GPs are in a unique position to offer holistic care to patients with addiction, but more help is needed.

In the same way some illnesses are more difficult for GPs to treat than others, certain patients can be more challenging to deal with. Patients are people after all, and some people can be a handful. But as health professionals, GPs are trained to look past these difficulties and treat the illnesses, and the people, they are presented with.

In the case of patients who need treatment for addiction, however, this can become something of a grey area and many are often reluctant to treat them.1

‘There is a lot of fear and insecurity. There are biased [health professionals] who don’t want to know them,’ Melbourne GP and Chair of the RACGP’s National Faculty of Specific Interest (NFSI) Addiction Medicine network, Michael Aufgang, told Good Practice. ‘They see them as junkies and druggies, alcoholics, whatever. They don’t actually see them as people who need extra help.’

A long tail
The types of addiction GPs typically treat range from tobacco and alcohol to cannabis and amphetamines to powerful opiates. But in terms of the healthcare they can offer, GPs are in a somewhat unique position in that they are equipped to offer treatment for problems beyond the addiction itself.

‘I think that is one of the advantages that we have as GPs, that we are in a position to offer that ongoing holistic care,’ inner-city Sydney GP and member of the NFSI’s Addiction Medicine network, Hester Wilson, told Good Practice. ‘In a general practice setting [you] can deal with preventative health, see the kids as well, see the partners.’

According to Aufgang, people with addiction usually present with a number of other health problems and it is a GP’s role to ‘treat the whole’, just as they would with any other patient.

‘There’s a whole range of things to do, whether they be the infectious diseases complications or the secondary organ damage, the psychiatric issues,’ he said. ‘We build a long-term relationship with the patient to make an impact. It’s a matter of looking at all different sorts of problems.’
“As GPs we are in a position to offer [addiction patients] ongoing holistic care”

Wilson agrees that tackling addiction with a long-term care plan is an optimal approach, but believes the ever-present stigma of addiction can get in the way for some GPs.

“We have this weird thing in our culture ... that these conditions are self-inflicted,” she said. “There is quite a lot of judgement around, “You chose to do this behaviour and gave yourself these issues”.

“We all have patients who find it difficult to manage their diabetes. All of us have patients who find it difficult to manage their hypertension. I would dearly like us to see us treating dependency in exactly the same way.

“IT is a chronic illness just like anything else.”

In training

While those working in general practice are indeed well suited to offer care for the range of problems that present in relation to addiction, treating the addiction itself can be complicated and extra training or accreditation may be required.

“In the NFSI, we are starting to develop a curriculum and people branch out with what they want,” Aufgang said.

Given the importance of prescribing powerful opiates such as methadone and buprenorphine in treating addiction, specific training is often needed. However, these requirements differ from state to state.

“That’s probably what is a little confusing,” Wilson said. “In NSW, we’ve got online training which you do on your own time over a period of two to three weeks. It is very clinically based, and then you do a half-day placement with an accredited prescriber? Once you’ve done that you can prescribe for up to 200 [methadone patients] in the community.

“There are national guidelines being written to guide opioid pharmacotherapeutic treatments for opioid dependency, but there are still state jurisdictions and state law.”

Obstacles

In addition to any extra training required in treating addiction, many believe GPs and other health professionals are reluctant to treat people for addiction due to beliefs that such healthcare is potentially very problematic and not sufficiently rewarding.

While Aufgang and Wilson enjoy treating addiction and would like to see more GPs become involved, they also admit the patients and, in particular, the labour-intensive nature of the care can be challenging. In addition, Wilson points out the fact that, despite all of the extra work often required, GPs feel they will not be adequately supported.

“It is a sense that, “If I take this on, I am stuck with it and there is nowhere for me to go to help. There is no one who will actually assist me with this”,’ she explained. “The other problem is, the payment system does not reward the level of work that GPs do.

“We know that this group of people have much poorer health outcomes and are much more likely to be smokers and not [have] done their preventative healthcare, their nutrition is going to be poor. Those kinds of issues that do need to be dealt with.

“They can do that from within a general practice it’s just, financially, GPs aren’t well supported to do that.’

Dr David Helliwell, a former GP and Foundation Fellow for the Royal Australian College of Physicians’ Australasian Chapter of Addiction Medicine who now treats addiction as clinical lead for Northern NSW Local Health District, believes inadequate financial compensation is one of the primary reasons GPs can be reluctant to treat addiction.
RACGP resources

The RACGP is developing new benzodiazepine prescribing guidelines, which will be out in draft form for consultation in late March 2014. Recognising the complexity and sensitivity of the issues surrounding prescribing and treatment with addictive medication, the RACGP is also developing a good practice guide to prescription drugs of addiction. Also available in March, this guide will summarise the complex levels of formal and informal controls around these drugs and describe how applying a clinical governance framework can improve patient care and reduce abuse, misuse and dependence.

For more information, contact simone.gleeson@racgp.org.au or visit www.racgp.org.au/your-practice/guidelines/drugs-of-dependence/

‘It would be really wonderful if there were some specific [Medicare Benefits Schedule] item numbers in addiction medicine for GPs because, in the end, you do need to remunerate people,’ he told Good Practice. ‘Patients of this nature have multiple pathologies, multiple psychosocial issues and they require a lot of time. They take a lot of sorting out.

‘They come to you when they’re in dire straits. They don’t come to you when their problems start. They come to you when they are falling off the precipice, so to speak.’

While the Federal Government’s Medical Services Advisory Committee provisionally supported applications for increased fees under the MBS from the Australasian chapters of Addiction Medicine and Sexual Health Medicine in August 2013, the item numbers are yet to be formally introduced.

Team effort

Helliwell agrees GPs are in a unique position to provide more complete care planning for addiction patients, but he is also in favour of a multidisciplinary team approach.

‘You’re looking at things like counsellors or social workers, mental health nurses, drug and alcohol clinicians, case managers,’ he said. ‘It really is important to have those networks available to you.’

For Hester Wilson, however, building such a team has proven difficult and a lack of government funding has been an obstacle.

While she would like to have a credentialed mental health nurse in her practice to offer some immediate support in treating addiction patients, the fact the Federal Government froze funding for the Mental Health Nurse Incentive Program (MHNIP) at the 2011–2012 Budget levels means no new mental health nurses or general practices are able to join the program.

‘It would be nice to have someone to discuss [addiction treatment] with,’ she said. ‘That is one of the issues that happen to us as GPs; even though we might work in a group setting, in many ways, the work is quite isolating.

‘To have the capacity to talk to someone who obviously knows the patient, to give a sense of what might be the best plan, would be terrific.’

Wilson has managed to secure the services of mental health practitioner, but admits it will still be challenging from a monetary standpoint.

‘The two of us will be working together as a team [but], financially, that will be tricky. The Medicare rebates are not great,’ she said.

Helliwell believes increasing this type of government support will go a long way in getting more GPs, young and old, treating addiction, and more work needs to be done in order to secure it.

‘I would love to see more support for GPs working in addiction medicine, both in terms of the people resources and also the financial remuneration,’ he said. ‘To some degree, if we want GPs to pick up addiction medicine then it’s really up to us to get those sorts of resources in place.’

But regardless of the obstacles, financial or otherwise, that stand in the way of treating addiction, Wilson believes treating the people who walk through her door is fundamental to her job as a GP and gets genuine fulfilment from treating these patients.

‘In many ways, [treating addiction] makes the job more time consuming, and a little more tricky, but it is much more rewarding. I guess that is the point,’ she said.

‘I get to the end of the day and know I’ve done a really good job and I’ve been an important part of people’s change. People being able create and have the lives that they want to have.’

References


Information on nutrition

- The Mediterranean diet
- The 5:2 diet and intermittent energy restriction
- Irritable bowel syndrome
- Nutrition in pregnancy
- Polycystic Ovary Syndrome
- Vegetarian nutrition

Visit www.educationinnutrition.com.au for a full list of our nutrition DVDs @ $38 each