

# A decade of caring for drug users entirely within general practice

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## SUMMARY

**Background.** The government encourages general practitioners (GPs) to become involved in caring for drug users. However, in some areas of the country, including Bedford, secondary care support is inadequate. GPs in these areas have to decide how to cope with such patients entirely within general practice.

**Aim.** To assess the characteristics and quality of care given without secondary care support to drug users by one practice in Bedford over a decade.

**Method.** A search was made of the practice computer for all patients with a problem title of 'addiction drug' between 1986 and 1995. The age, sex, social characteristics, and drug history were recorded.

**Results.** One hundred and ninety-two patients were found, of which 155 took part in the practice programme; i.e. they consulted more than three times. Forty-three patients (37%) who took part and were prescribed Methadone were prescribed this drug as ampoules. Sixty-three patients (40.6%) who took part in the programme stopped using drugs. Thirty-two (33.6%) of the Methadone users became abstinent. A higher proportion of women (13–48%) than men (19–27.7%) stopped using Methadone ( $P = 0.019$ ). Among patients who had a stable lifestyle, a higher proportion had been prescribed ampoules than mixture (22 out of 28: 78.6%;  $P = 0.001$ ). Similarly, of those who had a job, eight out of 11 (72%;  $P = 0.037$ ) had been prescribed methadone ampoules. Two-thirds of all patients prescribed amphetamines stopped using drugs.

**Conclusion.** Long-term care of drug users entirely within general practice is feasible. Among those prescribed methadone ampoules, a higher than average proportion had stable lifestyles and had a stable job.

**Keywords:** drug misuse, general practice; quality of care.

## Introduction

IN the early 1980s, drug addicts were regarded in our practice in Bedford in much the same light as badgers; we knew they existed but we had never actually seen one. However, increasingly we found that we were meeting our patients in the local prison, which we also looked after, convicted of drug-related crimes. Our patients told us that, if they could obtain their drugs legally, they would not need to commit crimes and they would have more money to feed themselves and get better housing. After much discussion and some disagreement within the practice, we decided that we would prescribe opiates for our own

patients who could be shown to be opiate dependent.

At this time there was no community drug unit in Bedford. We were also very afraid of the consequences of our actions, as Dr Anne Daly had recently been removed from the medical register for prescribing opiates to drug addicts. However, we made careful notes of our contacts with patients, met with the drug squad to confer with them about our actions, and worked out our own system of checks, urine testing, and frequent appointments. We rapidly found that, as later reported by Hindler *et al.*,<sup>1</sup> drug users seek out GPs who they feel understand their problems and will care for them competently.

Limits were placed on the numbers of drug users that the practice was prepared to care for. Later, a community drug unit opened in the town but there was no consultant input to their services, and the practice programme received no support from this unit. The numbers of drug users cared for varied between 12 and 60 at any one time, and the average number of consultations per year was 28 per patient. Thus, the commitment in time was very high. This high commitment in time considerably reduced the time available for other revenue-earning activities and consequently caused a loss of income to the practice.

The early experience of the practice in caring for drug users has been published.<sup>2,3</sup> In 1995, an experienced primary care drug support worker was employed within the practice to take over much of the counselling and social care of these patients, and to adopt a role as patient advocate. The philosophy of the practice is that it will accept patients as they are, and, as far as possible after suitable checks, to prescribe the drugs used by the patients in the form in which they were originally being used; i.e. orally or parenterally. No pressure is put on patients to change or reduce their drug use, though patients are given information about the health consequences of their activities and preventative action possible to reduce their risk of deteriorating health. Patients are also given the personal space and professional time to consider why they have got into the situation of being drug users and what their personal aims in life are. We hope to help the patients achieve these aims.

The doctors in the practice prescribe methadone amphetamines and benzodiazepines as a substitute to street drugs to patients presenting as abusing these classes of drugs. Urine samples are tested repeatedly to confirm the patients' history. Benzodiazepines are prescribed orally up to the equivalent of diazepam 30 mg daily. Amphetamines are prescribed orally as dexamphetamine 5 mg tablets up to 40 mg daily. Methadone is prescribed orally or parenterally according to evidence collected from examination about how the patient is using their drugs and according to the patient's wishes. If patients are using their methadone parenterally, they pick up needles and syringes either from local chemists or from the needle exchange. Methadone is prescribed in doses between 10 mg and 150 mg daily. Prescriptions are not necessarily given for daily pickup. A discussion is made about pick-up intervals depending on the stability of the patient. As well as carrying out urine tests at random intervals, patients are also requested to take their dose of drugs in front of the doctor and wait in the surgery for 45 minutes to help assess whether the patient is taking all of their drug or selling some to other people. This practice is unusual in prescribing parenteral methadone and amphetamines. The survey was carried

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out to assess the outcome of the services given. Our hypothesis is that this service can be given effectively in general practice even when unsupported by secondary care services.

### Method

A computer search was carried out for the period from January 1986 to December 1995. The search was for all patients with a problem title of 'addiction drug'. The records of these patients were surveyed. The age, sex, social characteristics, consulting pattern, drug use, and prescription history were recorded. Patients were recorded as becoming abstinent from drugs if:

- there was a computer record that the patient was seeking to withdraw from drugs and had stopped using them;
- there was no further record on the computer of drug use; and
- there were no reports that the patients had resumed using drugs if they had moved away from Bedford.

Statistical analysis was carried out using the SPSS MS Windows 6.1 package. Levine's test for equality of variance was applied.

### Results

Over a 10-year period, 192 drug-using patients were cared for in this general practice. The definition of a drug using patient was one who sought advice for this problem.

The practice had no secondary care input during this time. Of the 192 patients, 37 patients did not take part in the drug care programme. Engagement with the programme was defined as consulting with the practice more than three times about the problems of drug abuse. The average time the patients who engaged with the programme were treated was five years and one month. This varied from a few months to 10 years. Patients younger than 30 years were less likely to engage with the programme than those in the older age groups ( $P = 0.022$ ; Table 1). Of the patients who engaged with the programme, 95 (61.2%) were using opiates, 21 patients (13.5%) were using benzodiazepines, and 18 patients (11.6%) were using amphetamines. Prescriptions were given for methadone, benzodiazepines, and amphetamines. The drug use of males and females was different (Table 2). A higher proportion of males than females used methadone, and a higher proportion of females than males used benzodiazepines ( $P = 0.018$ ). The use of amphetamines was about equal (Table 2). The group aged 31–40 years had the high-

est use of methadone (42%–66.7% of the group) and the lowest use of benzodiazepines (5%–7.9%) of the group. The group aged less than 30 years had the highest use of amphetamines. Patients who were already using opiates intravenously were prescribed intravenous methadone after suitable checks.

Of those who engaged with the programme, 39 out of 95 (41%) patients using methadone used these drugs intravenously, while among those who did not engage with the programme, four patients out of 21 (19%) used methadone intravenously. There was a difference between males and females in the use of intravenous methadone. Thirty-three males out of 68 (48%) took their methadone intravenously whereas only six females out of 27 (22%) took their methadone by this route ( $P = 0.019$ ). Sixty-three (40.6%) patients who engaged with the practice stopped using drugs. Thirty-two (33.6%) patients withdrew from methadone use: this varied from 19 (27.7%) among the males to 13 (48%) among the females ( $P = 0.019$ ). Two-thirds (12) of all patients using amphetamines withdrew from drug use and there was no difference between the sexes. Eight (38%) of the benzodiazepines users withdrew from drug use. In this small group there was a trend for more women than men to become abstinent, but this did not reach statistical significance (Table 3). Among the patients using methadone intravenously, four out of 32 (12.5%) made the decision to withdraw from drugs at a time when they were still using the drug parenterally. This is below the average for all methadone users (33.6%;  $P = 0.001$ ). Twenty-eight of the 155 (18%) patients who engaged with the programme were classed as stable. This was defined as:

- having a stable address and social groups,
- attending regularly and on time for their prescriptions,
- Not asking for early pick-up for their drug or changes in medication.

Of these 28 patients, 22 (78.6%) used methadone and 17 patients used methadone intravenously; this was 60% of the total group and 77.3% of the Methadone users compared, with the overall figure of 41% of Methadone users using the drug intravenously ( $P = 0.001$ ). Thus a higher than average percentage of the stable patients were using their methadone parenterally.

Of the 155 patients participating in the programme, 11 (7%) had a stable job. Of these, 8 (72%) used methadone intravenously; again compared with 41% of all methadone users ( $P = 0.037$ ).

During the 10 year period, 23 patients (6.8%) demonstrated aggressive behaviour towards the doctor or practice staff members: 10 of these (4.2%) were verbally aggressive and three

**Table 1.** The ages of drug using patients engaged with the programme and not engaged with the programme

Age (years)	Number engaged with programme (%)	Number not engaged with programme (%)	Total
0–30	43 (70.5)	18 (29.5)	61
31–40	63 (81.8)	14 (18.2)	77
41+	49 (90.7)	5 (9.3)	54
Total	155 (80.7)	37 (19.3)	192

**Table 2.** Drug use among males and females participating in the drug programme.

Drug	Males (%)	Females (%)	Total (%)
Methadone	68 (64.1)	27 (55.1)	95 (61.2)
Benzodiazepine	9 (8.5)	12 (24.5)	21 (13.5)
Amphetamines	12 (11.4)	6 (12.2)	18 (11.6)
Others	17 (16)	4 (8.2)	21 (13.7)
Total	106 (100)	49 (100)	155 (100)

**Table 3.** Patients who withdrew from drug use among the group of patients who engaged with the drug programme.

Drug used	Total			Males			Females		
	Number using	Number stopped	Percentage stopped	Number using	Number stopped	Percentage stopped	Number using	Number stopped	Percentage stopped
Methadone	95	32	33.6	68	19	27.9	27	13	48
Amphetamines	18	12	66.6	12	8	66.6	6	4	66
Benzodiazepine	21	8	38	9	2	22	12	6	50
Others	21	11	52.4	17	8	47	4	3	47
Total	155	63	40.6	106	37	34.9	49	26	53.1

(1.6%) were physically aggressive. During the period of the survey, 14 patients (7.3%) were removed from the list. The commonest reasons for removal were aggression (eight patients), the discovery that patients were also registered with and receiving drug prescriptions from another doctor (six patients), and persistent refusal to keep appointments (four patients). In some cases, patients were removed for more than one reason.

Nine (6%) of the patients looked after within the practice also had a diagnosis of a psychotic illness. Only one of these patients had a history of LSD use.

Eight (5%) of the patients cared for in the programme were currently living on the streets. Their average age was 30 years. Many more patients were living in hostels for the homeless, on friends' floors, or in low quality rooming houses.

Over the 10 years, seven (3.8%) of the patients engaging with the programme died. Two of these deaths were for causes unrelated to their drug use (asthma and subarachnoid haemorrhage).

At the end of the study, 38 patients were being actively treated for their drug use and there were 11 patients still on the list who had become abstinent.

## Discussion

It is 33 years since the first report of effectiveness of methadone maintenance.<sup>4</sup> Methadone treatment has also been adopted as a management for opiate abuse in the United States of America,<sup>5</sup> Germany,<sup>6</sup> and more generally in Europe.<sup>7</sup> It has previously been reported that the care of opiate users using methadone prescriptions in general practice is feasible in the United Kingdom.<sup>8</sup> However, it is still acknowledged that evaluating the effectiveness of methadone maintenance is difficult.<sup>9</sup>

Various outcome measures have been suggested for evaluating the efficiency of treatment, such as reduction in substance use, improvement in personal health and social function, and reduction in public health and safety risks.<sup>10</sup> Very little has been written about substitute prescribing of amphetamines.

Our experience is that long-term care of drug users, including those using their drug parenterally, is possible entirely within general practice by a GP and dedicated drug support worker.

Only 27.7% of the patients treated in this practice were aged under 30 years, 31.6% were over 40 years. Many of our patients had started using drugs in the 1960s and 70s, and had become unhappy with the irregular lifestyle associated with using drugs off the street. The younger patients used more amphetamines and the older patients more methadone. More than two-thirds of the patients for whom we prescribed amphetamines stopped using this drug. Of the patients for whom we prescribed methadone and used this drug parenterally, 37% were prescribed ampoules. This varied from nearly 50% of the males to under a quarter of the women.

It has been pointed out recently that it is against guidelines to prescribe injectables in non-specialist settings.<sup>11</sup> Also, we do not

necessarily prescribe ampoules to patients on a daily pick-up basis, though we did check regularly that patients were taking their methadone as described earlier. However, a higher proportion of patients using and being prescribed parenteral methadone became engaged with our programme than those who used methadone orally. Also, the use of intravenous methadone was more common among patients who had a stable lifestyle and who had a job, but these patients had a lower chance of becoming drug free than those who took methadone orally.

A higher percentage of women than men became abstinent from drugs. This was true both for the benzodiazepine and opiate users. Worries about children and the effect of their parents' drug use on them arose more in discussion with women users than with males. This may be one reason for the higher abstinence rate of women.

Reasons given by GPs for not wishing to care for drug users are dishonesty, violence, and general distaste for their lifestyle.<sup>5</sup> However, over the 10 years of this survey, only 6.8% of patients demonstrated any sort of aggression and only 1.6% were physically aggressive. Only 3.8% of patients were found to be getting prescriptions from more than one doctor, and only 7.3% of patients needed to be removed from the list for any reason.

Over the 10 year period, seven patients — 3.8% of the total — were known to have died. Two of these patients died of causes not related to their drug use. One patient had a row with the practice, left the list, and returned to the street drug scene. He died of necrotising fasciitis. Work in Sweden<sup>12</sup> indicated that death rates are eight times lower among opiate users cared for in a methadone prescribing programme than among those obtaining their opiates on the street. Even in this Swedish programme, the death rate was 1.4% per year. A 22-year follow-up of 128 drug users who had been cared for in London Clinics found that 34%–43% had died.<sup>13</sup> It is possible that the low death rate in this 10-year survey reflects the advantage of a drug user getting all his medical care from one general practice.

## Conclusion

Drug users can be effectively cared for entirely within a general practice by a general practitioner and a dedicated drug support worker. Among patients prescribed Methadone ampoules fewer than average patients became drug free but a higher than average proportion had a stable lifestyle and a stable job.

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