Treating heroin addiction in general practice

GPs are ideally placed to deliver ongoing care to methadone patients, write Caitríona Waters and Anna Nic Con Iomaire

METHADONE SUBSTITUTION is the most common form of treatment for heroin addiction and is the most extensively researched intervention worldwide. Internationally, there is evidence to suggest that methadone treatment reduces drug-related morbidity and mortality and improves a person’s health and social wellbeing. It has a positive effect on society with a reduction in criminality.

Cox and Lawless1 evaluated a service to examine the role that prescribed methadone plays within the lives of a cohort of opiate-dependent individuals in Dublin City. The main findings of that study suggest that methadone maintenance therapy was successful in stabilising heroin users and in assisting them to establish a positive lifestyle.

The provision of services at primary care level was found to improve the access to therapy and helped to remove some of the stigma associated with drug dependence. Issues that inhibit successful treatment include polydrug abuse, mental illness and infection with HIV or hepatitis C. Comprehensive services to deal with such co-morbidities are recommended.

Similarly, research published by the National Advisory Committee on Drugs in 2007 showed that continued participation in a methadone programme substantially reduced individuals’ drug use and their involvement in acquisitive crime.

The Research Outcome Study in Ireland (ROSIE)2 is a national multi-site drug treatment outcome study, conducted by a team at the National University of Ireland, Maynooth. Findings of the report include an increase in participants’ contact with GPs, employment/education services and housing/homeless services.

The authors state that the findings presented in that paper demonstrate that retention in methadone treatment is high, and continued participation in a methadone programme substantially reduces opiate use, injecting drug use and involvement in crime; however, rates of improvement in physical and mental health were disappointing. The results compare favourably with international outcome studies.2

Aims of this study

The aim of this audit was to evaluate a Galway city practice-based methadone maintenance programme. Data was collected from patient records in the practice including letters of correspondence from the methadone clinic, psychiatric services, drug counselling services and infectious disease clinic.

Each patient’s progress was reviewed over an 18-month period. Details regarding patients who relapsed and used illicit drugs during the 18-month period were also gathered. Patient nationality, urine screening, viral screening, psychiatric and other co-morbid conditions were reviewed. There were 15 patients reviewed in the audit, seven females and eight males.

Results

Discontinuation from the programme

Five patients left the programme during the 18-month period. One of these patients was gradually detoxified from methadone and has been discharged from the programme. This patient has remained stable, drug-free and continues to do very well. Two patients discontinued attendance. One patient failed to keep appointments and it is believed she left the country. The other patient, who previously had been doing very well, believed she could safely discontinue methadone substitution. She was working full-time and was unhappy with having to attend the surgery on a weekly basis. She stopped attending the surgery and relapsed shortly thereafter. Neither patient responded to invitations to return to the programme. Another patient moved to England and it was pre-arranged that his care be taken over by the drug services in the UK. The fifth patient’s care was taken over by the methadone clinic, HSE West, as this patient had erratic behaviour and was at risk of destabilising.

Therefore, over the course of the 18 months, two patients failed to return to any form of support service. This gives a dropout percentage of 13%. While we appreciate that we are dealing with a small sample size, this is nonetheless a significant number of patients who failed to continue the programme and are at high risk of re-using heroin.3 However, it must be emphasised that during the 18-month period, 10 patients remained stable on the programme and one remained stable after detoxification.

A study performed in China4 examined predictors of early dropout in a methadone maintenance treatment programme. They concluded that early dropout rate was related to ethnicity, poor clinic accessibility, living with drug users and inadequate methadone dosage. Interestingly, the findings of the China study did not concur with findings of this audit. Both patients in our study were Irish, female, aged 36 and 37 years. Both dropped out after 14 and 21 months respectively. Both patients lived in close proximity to the clinic. Neither individual lived with a drug user. Methadone dosage was adequate in both cases.

Relapse in opiate misuse

Four patients tested positive for opiates in their urine over the 18-month period. This is a 26.6% relapse rate. In a study performed in China,5 community-based methadone treatments protocols were examined and risk factors associated with heroin use during the treatment were identified.
It was revealed that on average, 27.7% urine samples showed positive opiate evidence, which correlates well with the percentage in this study. The Chinese study found that marital status, employment status, treatment continuation, self-satisfied evaluation score on dosage and dropout history were significantly associated with heroin use. Employment status was noted in our study. Two of the 15 patients were documented to have gainful employment.

The remainder were unemployed. Of the two patients with employment, one of these patients experienced a relapse in using opiates and the other patient did not relapse. Marital status was not recorded in this study. Interestingly, in the Chinese study, it noted that a self-satisfied evaluation score on dosage was associated with lower rates of relapse.

Urine testing

Urine testing was performed weekly. None of the patients tested positive for amphetamines during the 18-month period. Ten patients out of 15 tested positive at some stage for benzodiazepines. The number of times patients tested positive for benzodiazepines ranged from one episode to 11 episodes per patient. Four patients tested positive for opiates. The patient with the most episodes of opiate usage (three episodes) also had the highest recording of benzodiazepine usage (11 episodes) during treatment.

A urine test was performed at 80% of consultations. Some reasons identified for the patient’s urine not being tested include patients unable to give a sample at the time of consultation, patients rushing at the consultation and occasionally no testing kits were available at the practice. Previous studies report that patients found the monitoring of drug use by urinalysis humiliating and recommended that other methods be introduced.1

Viral screening

Hepatitis C viral (HCV) screens were performed in 14 of the 15 patients, with one refusing the test. Six patients were HCV positive (40%) and all were referred to the infectious disease clinic and attended regularly. In a New York study, a group of patients on a methadone maintenance programme were tested for HCV, and 65% were positive. This same article highlighted the opportunity to successfully evaluate and treat patients with HCV infection when these services are co-located with a methadone maintenance programme.6

This opportunity was taken advantage of in this Galway-based service, with excellent results. The feasibility and effectiveness of integrating HCV care and methadone maintenance cannot be understated.

Viral screening for HIV and hepatitis B virus (HBV) was also performed in 14 out of the 15 patients. No patient tested positive for HBV or HIV infections. Eleven patients from the sample of 15 (73.3%) were vaccinated against HBV. All patients with a known viral infection were referred to the infectious diseases clinic.

Psychiatric and alcohol dependency co-morbidity

Five patients of the sample 15 have a documented psychiatric condition, giving a percentage of 33.3%. Six of the 15 patients (40%) had a documented history of alcohol dependency. Two patients were documented to have a psychiatric condition and alcohol dependency. In an article discussing the ‘VEdeTTE study’,7 psychiatric co-morbidity was associated with an increased risk of dropout from the programme. In our audit, both patients who dropped out had a history of alcohol dependency and one had a documented psychiatric history other than alcohol abuse.

The high prevalence of dual diagnosis of mental disorders and addiction is widely accepted.8,9 Figures published in the Journal of the American Medical Association10,11 discussed percentages of patients with co-morbid substance misuse and mental disorders. It reported that approximately 50% of individuals with severe mental disorders are affected by substance abuse. Furthermore, it noted that 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. In our study, we found that 33.3% patients had a documented psychiatric history (other than alcohol dependency).

Other medical issues

Four of the 15 patients (26%) had a medical condition that required long-term attention by their GP. These included hypercholesterolaemia, hypertension, epilepsy, venous thromboembolism and psoriasis. This highlights the advantage of a GP-based methadone maintenance programme to deliver a complete package of care. An article published in the BMJ12 noted that providing methadone maintenance in general practice is feasible and also allows this population, in which morbidity is considerable, to receive more comprehensive healthcare.

The role of general practice

The majority of patients on this programme remained stable and opiate-negative. They received continuous and comprehensive healthcare, especially in relation to co-morbid psychiatric and infectious diseases. Once initiated and stabilised on the programme in a methadone clinic, general practice is then an ideal setting in which to deliver ongoing care to this population.1

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References on request