The Fraserburgh Situation

INTRODUCTION

Fraserburgh; 'The Broch' in Doric, the local dialect, straddles Kinnaird Head, that pointy corner of Scotland north of Aberdeen that sticks out beyond the Moray Firth into the North Sea. The largest shellfish port in Europe with a population of 12 500, it is the archetypal northeast fishing town where the fishing industry still provides 60% of employment.

Famous not only as the location for the surprise television hit documentary *Trawlermen* (subtitled in English) but also as the birthplace of serial killer Dennis Nilsen, the indigenous population have a firm grasp of the harsh realities of life here. Deep sea fishing carries the highest occupational death rate in the UK,[1] easily outstripping even the construction industry. Most people here have lost a relative to the sea. No wonder then, if a Brocher's perception of risk-taking behaviour might be somewhat different to the average UK city dweller.

There is a long tradition of alcohol abuse in Scottish fishing ports; young men home from a fortnight at sea with pockets bulging with cash go straight to the pub and drink for a week or two until it's time to go to sea once more, ('The Holy Ground': traditional drinking song.)

This tradition has been perpetuated in the offshore oil industry, and with modern times come modern alternatives to alcohol; for Fraserburgh an epidemic of heroin use.

The typical heroin user here cycles between 2 weeks of heroin use followed by a 4-day 'rattle' once back aboard, which gradually increases in intensity and duration over several months or years, perhaps partly alleviated by some dihydrocodeine obtained on the street or by a well-meaning GP. At some stage however, either because of redundancy in a contracting industry or because of failing performance, the cyclical user loses his job and with it his means of financing (and controlling) his habit. The next cycle doesn't end after 2 weeks but continues until the money runs out. This rattle becomes full blown withdrawal and a habit has become a heroin addiction leading to a rapid spiral into debt, relationship and family breakdown. Desperate cravings in combination with severe financial constraint leads individuals who would previously never have considered themselves capable of doing so to resort to acquisitive crime, dealing and prostitution. The loss of self-respect associated with this has often been cited to me by patients as one of the stronger motivators for change.

Physical and mental deterioration advances rapidly with rotting teeth, cachexia and abscesses the norm, and for some accidental or deliberate overdose, Hepatitis C (HIV is surprisingly rare here), subacute bacterial endocarditis, violent injuries, hopelessness and often death. Every addict I have met here has lost at least two friends or relatives to heroin.

THE FRASERBURGH SITUATION

These factors culminated in an exceptionally high rate of heroin use and addiction, (several hundred at least in this small population) initially largely tackled by one of the local GPs, Dr Sandy Wisely (now sadly deceased), and subsequently augmented by specialist substance misuse services at the Kessock clinic. Dr Wisely retired in August 2008 leaving a partial vacuum, and I was approached by Grampian Health Board to take up a post as GPwSI in Substance Misuse at the Kessock clinic, in the face of lengthy waiting lists and full caseloads, to assist in making an attempt to minimise the impact of possibly more than a hundred addicts being withdrawn from their methadone over a matter of weeks, and the anticipated rise in heroin related morbidity, mortality, social breakdown and crime.

First to be tackled were the group of patients who were still in treatment albeit on a tapering-off dose. Patients in this group who had been consuming their methadone on the premises were taken over unseen and titrated back up to their previously 'stable' dose, for this group between 50 and 80 mls of methadone daily. With this cohort in a relatively stable (I thought) holding situation, another group who had been 'doing well' in treatment but whose scrips had ceased were reviewed first. I quickly became familiar with the severity and length of the opiate withdrawal syndrome in patients rapidly tapered off methadone; just as severe as acute heroin withdrawal and longer lasting.

Optimised methadone maintenance (OMM) therapy as described by the National Treatment Agency[2] (NTA) and used in the RIOTT trial[3] was then applied to these two groups. The pharmacological elements of OMM include a recommendation that at least 80 mls methadone daily is prescribed up to a maximum of 300 mls daily. However advice in the UK clinical management guidelines the 'Orange Book'[4] is rather limited to 'a level at which the patient reports feeling comfortable and is no longer using illicit heroin'.

The psychotherapeutic approach was that of a GP with more than 20 years experience of substance misusing patients and approximately 150 000 consultations in a medical lifetime. During the course of reading around the subject over this period I came to the realisation that the non-judgemental approach I employed to empathise with and motivate patients was very similar to motivational interviewing as described by Miller and Rollnick.[5] I had previously assumed this was a complicated and esoteric technique employed only by psychologists, but in fact it has a lot in common with standard consulting techniques as taught for the MRCGP exam. Honesty, trust, and mutual respect are key and can be encouraged by an empathetic, constructive, and non-punitive approach to admissions of drug use or positive drug testing.

Of the patients reviewed, all bar one admitted to ongoing illicit opiate use; the remaining one patient tested positive for opiates at first review and later admitted she had been lying once an open and honest relationship had been established.

After several months I realised to my surprise none of the patients I was seeing had died or dropped out of treatment and began to crystallise in my mind what elements above and beyond the simplistic Orange Book and NTA guidelines were contributing to this.

I came to the conclusion that a therapeutic alliance needs to be established with the patient, not merely to reduce heroin usage or

to make withdrawals tolerable but to aim for total abstinence. I believe achieving this requires total opiate μ receptor blockade for more than 24 hours after each daily dose of methadone initially. It is possible to establish this has been achieved when the patient reports no craving or symptoms of withdrawal even when a daily methadone dose is taken hours later in the day than usual and in addition feels no effect ('hit') when heroin is used on top.

This is often enough to improve sleep, mood and allow cessation of heroin use, but not always; increasing methadone doses when opiate receptor blockade has already been achieved just because a patient continues to use illicit opiates on top is unhelpful — it spurns the opportunity to discuss why the patient continues to use heroin despite experiencing no craving and no hit. This is a potential moment of epiphany if the patient can be aided to the realisation that there is no longer any point of using — and that it's a waste of money!

Total μ receptor blockade therefore facilitates total abstinence from illicit opiate use and consequently withdrawal from the drug scene. The importance of achieving more than 24-hours blockade is that it allows the patient to take the daily dose of methadone when it suits them; that is, to start taking control of their addiction rather than their daily life continuing to be ruled by that addiction. For a heavy user this is rarely achieved with less than 80 mls and usually requires between 100 and 160 mls of methadone daily. Sub-blockading doses only provide partial blockade for part of the day, so patients still experience craving and a pleasurable hit when heroin is used on top, providing little incentive for abstinence. This common prescribing pitfall, driven by the understandable fear of practitioners wary of overdose deaths, has contributed to the often negative public image of methadone substitution since patients in this situation continue to use heroin regularly on top and therefore fail to remove themselves from the drug scene and move on to recovery.

Concurrent benzodiazepine use can be a confounder: patients who report no withdrawal symptoms but are still using benzodiazepines often need 20 mls or more additional methadone to achieve true blockade and allow cessation of benzodiazepine use; unfortunately it is often at this point the realisation comes that the patient is also addicted to benzodiazepines or has an underlying anxiety disorder. Psychotherapeutic interventions can be useful for the latter but dealing with the former is very difficult, especially when the supply is illicit, that is, uncontrolled.

It is unreasonable to expect a heavy heroin user to cease use immediately starting on 30 mls of methadone daily; patients describe this dose as 'not even touching the sides'. This has to be acknowledged to encourage the patient to be honest in reporting ongoing level and route of use, and allow open discussion of the risks of mixing methadone, heroin, benzodiazepines and alcohol in such a way as to minimise the risk of overdose. Given that most opiate overdose deaths involve alcohol and/or benzodiazepines,[6] my advice to patients is to avoid benzodiazepines totally and to use heroin only if they absolutely must due to severe symptoms of withdrawal, and then much less (say a third) than they usually would, preferably smoked rather than injected.

Over a few weeks heroin use goes down as methadone dose goes up to the point of μ receptor blockade. During this titration phase I don't generally screen for illicit opiates: instead, working towards the day when a now visibly healthy patient wearing an expensive new pair of (paid for) trainers announces proudly that he will be able to provide a clean specimen. The use of an instant near-patient test at this pivotal moment allows for congratulations and a tremendous feeling of achievement for both patient and doctor.

I am not advocating starting doses of higher than 30 mls; several weeks or months of dose titration are needed to give the patient confidence not only that their methadone obviates any physical need for heroin but to withdraw from the ingrained ritual and psychological habit of years of use. Whatever we tell patients most will initially use risky doses of opiates and benzodiazepines on top of prescribed methadone; better that this dose is only 30 mls.

I have only attempted to describe how to achieve engagement and chemical stabilisation; but I believe chemical stabilisation and abstinence are prerequisites for social stabilisation, which must be achieved before methadone withdrawal can be contemplated. Attempting to reduce and withdraw methadone while the patient continues to have active contact with the drug scene invites relapse. The return to the company of old non-drug using friends, employment or a new passion in life (in one case snowboarding) are the building blocks for full recovery.

Methadone substitution after all is not a cure for heroin addiction; it merely exchanges an illegal and unsustainably expensive addiction that carries a very high mortality, for a legal addiction provided free of charge with a much lower mortality. It also allows the patient to start the process of reintegrating with society by being able to re-establish relationships, hold down employment, abandon crime and be a competent parent.

David Stevenson

REFERENCES

1. Wallechinsky D. Wallace A. *The book of lists: the original compendium of curious information.* Edinburgh: Wallechinsky and Wallace, 2004.
2. NHS. National Treatment Agency for Substance Misuse. *Injectable heroin (and injectable methadone). Potential roles in drug treatment.* Full Guidance Report, May 2003. http://www.nta.nhs.uk/uploads/nta_injectable_heroin_and_methadone_2003_fullguide.pdf (accessed Feb 4 2011).
3. Lintzeris N, Strang J, Metrebian N, *et al*. Methodology for the Randomised Injecting Opioid Treatment Trial (RIOTT): evaluating injectable methadone and injectable heroin treatment versus optimised oral methadone treatment in the UK. *Harm Reduct J* 2006, **3**: 28.
4. Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. *Drug Misuse and Dependence UK Guidelines on clinical management.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104819 (accessed 4 Feb 2011).
5. Miller WR, Rollnick S. *Motivational interviewing: preparing people for change.* New York, NY: Guildford Press, 2002.
6. Reducing drug-related deaths. Advisory Council on the Misuse of Drugs. London: Home Office, 2000.

Further reading

Liquid Kids by Scott G. Buchan: Lulu press, 2008. A coming of age tale surrounded by alcohol, drugs and violence in Fraserburgh.

Acknowledgements

The author would like to thank Dr Andrew Robinson, Dr Iain Mackaskill, Fiona Molloy and all the staff attached to the Kessock clinic for their help and support in devising and enacting the described action plan.

DOI: 10.3399/bjgp11X561483