Supporting problem drug users: improving methadone maintenance in general practice

OPIATE injection is a major public health problem which cannot be ignored. Its prevalence among adults in cities in the United Kingdom lies between 1% and 2%.[1,2] In Glasgow, drug injection is now the major cause of death among young adults (personal communication): concurrent opiate injection and use of benzodiazepines (orally and by injection) appears to be particularly hazardous.[3] Throughout the world, the human immunodeficiency virus (HIV) and viral hepatitis are rife among drug injectors.[4,5] Drug misuse is also responsible for a great deal of misery among patients' families,[6] and a high proportion of crime is drug related.[7] The scale of the problem can easily be imagined by considering that, very conservatively, more than 100 000 individuals in the UK[2] each need to raise more than £10 000 per year to support opiate use.

Those who misuse drugs by injection tend not to be general practitioners' favourite patients. The reasons include:[8,9] general practitioners' prejudice against patients with self-inflicted morbidity; lack of perceived skill or training in dealing with drug injectors; scepticism about the value of treatments; concern about the cost of treatments; worries about illicit sale of prescribed drugs; the dangers of these prescribed drugs to patients and their families; and fears for personal safety. Furthermore, consultations with drug injectors are often unsatisfactory and characterized by dishonesty on the part of the patients.[10] Most general practitioners will have been bewildered by tales of family tragedy or renal colic told by young temporary residents late on Friday afternoons.

Many doctors in primary and secondary care believe that medical involvement in a social problem such as drug dependence is inappropriate. Many also resent being the only lawful custodians of narcotic supplies. Nevertheless, local liberalization of non-medical drug supply has not proved successful, partly because of large-scale migration of users into designated areas.[11] Without international agreement to legalize drugs supply, the medical profession will probably retain considerable responsibility for controlling availability of narcotics.

Knowledge of the potential advantages and difficulties of treatment (both for general practitioners and patients) will help general practitioners deal with requests for help with drug dependence. While prescribing opiates for the treatment of opiate dependence may be valuable, there is no convincing evidence that prescribing for other types of chemical dependency (except possibly nicotine) is beneficial. Many problems can be avoided by understanding that drug dependence is usually a chronic condition and that relapse is to be expected. Long-term treatment may therefore be needed. General practitioners should be clear about how much work they are prepared to take on: sympathetic general practitioners risk being swamped by demand. Unambiguous written protocols and contracts detailing expected standards of behaviour by the patient (and sanctions for breach of rules) allow general practitioners to place the onus of responsibility on the patient seeking treatment. Conflicts with patients are uncommon if these approaches are used.

Some studies have looked at the ways in which general practitioners treat problem drug users.[12-14] Some doctors refuse to register any identified drug misusers,[15] which may create problems for colleagues. A larger number will accept such patients but will not offer substitute prescribing unless the patient is supervised in secondary care. Appropriate specialist secondary care services are not, unfortunately, always available. Other general practitioners may attempt some form of prescribing but only on a reducing (detoxification) basis over several days or weeks.[16] The hope here is that the dependence will end with the course of treatment. Unfortunately, in most cases this does not happen: most studies of detoxification report low long-term success rates.[17] While claiming that detoxification is the only treatment they offer for drug dependence, many general practitioners actually continue prescribing for the drug misuser for many years.

With maintenance treatment, on the other hand, the aim is to reduce physical harm to the patient and to allow more normal psychological and social functioning. Treatment will continue for as long as the patient needs it: in some cases, this may be for 10 years or more.

There is widespread support for maintenance prescribing for opiate dependence with the synthetic opiate, methadone. Methadone (prescribed as methadone hydrochloride 1 mg ml^{-1} oral mixture) has many advantages in the treatment of opiate dependence.[18] Evaluating the effectiveness of methadone maintenance treatment is, however, not easy. This is partly a result of problems in controlling for case mix and in following up subjects, and partly a result of difficulties in obtaining accurate outcome measures. Nevertheless, effective treatment programmes are associated with marked reductions in illicit drug use, injecting behaviour, and physical, psychological and social morbidity.[19,20]

Unlike other oral opiates, methadone has a long plasma half-life and can be taken once daily. This allows administration to be supervised by a pharmacist, thereby reducing the risk of the methadone being sold illicitly (street diversion). Many retail pharmacists will offer this service,[21] which brings with it the potential for a valuable relationship between patient and pharmacist, as well as the reassurance of daily monitoring. As a result of the stability of plasma levels of methadone, fluctuation between minimal effect and intoxication are not seen once the patient is established on treatment. In the absence of use of any drug other than methadone, patients established on methadone maintenance, even at high doses, do not experience psychomotor impairment: driving is permitted by the Driver and Vehicle Licensing Authority on the authority of a general practitioner or specialist experienced in substitute prescribing. There is increasing evidence that higher doses of methadone (more than 60 mg daily) are more effective in reducing illicit drug use than lower doses.[22] In our opinion, high doses should usually be prescribed for administration under supervision: otherwise the patient may take enough methadone to stave off the opiate withdrawal syndrome, and sell the remainder. In established heroin injectors, prescribing can start at a dose of 40 mg daily, and the daily dose can be increased by 10 mg each week until the patient feels that the dose is adequate. Final maintenance doses may approach 200 mg daily. The authors have seen no case of intoxication using this regimen, and conflicts between doctor and patient about dosage appear not to occur.

There are, however, disadvantages to methadone maintenance prescribing. These include its open-ended nature and the costs in time and money. Methadone is a controlled drug under the terms of the misuse of drugs act 1971 and subsequent regulations, and prescriptions must be written accordingly. The government Home Office drugs branch does, however, issue handwriting exemption certificates to general practitioners treating more than

10 patients on methadone maintenance. More importantly, those who misuse drugs by injection carry a burden of physical and psychological problems which can be effectively submerged in the frantic daily search for money, drugs and veins. These problems will emerge in regular contact with health services. The general practitioner may need to deal with a patient in poor physical health: from abnormal cervical smears in female drug injectors (who often have a history of childhood sexual abuse)[23] to active hepatitis[23] or diseases associated with HIV.[5] Patients stabilized on treatment are likely to feel guilty for the damage done to their families, and may for the first time need to face the difficulties which initially led them to drug dependence. Finally, social problems such as child care difficulties, violent relationships and homelessness are found among many patients on treatment for drug dependence. It is therefore not surprising that the prescription of methadone alone without the provision of other forms of support is likely to be ineffective.[24]

The range of physical, psychological and social problems makes the treatment of those who misuse drugs by injection a general practice problem. Furthermore, general practice is the setting where most drug misusers would like to receive treatment.[25] Nevertheless, few family doctors will be able to manage more than a handful of patients on maintenance treatment without help, and many patients need more specialized medical or psychological services. In some areas of the UK, community drug teams will assess patients and provide follow up, while general practitioners retain responsibility for prescribing.[26] Although many general practitioners might feel supported by this type of arrangement, possible disadvantages include stigmatization of users attending treatment centres, and communication difficulties between general practitioners and drug workers not working in the same premises.

The authors have established three separate weekly clinics, based in two practices, run with the help of a drug counsellor and have obtained good results.[23] Although general practitioners may be able to delegate much of the routine follow up of maintenance patients to drug counsellors, practice nurses or health visitors, the costs to the practice remain considerable. General practitioners in Glasgow have successfully argued that properly conducted methadone maintenance treatment lies outside the scope of general medical services, and clinics are now funded from the general budget of the Greater Glasgow Health Board.[27] Payment is contingent on the provision of counselling in the surgery premises, daily dispensing supervised by a pharmacist, appropriate prescribing policies, attendance at continuing education meetings for participating general practitioners, and submission of audit data. It is hoped that similar initiatives in other parts of the UK will allow those who misuse drugs by injection to gain access to high-quality, effective care in general practice.

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