Problem drug users known to Bristol general practitioners

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SUMMARY. A 12-month prospective survey was undertaken of all 239 problem drug users known to general practitioners in Bristol and the doctors' attitudes towards them. The drug users were predominantly young, aged 15–35 years, and males outnumbered females by approximately two to one. Seventy-eight per cent had problems associated with opiates, almost invariably heroin, 10% had problems with stimulants (mainly amphetamine powder), and others had problems with hallucinogens, cannabis, barbiturates and solvents. Opiate dependence was the commonest single problem but ill health, hepatitis, psychiatric illnesses, relationship problems, work and financial difficulties were also frequently mentioned.

There was a wide variation in the numbers of problem drug users seen by individual practices, which related both to the situation of the practice and the widely varying attitudes of the partners towards drug users and drug problems. General practitioners were aware of the grapevine that transmits news of their treatment to other users, and individual practices had typically evolved a general strategy for all drug users, to minimize arguments. General practitioners were asked their views about specialist services: they thought that services in the area for drug users were inadequate to help them and their patients in 58% of cases. Several suggestions were made for additional services which were needed.

Introduction

IN 1981 Edwards[1] wrote, 'The role of the general practitioner in relation to treatment of drug problems is ... to a large extent unexplored and unrecorded'. Since then, although there has been public debate over issues relevant to general practitioners treating drug users[2,3] and the *Guidelines for good clinical practice in the treatment of drug misuse*[4] have been circulated, few general practitioners have participated in the discussion. Robertson[5] has been a notable exception. He identified 162 heroin users in a large Edinburgh group practice of 18 000 patients. He remarked that general practitioners were dealing with drug problems in many parts of the UK with little back-up advice or support from hospitals, and that recognition of this was necessary.

A postal survey of a 5% sample of general practitioners in England and Wales[6] has indicated that in a four-week period, approximately one fifth of general practitioners had attended a patient with problems associated with opiates, and that if there was a difference between London and the provinces, the provincial general practitioners were attending more cases.

The results presented here are from a prospective survey of general practitioners' knowledge of problem drug users. It was undertaken as part of a wider survey into problem drug use in Bristol carried out by the Avon Drug Abuse Monitoring Project[7].

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Method

With the agreement of the local medical committee a letter from both authors was sent to all general practitioners in Bristol to inform them of the survey and to request a meeting. The senior partner of each practice was telephoned (by J.P.), and where possible a joint meeting was arranged with all partners. Individual arrangements were made for the small number of practices which did not meet regularly. All the practices were visited (by J.P.) and the general practitioners were asked about (1) their knowledge of drug and solvent abuse in the locality, (2) their attitudes towards problem drug users and (3) their views about the specialist services. They were asked to complete an individual questionnaire on each problem drug user they knew on 1 March 1984, and on anyone coming to their attention over the next 12 months. The questionnaire requested anonymous identifying details; information about the patient's drug taking; details of the medical, social or legal problems associated with drug taking occurring in the 12-month period; and details of the services and/or support necessary to help in the individual case. (Copies of the questionnaire can be obtained from the authors.)

The definition of 'problem drug user' was based on that recommended by the Advisory Council on the Misuse of Drugs:[2] 'any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs'.

The drugs included were opiates, stimulants, hallucinogens, barbiturates, cannabis and solvents. General practitioners were reminded of the survey by letter every three months.

Results

In March 1984 there were 211 general practitioners based in the city, working from 76 practices. One third were single handed practices. All practices in Bristol were contacted and all but six agreed to take part. Five of the six refused because they never saw drug users or drug problems and the sixth was too busy and saw few. Thirty-two practices completed 239 questionnaires. Thirty-eight practices did not report any cases, although 13 of them had indicated at the initial meeting that they knew at least one problem drug user and one of these practices had reported knowing approximately 12 heroin addicts. It is estimated, therefore, that approximately 30 to 40 cases were initially known to this group and not reported.

Of the 32 practices who completed questionnaires, 25 sent between one and four, five practices sent between five and 15, but two practices each reported 60–70 cases. Thus two practices accounted for more than half of all patients reported. No distinction was made between problem drug users known on 1 March 1984 and those coming to the attention of the doctors during the 12-month survey period.

The problem drug users were predominantly young adults, aged between 15 and 35 years, and males outnumbered females by approximately 2:1 (Table 1). There was a small group of older patients who were dependent upon drugs which had been prescribed for therapeutic reasons and which had been continued often against the general practitioner's better judgement.

Table 1. Age and sex distribution of problem drug users.

Sex	Age group (years)												
	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+	Not known	Total
Male	2	22	33	34	31	12	8	2	0	1	3	8	156
Female	0	13	21	15	20	2	1	0	1	0	3	6	82
Total	2	35	54	49	51	15[a]	9	2	1	1	6	14	239

[a]Sex unknown for one patient.

The majority of the 239 patients had problems associated with opiates (78%), mainly illicit heroin. Ten per cent had problems associated with stimulants, which were mostly illicitly manufactured amphetamine except for three individuals who received prescriptions for diethylpropion hydrochloride (Tenuate Dospan, Merrell) or dexamphetamine sulphate (Durophet, Riker; Dexedrine, SK & F). Cannabis was associated with problems in 3% of cases, hallucinogens in 1% and barbiturates in 1%, while 6% had problems associated with solvent misuse. This bore out the general practitioners' comments at the initial meeting that although they were sometimes aware of solvent sniffing in their locality, and parents sometimes asked their advice, they rarely saw solvent misusers themselves.

Problems associated with drug misuse

The patients had wide ranging medical, social and legal problems (Table 2). Some general practitioners mentioned the difficulty of abstracting information about problems occurring in a 12-month period from the notes of patients who had been known to them for many years. Indeed, the clearest descriptions often related to young people whose drug or solvent use had recently come to attention because of hepatitis, psychosis or family problems. Opiate dependence was the commonest single problem mentioned, but by talking to general practitioners it was apparent that some used the term (or that of 'addict') as a shorthand for a host of medical and social difficulties. Other frequent problems included ill health, hepatitis, psychiatric illnesses, dependence upon drugs initially prescribed for medical reasons and obtaining drugs by deception. Thirty-two patients were reported to have poor or ill health, which included poor health due to neglect, and medical conditions (such as recurrent chest infections) exacerbated by their life-style.

Relationship difficulties were the commonest social problems. The younger patients frequently had difficulties with their parents, for example 'parents breaking up — long term difficulties but aggravated by his behaviour' or 'family friction and rows'. The older ones had problems with their boy or girl friends, spouses, friends or children, for example 'kicked out of home by consort', 'has lost all contact with her old friends and is isolated', 'his drug taking has caused separation from his wife and children', 'is barely coping with her two young children' and 'divorce pending'. Work and financial difficulties also featured, and for others their involvement with other drug users appeared to doom to failure their stated wish to discontinue drugs. Twenty-three per cent had legal problems known to the general practitioner.

General practitioners' attitudes to drug users

The initial interview showed that general practitioners' views on their role in treating drug users were very varied and fell roughly along a spectrum. At one end were practices which had a clear policy not to accept drug users onto their lists. The policy was justified by stories of burglaries or threats of violence from addicts in the past, and it was sometimes associated with a firm conviction that legal measures were the only way of dealing with drug users. Other practices did not have such a definite policy, but did not believe they had anything to offer patients with drug problems and did not know of any on their lists. Typical comments would be, 'Word gets around that we don't give them anything and they don't bother us'. Towards the middle of the spectrum were practices which would accept medical responsibility for drug users, but had a clear and explicit policy against the prescription of controlled drugs, to avoid attracting such patients. Towards the opposite end of the spectrum was a small group of practices who would prescribe opiates to help a patient withdraw, or who had maintained several addicts each over a period of years. At the far end was a smaller number who

Table 2. Problems associated with drug abuse reported by general practitioners.

Problems	Number of cases[a]
Medical	
Opiate dependence	135
Poor health	32
Hepatitis	30
Infections related to injection	20
Pain/self medication	15
Dependence on other drugs than opiates	10
Deliberate self-harm	6
Trauma	2
Drug use in pregnancy	1
Not specified	20
Legal	
Theft/deception	15
Offences under Misuse of Drugs Act	8
Prostitution/soliciting	7
Prison during study year	4
Assault	1
Not specified	21
Social	
Relationship difficulties	60
Financial problems	15
Spouse or social group using drugs	15
Work problems	13
Behavioural problems	10
Accommodation problems	8
Children in care	2
School problems	2
User in care	1
Not specified	4

[a]Some patients had more than one problem.

felt strongly that the psychiatrists were not interested in addiction, and who prescribed opiates independently, and attracted patients by their attitude. There was no evidence of private prescribing of opiates in Bristol.

Services needed to help drug users

The questionnaire asked if the general practitioner had adequate services and/or support to help the individual patient with his or her drug problems. This was answered in over half of the cases (149). Responders thought the services/supports available in the area to help them and their patient were inadequate in 58% of these cases and adequate in 42%. Those who said the services were adequate had undertaken counselling themselves (sometimes with a social worker), or had referred the patient for specialist treatment successfully; in some cases patients did not want help. Those general practitioners who believed the services to be inadequate frequently commented, however, that the major stumbling block was the lack of motivation or a wish to change on the patient's part.

Services that were frequently described as necessary were:

— a prompt response, whether for assessment or detoxification.
— a specialist psychiatric unit for assessment, treatment and follow-up. There were many complaints about lengthy waiting lists and patients not being taken on for treatment by psychiatrists.
— rehabilitation in a drug-free environment.
— social support.
— consistent supervision of a prescription.

For teenage drug users, typical comments were that the problems were 'not really medical' and that informal community workers or self-help groups would be valuable. The 'therapeutic' addicts evoked questions such as 'How do I wean her off?' or 'no room for change, he is stuck in a sick role', but there were no requests for other or specialized services.

Discussion

These results should be seen in the context of the limited facilities for drug users in Bristol, together with the results of the wider survey into the extent of problem drug use in the city.[7] In 1984 an experimental drug treatment centre for heroin addicts had just been established by one psychiatric team. Previously there had not been a specialist psychiatric service for drug users, but referrals could be made to any general psychiatric team. In the voluntary sector there was a Christian community for the rehabilitation of male addicts, and a network of Narcotics Anonymous groups. A private drug and alcohol treatment unit nearby offered a small number of charity places. The full survey[7] identified 759 problem drug users over the 12-month period. Its five best sources of information were general practitioners, the Home Office (which knew of 196 opiate addicts), the accident and emergency departments, the probation service and psychiatrists (which reported respectively 172, 128 and 80 problem drug users). The experimental drug treatment centre treated a further 80 addicts over this period.

Individually most of the general practitioners in Bristol saw few problem drug users in 1984, but collectively they saw at least 239 people over 12 months, more than any other professional group. The majority of the patients had problems related to using opiates, mainly heroin. Asking so many doctors to cooperate with a survey prospectively will have inevitably led to incomplete reporting. The pattern of problems and the distribution of patients, however, confirmed impressions from the initial interviews with general practitioners and the wider survey findings. The group is one of young adults, with men outnumbering women by two to one. In these respects it is not dissimilar from the populations of heroin users known to general practitioners in Edinburgh[5] or throughout England and Wales.[6]

General practitioners' involvement with drug users

The results demonstrated a wide variability in the extent of general practitioners' involvement with drug users in Bristol, which appears to be related both to the situation of the practice catchment area, and to the attitude of individual general practitioners and practices. From the initial interview with the practices, it was apparent that views on the part general practitioners have to play in treating patients with drug problems or drug users were very varied, and many said their views had changed (usually hardened) over time. Glanz[8] also reported that general practitioners who had qualified recently were 'somewhat less unfavourable' in their views of drug users than older hands. In Bristol few doctors had seen good outcomes, and there was in general a pessimistic view of the prognosis for drug users.

At times practices based in the same health centre had very different contact rates with drug users. A postal survey of a random sample of one in four general practitioners in north-east London also found that problem drug users were unevenly distributed between practices. (Hartnoll R, *et al.* Unpublished interim report of the Drug Indicators Project, 1981.) This appears to be due in part to the 'grapevine' which transmits news of treatment offered by one general practitioner to other drug users. This social dimension makes problem drug users different from other patient groups, who do not arrange consumer feedback, and it appears to limit general practitioners' flexibility. Most practices had evolved a general strategy for all drug users. The general practitioners who refused to treat drug users emphasized their deceit and cunning, and the difficulties attendant upon the ability to prescribe. Other general practitioners found they could best maintain a long-term relationship with the patient and treat all health problems by making it explicit that they would not prescribe controlled drugs.

While a proportion of problem drug users sought help for their drug problems, a large number came to their general practitioners' attention for other reasons, and the part that their drug or solvent use played in their medical or social problems became apparent over time. General practitioners' contact with drug users differed from that of psychiatrists in that they retained medical responsibility, regardless of whether the patient accepted he had a drug problem, was having treatment for it, or had failed in treatment. Connell[9] emphasized that it must be accepted that there will be a sizeable group of 'handicapped' drug users who see drugs as the solution to their problems, no matter what treatment options are available. The Bristol general practitioners were aware of many such patients, who acknowledged that they had problems and that they took drugs but who demanded 'help' while not wishing to change in any way.

Implications for general practitioners

Over the 1980s the numbers of drug misusers have continued to increase throughout Britain, and as specialist resources are scarce and often over-stretched, general practitioners are becoming more involved in their treatment. Indeed, collectively, general practitioners saw more problem drug users than did any other professional group in Bristol. The Advisory Council on the Misuse of Drugs[2] was cautious about involving general practitioners in the treatment of drug misuse, as it feared that without supervision they would over-prescribe and contribute to the availability of drugs, as happened in London in the 1960s. The DHSS-appointed Medical Working Group has wanted to encourage general practitioners to take a part in providing both general medical care and specific treatment for drug problems.[4]

It appreciated that treatment is much more than the issuing of a prescription. This is exemplified by the work of some Bristol general practitioners who are actively involved in counselling young solvent or drug misusers and their families, assessing when to refer those dependent on drugs for specialist help, liaising with voluntary groups and other professional disciplines to find appropriate facilities, providing general medical care and bearing the demands of those who do not wish to change.

The government strategy for tackling drug misuse relies on general practitioners accepting responsibility for the health needs of drug misusers.[10] The special difficulties these patients encounter should be faced, however, and not dismissed.

There is a social dimension to drug taking that makes drug users different in some ways from other patient groups. Robertson[5] notes that general practitioners treating heroin users can feel isolated and at times guilty for prescribing anything at all. Few have much experience. Our involvement with Bristol general practitioners would support the result from the national survey[8] that general practitioners say they would be more likely to play an active part in treatment if more back up resources were available to them.

It is now time for all general practitioners — especially those with little experience of drug misusers — to consider what they could offer to such patients, and to help to actively shape the development of specialist and voluntary services in their districts.

References

1. Edwards G. The background. In: Edwards G, Busch C (eds). *Drug problems in Britain.* London: Academic Press, 1981.
2. Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation.* London: HMSO, 1982.
3. Ashton M. Doctors at war. *Druglink* 1986; **1:** 13-15.
4. Medical Working Group. *Guidelines for good clinical practice in the treatment of drug misuse.* London: HMSO, 1984.
5. Robertson JR. Drug users in contact with general practice. *Br Med J* 1985; **290:** 34–35.
6. Glanz A, Taylor C. Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers. *Br Med J* 1986; **290:** 427–430.
7. Parker J, Pool Y, Rawle R, Gay MJ. Monitoring problem drug use in Bristol. *Br J Psychiatry* 1987 (in press).
8. Glanz A. Findings of a national survey of the role of general practitioners in the treatment of opiate misusers: views on treatment. *Br Med J* 1986; **293:** 543-545.
9. Connell P. I need heroin. *Br J Addiction* 1986; **811:** 461-472.
10. Home Office. *Tackling drug misuse: a summary of the government's strategy* (2nd edn). London: HMSO, 1986.

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