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Caring for patients with opioid dependence

Australian general practitioners have a pivotal role in helping their patients with problems of alcohol and tobacco dependence, but have been less likely than their peers in the United Kingdom to be involved in the management of opioid dependence.[1,2] This is despite the fact that most GPs are seeing opioid dependent patients whether they know it or not, and that GPs are ideally placed to manage this problem given the other advantages of the general practice context – continuity, accessibility, and whole patient care, including the ability to address other health issues.

Treatment options

Once established, dependence on opioids tends to be a chronic relapsing problem characterised by multiple episodes of remission and relapse with significant morbidity and mortality. Drug seeking takes precedence over other activities, obligations and functions including self care, personal relationships and the care of children. Patients dependent on illicit opioids are thus often highly dysfunctional and marginalised, involved in crime, and at increased risk of disease and death. Associated psychiatric illness is common as a predisposition to, or a consequence of, addiction. Physical health may be affected by blood borne virus infection, sepsis complicating unsafe injecting practices, and the use of other substances. These physical and mental health problems are difficult to assess and manage in a chaotic patient with disrupted personal, social and financial supports, unengaged in any meaningful therapeutic relationship with health care practitioners.

A range of treatments is available including detoxification and most effectively, longer term opioid pharmacotherapy. Treatments for which there is best evidence of favourable outcomes involve replacement pharmacotherapy with either methadone or buprenorphine. This is a harm reduction approach, which focuses on reducing the disability of established disease (tertiary prevention) as well as allowing opportunities for primary and secondary prevention. Opioid replacement pharmacotherapy has a protective effect against fatal overdose and blood borne virus infection,[3] is associated with reduced heroin use, a reduction in crime, and improvement in social functioning.[4,5] Comorbid mental health problems improve when patients are stabilised with opioid pharmacotherapy.[6] Higher doses of methadone (60–80 mg/day) are associated with longer retention in treatment, which in turn is associated with better clinical outcomes.[7]

Primary care physicians can effectively prescribe and supervise opioid pharmacotherapy for the treatment of opioid dependence.[8,9] While methadone and buprenorphine are the most widely used pharmacological agents, a buprenorphine/naloxone combination (ratio 4:1 Suboxone) has become available recently. The addition of naloxone was driven by the desire to reduce the potential for abuse of buprenorphine by injection. Taken sublingually the combination product will act like buprenorphine (due to the poor sublingual bioavailability of naloxone) but if injected will deliver a bolus dose of naloxone. Injecting the combination produces a more severe precipitated withdrawal than buprenorphine alone (being a partial agonist it can also precipitate withdrawal in individuals who have opioids on board). The increased likelihood of an enhanced aversive response when the drug is injected may make the combination product less attractive to illicit users as an injectable preparation. The introduction of Suboxone in some states has permitted an increase in the number of 'take away' doses of medication a stable patient may be provided with.

Table 1 outlines the pharmaceutical options available for maintenance treatment. *Figure 1* indicates a common pathway to and through opioid pharmacotherapy.

Basic principles of care

For any chronic health condition, the patient's readiness to change and willingness to accept the requirements of medications, monitoring, and third party involvement (by other health care workers, specialist services) are important considerations for the GP and predictors of success or otherwise. In turn, a patient's readiness to change and willingness to engage in treatment are influenced by the provision of accurate information by a nonjudgmental, patient centred practitioner. Many of the skills used by GPs in assisting patients in the management of chronic conditions are vital in assisting patients in making decisions about treatment and supporting them through the course of their illness.

A model of care that sees occasional relapse as part of the normal course through engagement and treatment, rather than evidence of failure, is more likely to be successful. Guidelines are available from state and commonwealth health departments.[10] Relapse is often addressed in part by increasing the dose of opioid pharmacotherapy, inducing further tolerance to opioids and reducing the effect of illicit opioids.

Unfortunately the common 'default' arrangement where opioid pharmacotherapy prescribing resides with a specialist clinic has its problems. Even if the patient has a GP, fragmentation of care, with lack of a coordinated approach to comorbid mental health problems, other substance use, and physical health problems is common. Enabling GPs to confidently assume the role of pharmacotherapy prescriber allows true integration of care.

Integrating care into general practice

Some practitioners fear the disruptive effect of chaotic aggressive opioid dependent patients on the practice environment and feel under prepared to deal with patients with opioid addiction.[11–13] Practice staff and other doctors working within the practice may share these fears. However, this stereotype is less likely to apply to appropriately selected patients with adequate support and advice available for patients and practitioners. The stable patient is likely to attend appointments, particularly if the same recall and reminder arrangements used for patients with other chronic diseases are applied.

The attitudes and information needs of practice staff will need to be explored, and concerns about safety and security addressed. Practice policy and procedures will need to be developed and

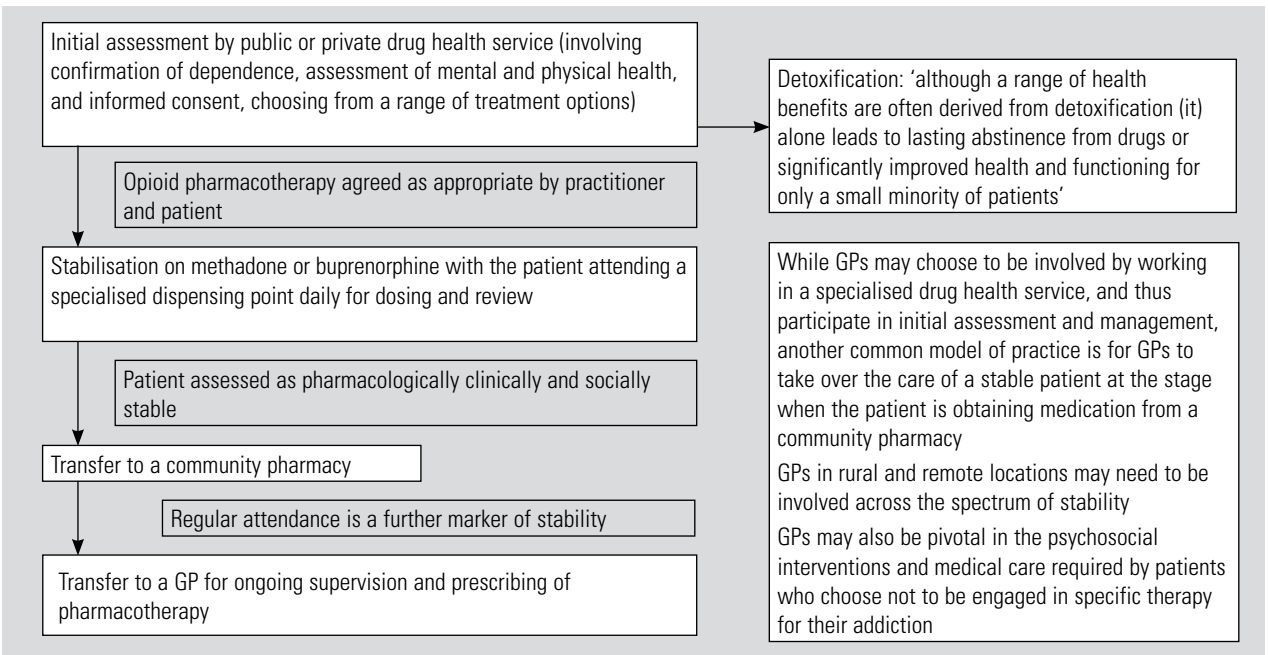
Table 1. Pharmaceutical options for maintenance treatment

Medication	Dose	Frequency	Presentation	'Take aways'**
Methadone (Biodone forte, Methadone Syrup)	*Up to 150 mg	Daily	Oral liquid (5 mg/mL)	Dependent on state regulations (up to 4 weekly in NSW)
Burprenorphine (Subutex)	*Up to 32 mg	Daily to 3 times per week	Tablet (0.4 mg, 2 mg, 8 mg)	Dependent on state regulations (none in NSW)
Buprenorphine/naloxone (Suboxone)	*Up to 32 mg (buprenorphine)	Daily to 3 times per week	Tablet (2 mg buprenorphine, 0.5 mg naloxone, 8 mg buprenorphine, 2 mg naloxone)	Dependent on state regulations (up to 28 monthly in NSW)

* Maximum doses vary by state and territory and local regulations should be consulted

** 'Take aways': doses patients are provided with by the dispensing point for use on other days, thereby reducing the number of attendances required at the dispensing point

Figure 1. A common pathway to and through methadone or buprenorphine maintenance treatment



formalised so that patients and practitioners are supported by a consistent, whole of practice approach. This will cover procedural areas such as:

- recall and reminder systems
- billing
- managing missed appointments
- expired prescriptions
- requests for takeaway doses, and
- clinical areas such as concurrent prescribing of psychoactive medications.

Communication and shared care arrangements with local pharmacists and drug heath services will need to be defined, and the practice's referral directory updated.

Practitioners may need to develop the business case for such involvement by defining the way GP Management Plans, Team Care Arrangements, Home Medicines Reviews, and Mental Health Assessment and Care Planning item numbers may be applied in the care of opioid dependent patients. Indeed, the introduction of these Medicare item numbers has increased the financial viability of caring for drug users.

How GPs can become involved in caring for opioid dependent patients

The Commonwealth Government Department of Health and Ageing prepares national policies and guidelines on the use of methadone and buprenorphine. These are then interpreted and applied by each state and territory. In most jurisdictions a pharmacotherapy accreditation course or similar equips GPs with the skills and knowledge to become methadone and buprenorphine prescribers. In some states, nonaccredited practitioners may prescribe for a small number of patients under the supervision of a drug health specialist. *Table 2* lists contacts and resources for education, training, clinical and patient information.

In New South Wales, a Pharmacotherapy Accreditation Course sponsored by NSW Health and coordinated by the Coppleson Committee for Continuing Medical Education (Faculty of Medicine, University of Sydney) is run 4–5 times per year or on request. It is designed for face to face or online delivery, and covers: the rationale for opioid pharmacotherapy, features of dependence and withdrawal, pharmacology of opioids, and the assessment and management of patients with dependence. After completing a half day clinical attachment with a drug health specialist and a postactivity test, GPs

Table 2. Opioid pharmacotherapy training

State/territory	Requirements	Workshop delivery	Contact
Australian Capital Territory	1 day workshop with pre- and post-activity test	Face to face	www.health.act.gov.au Phone 02 6205 0959 Email kevin.foreman@act.gov.au
New South Wales	1 day pharmacotherapy accreditation course; postactivity test and clinical placement	Face to face or online	www.pac.med.usyd.edu.au Phone 02 9351 7317 Email phoebea@med.usyd.edu.au
Northern Territory	Open book test, supervised clinical assessments and mentoring		Alcohol and Other Drugs Clinical Services, North Royal Darwin Hospital Phone 08 8922 8161
Queensland	1 day workshop and postactivity test, clinical placement and mentoring	Face to face	Queensland Alcohol and Drug Research and Education Centre, University of Queensland Phone 07 3346 4670 Email c.kempnich@sph.uq.edu.au
South Australia	1 day workshop and postactivity test, clinical placement and mentoring	Face to face	Pharmacotherapy Research Unit Drug and Alcohol Service SA Phone 08 8130 7575
Tasmania	Undertaken by clinical director of the alcohol and drug service	Individually negotiated	Department of Health and Human Services Alcohol and Drug Service Phone 03 6230 7026
Victoria	Two online learning activities and 1 day workshop, pre- and post-activity test, optional clinical placement and mentoring	Face to face	www.turningpoint.org.au Turning Point Drug and Alcohol Centre, Education and Training Services Phone 03 8413 8721
Western Australia	Half day workshop and postactivity test, clinical placement and supervision of initial patients	Face to face	Next Step Community Clinical Programs Phone 08 9219 1907

are accredited to prescribe methadone and buprenorphine. Most area health services offer clinical attachments (some are paid), and many have liaison workers who link GPs with drug health services, community pharmacists, and fellow GPs with similar clinical interests. Most divisions of general practice have a drug health program that provides resources, continuing professional development activities, and liaison with drug health services and practitioners.

General practitioners may choose to further an interest in addiction medicine with the Royal Australasian College of Physicians Chapter of Addiction Medicine. The Royal Australian College of General Practitioners is in the process of developing a special interest group in this area (see *Resources*).

Patient selection

Most GPs starting to work in this area will receive their first patients on referral from the local drug health service. General practitioners should negotiate with the service about the patients they are prepared to accept. Important points that may arise in these negotiations are:

- the necessity for accurate and complete clinical information
- identification of appropriate contacts within the service for further advice if required
- the need for an initial interview with the patient before accepting them as a client
- 'return' arrangements should the transfer to GP care not work out.

General practitioners taking their first steps in this field will probably feel more comfortable if the initial assessment and stabilisation of the patient has been undertaken by a more experienced prescriber, usually working as part of a team in a specialised drug health service. Alternatively, they may be prepared to take over prescribing methadone or buprenorphine for a patient who they already know. Patients are stable, and therefore suitable for care in a general practice setting when they have shown acceptance of and engagement in treatment by:

- consistently attending appointments with health workers and dispensing points
- attending dispensing points reliably and behaving appropriately (not intoxicated) – communication with the dispenser is essential to ascertain this
- reducing illicit and other drug use (as supported by physical examination for needle marks and results of urine drug screens)
- commencing social re-integration (as supported by stability of accommodation arrangements, relationships, engagement with work, work seeking, or rehabilitation processes).

Depending on local procedures, there may be a transitional arrangement where care is shared between the GP and the drug health service. Alternatively the GP may be responsible for physical health management while pharmacotherapy prescribing resides with the drug health service.

Conclusion

Managing opioid dependence is an opportunity to develop a relevant clinical interest in a challenging area, where the ability of the GP to synthesise mental and physical health care for a group of marginalised patients is supported by specialist colleagues and services. The rewarding experience of assisting an opioid dependent patient get their life back on track – obtaining and holding down a job, disengaging from the criminal justice system, and seeing improvement for the other people in their lives – delivers positive health outcomes for the individual, dividends for the community, and professional satisfaction. The skills honed in assisting opioid dependent patients with their addiction are generalisable to those common situations in general practice where hazardous behaviour and lifestyle modification are part of the agenda for individual patient care.

Resources

- The Australian Drug Foundation is an independent, nonprofit organisation working to prevent and reduce alcohol and drug problems in the Australian community: www.adf.org.au/
- The Australian Drug Information Network provides a full listing of alcohol and other drug services in each state: www.adin.com.au
- For a listing of state, national and international resources on alcohol and other drugs: www.aodgp.gov.au/internet/aodgp/publishing.nsf/Content/trainers-resource-kit-
- Royal Australasian Chapter of Addiction Medicine (AChAM) has been established within the RACP, and is seeking recognition of addiction medicine as a medical speciality through the Australian Medical Council processes. Information is available regarding addiction medicine and the Fellowship training program: www.racp.edu.au/public/addictionmed.htm.

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