try again later. For this reason, GPs may also be better able to complete the research.

Key words

Opiate dependence, community detox, methadone countdown, polysubstance abuse, clinical audit

Introduction

Management of drug dependence is very important. It is a key government health directive, featuring directly in two of the thirteen population health objectives of the NZ Government Health Strategy and indirectly in four others.[1]

The hard drug scene in this country differs from that overseas – even from our closest neighbour. New Zealand border control restricts availability of cocaine and heroin. Stimulants, mainly with amphetamines, are an emerging phenomenon but not yet well understood. The common opiates of abuse in New Zealand are two prescription medications, methadone and morphine.

Opiate abuse carries significant social, economic and personal health costs. In 1996 it was estimated that there were 13 500–26 600 people with opioid dependence in New Zealand, a number predicted to grow by 15% per annum.[2] It is estimated that 9.4% of the total mortality between the ages of 15 and 39 years can be attributed to use of illicit opiates in Australia.[3] The equivalent figure for NZ is unknown.

In contrast to resources available to assist community-based management of alcohol and tobacco dependence,[4,5] support is more limited for GPs managing their patients with hard drug problems. Some GPs offer supportive counselling for opioid dependent patients, others offer methadone maintenance (under authority). Community detoxification is another option.

What is a detox?

Detoxification is the management of the withdrawal syndrome that arises when a dependent person stops using the drug responsible. Detoxification from any substance requires provision of psychological support, monitoring for possible medical and psychiatric complications during withdrawal, and

offering pharmacological interventions where appropriate.

Pharmacological supports are not always necessary. Opiate detoxification without pharmacological support is unpleasant for the patient but safe. Community opioid detoxification by tapered methadone or morphine countdown is currently available in New Zealand from addiction services (doctors must be authorised by a gazetted medical practitioner or gazetted themselves by the Ministry of Health to prescribe methadone to addicts).

The setting for detoxification depends on the support needed by the patient: it may be in a detoxification unit or residential treatment centre but many patients can be successfully detoxed at home with GP support or shared care. The Addox protocol starts with an individualised methadone dose tapering over three months at a variable countdown rate. Patients continue their usual lives at home and at work, but are monitored weekly, including random urine testing. They are offered supportive counselling during and relapse prevention counselling after the methadone countdown.

Who seeks community detox?

A recent audit of a sample of patients receiving methadone-assisted countdowns gives us some insight. Addox staff identified twenty-three recent detox patients. Their notes were encoded to prevent easy identification. A graduate student (NG) undertook a record review, with authority and ethical approval from Capital and Coast District Health Board mental health services. A literature search guided development of an audit template by indicating the factors considered important in withdrawal. These included service factors such as methods of referral and patient factors such as age, sex, patterns and duration of opiate use, other substances of abuse, employment status, family, social, and justice history and previous treatments for addiction.

The results revealed that these patients were a heterogeneous group of opiate users, both male and female. Duration of opiate use varied from one to twenty years. Many had previous medically assisted opiate withdrawals (patients averaged two each). At their presentation 83% (19/23) used intravenous opiates, 9% (2/23) took oral opium preparations (poppy tea) and the remainder consumed both orally and intravenously. All met DSMIV criteria for opioid dependence at presentation.

Polysubstance use with tobacco, cannabis, benzodiazepines or amphetamines was common. Only 39% (9/23) patients used opiates alone. It is not known how many of these clients may have met the DSMIV criteria for polysubstance dependence.

Employment data was incomplete, and self reports unreliable due to undeclared under-the-table work, but at least 43% of the clients (10/23) were employed. Fifty per cent (12/23) had self-referred direct to the hospital service.

How effective is community detox in NZ?

At the first appointment, 17% (4/23) of this sample had already voluntarily curtailed their daily opiate use. By completion of the countdown 35% of clients (8/23) claimed abstinence for the duration but the remainder had failed to adhere fully to the programme, using extra opiates regularly or periodically, as well as continuing with the prescription countdown.

Those claiming abstinence generally had shorter duration of opiate use and fewer prior withdrawal attempts but were especially notable for lower polysubstance use. Voluntary self-referral did not predict attainment of abstinence.

There were no dropouts during the methadone countdown itself but 52% (12/23) did not return after their prescriptions had ended. Therefore longer-term outcome assessment was problematic, except for two clients who transferred to residential rehabilitation programmes. Good prognostic factors for community-based withdrawal could not be identified because most patients did not return for longer-term follow-up. As some patients had already stopped using before their first contact, and because of the small sample size of the audit, quantification of behaviour change achieved by the programme was not possible.

How do we compare with the rest of the world?

The results from this audit are similar to those from other centres.[6] Low retention after an opiate countdown is well described.[7,8] Although relapse is common after a drug detoxification,[9] there is steady patient demand. Many addiction services now offer community-based withdrawals as an alternative to their inpatient programmes.[6] There is no good evidence that any one detoxification method is superior to others. GPs can also support a reduction in drug intake with clonidine to control adrenergic symptoms of opiate withdrawal, or antidepressants. Benzodiazepines are best avoided due to abuse potential. The partial agonist buprenorphine with or without naloxone is now used extensively in Australia.[6]

Complete withdrawal is more likely in inpatient than outpatient settings,[8] a difference not attributable to pretreatment drug use, social or psychological factors. It is not known why patients might choose a community-based rather than inpatient detoxification.

Is the theoretical basis of detox treatment valid?

It is interesting to ponder why patients are motivated to seek a methadone countdown and participate until the prescribing ends but to also use extra drugs throughout the programme and fail to return for relapse prevention counselling.

Reduction of opiate use may be a more valued end point than sustained abstinence for these patients. In New Zealand, patients may have an incentive to over-state detoxification goals, because waiting lists for methadone countdown are generally shorter than for methadone maintenance. If this is so, the patient goals for community detoxification might differ substan-

tially from those of the health professionals delivering this service. In our experience the most common outcome for patients is experiential learning about opiate withdrawal through participation. They reflect upon the experience and often will discuss their insights at a later presentation.

This mismatch of outcome expectations requires further exploration

Detox programmes began in the 1970s for juvenile drug users and adult offenders.[10] After 30 years, much is still unknown. The value of outpatient detoxification programmes has been questioned, in particular for opiate dependence.[11] Community-based withdrawal costs less to providers than inpatient programmes, but if it is less effective, the cost falls instead upon individual patients, their families and society.[11]

What is the role for GPs?

Since attainment of abstinence through the methadone countdown was apparently associated with lower concurrent use of other drugs, GPs could use this information to assist in selective referral. GPs might wish to request authorisation from the local addiction agency to prescribe a methadone countdown for selected patients.

The GP has an important role in keeping in touch with the patient, monitoring for relapse and then encouraging him or her to try again. General practices could contribute to outcomes research.

It is clear from our audit that many patients continue to use opiates during and after a community opiate detox programme. This is consistent with the chronic relapsing nature of addiction. The patient's GP is well placed to encourage patients to try to reduce drug use again and to use motivational interviewing to maintain longer abstinence.[12]

Opportunities and barriers

A focus group of experienced NZ GPs has explored strengths, weaknesses, opportunities and threats in handling addiction issues in their practices.[13] Of the many difficulties identified in handling these patients, the development of an ongoing relationship with a GP is key. The advantage in offering community detox is that this is a short time-limited service. It offers an opportunity for general practices to do something positive for addicted patients, to help build rapport and mutual trust.

Payment of GP fees may be a barrier, but a successful detox will result in savings to the patient in the cost of illicit drugs. Consultations can be funded through application for a disability allowance. In some regions, GP monitoring of patients with addiction diagnoses may be funded by IPA-run mental health contracts.

The requirement to obtain authorisation to prescribe for addicted patients may appear to be a barrier to GPs, but is also an opportunity to get to know and work closer with the local addiction service.

Conclusion

The findings of overseas studies are not transferable due to our unique NZ drug scene. There are many factors that require further investigation, including appropriate measures of success and ways to engage patients in relapse prevention counselling. Failure of the patient to attain or maintain abstinence in a detoxification attempt should not be seen as failure, but as a learning opportunity for the patient and an expected step in the natural history of addiction disorders. This audit has highlighted how little is understood about the appropriateness of opiate detox programmes. Further understanding of the patient perspective has been explored in an unpublished qualitative patient survey recently completed by the authors.

GPs may be best positioned to assist these patients at all stages: selection and preparation before referral for community detoxification, the countdown itself and by providing follow-up and contributing to outcomes research in primary care.

Acknowledgements

The student researcher was supported by a summer research grant provided by the GP Department, Wellington School of Medicine and Capital and Coast District Health Board, Wellington.

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