Can primary care work for patients with complex needs?

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Primary Care services have become an increasingly prominent part of substance misuse delivery in the UK. They expanded in the last decade with many general practitioners catering for substance misuse patients in primary care. Nurses have also played a valuable part in helping GPs to work effectively in this area through liaison services and latterly, nurse prescribing clinics. This paper will examine whether problematic drug users can be stabilised and introduced to the idea of recovery, through primary care drug-based services in Islington.

KEYWORDS: Methadone ■ Complex needs ■ Primary care

Primary care services have become an increasingly prominent part of substance misuse delivery UK. Many general practitioners (GPs) have undertaken Royal College training in managing substance misuse patients in primary care, with nurses helping GPs to work effectively in this area through liaison services and nurse-prescribing clinics (Fernandez et al, 2004).

There is evidence that methadone prescribing is beneficial to patients’ wellbeing (Gossop et al, 1999). It has been particularly effective in reducing human immunodeficiency virus (HIV) rates and reducing drug-related crime (Schilling et al, 2006). This paper explores the benefits of methadone and buprenorphine treatment for those suffering from opioid dependence. The aim of this combination is to help drug abusers quit heroin, continue with methadone/buprenorphine (‘stabilisation’), and ultimately work towards abstinence through structured recovery.

The combination of methadone and buprenorphine has been promoted by the substance misuse management group in general practice (SMMGP) affiliated with the National Treatment Agency (NTA) (www.smmgp.org.uk). In Islington, GPs, supported by nurse liaison services, provide substitute prescribing for drug users in a place which is accessible and near their home. This is a tiered service with the most problematic drug users being managed by specialist drug agencies, and the GP shared care programme taking the more stable drug users (Fernandez, 2011). Research shows that this latter cohort of patients is able to engage in primary care and be treated just as effectively (Keen, 2001).

In Islington, the first goal is to engage and retain the patient in the primary service. This is achieved by providing a degree of flexible prescribing regimens. Once this has been established, treatment aims to stabilise the patient with substitute products. Additional illicit drug use can be prevented by adequate methadone/buprenorphine dose titration and effective motivational work through talking therapies. It has been found that high dose, flexible and responsive prescribing of methadone influences retention rates (Jarvinen, 2008; Kelly et al, 2011). For patients with complex needs, flexible prescribing, which involves frequent reviews to allow for easier and quicker titration of methadone/buprenorphine to an effective dose, and a willingness to prescribe at high doses (100mgs per day), help to reduce injecting in the majority of patients attending treatment (NTA, 2007; De Maeyer et al, 2011).

Our Service

Islington has one of the highest rates of problematic drug users in the UK according to data collected from the NTA (2011). Following a review of drug services in 2007, the service was re-organised and the emphasis of treatment provision was placed in primary care through the shared care scheme.

In 2011, an audit of 190 patients was undertaken to provide a baseline of their stability and average prescribed methadone dose (Fernandez, 2011). The average dose was 58.3mgs, although a cohort (n=14) of patients who had a range of problems from intravenous groin injecting to dependent drinking patterns, were on doses of 80–120mgs. However, reflecting the results of Thomson and Tiffen (2004) these patients were stable and using less. This led the authors’ clinic to explore whether or not more complex patients could be managed through the shared care scheme.

An audit of demographics showed that the patients were predominantly male, aged between 40 and 49 years old. All patients had a treatment history of over four years, and so were both familiar and experienced with the services, and thus more able to use them to achieve their goals (Fernandez, 2011). A significant percentage of patients (39%, n=75) were stable with no additional illicit use. At each visit,
patients undergo a urine test and are asked to state whether or not they have used illicitly. Sixty-one percent (n=115) stated they were still using once or twice a week while on their substitute medication.

Fourteen percent of audited patients were prescribed high dose methadone (80–120mgs), 86% of whom were male. The majority of clients on high dose methadone were over 50 years of age (78%) and had been in treatment for periods ranging from 2–5 years. This reflects the findings of the NTA, which conclude that there is an ageing population of drug users in treatment in the UK, with less young people entering the treatment system (NTA 2012).

**DISCUSSION**

The results of the audit at the authors’ clinic show that this small but significant cohort has benefited from high-dose prescribed methadone in primary care, as the substitute medication helps to stabilise drug abuse. The case report below shows that primary care can cater for patients who have a history of treatment and are prepared to engage with the treatment regimen, despite presenting with chaotic poly drug use. It also illustrates that primary care can move these patients into the recovery phase of treatment.

**Case report**

Tom is a 43-year-old unemployed man with a history of poly substance misuse from the age of 12. He has long-standing dependency on illicit opiates, benzodiazepines and alcohol. He experienced childhood physical and emotional abuse and his mental health diagnosis includes low mood and anxiety. He did not complete his education and has never been in full-time employment.

Tom has been registered at his GP practice since September 2005, and has been prescribed methadone for four years following transfer of his care from the specialist prescribing service. At the point of transfer, Tom was alcohol- and opiate-dependent, drinking approximately 25 units of alcohol daily and injecting £5 (occasionally £10) of heroin three to four times a week, despite receiving a methadone prescription of 80mgs daily. He was at that point, abstinent from illicit benzodiazepines but smoked cannabis each day.

His methadone dosage was increased to try and increase his stability and curb his illicit use of heroin. His alcohol consumption was considered to be in a dependent pattern and he was looking to address this in the future. However, before this he needed to achieve stability on his dose of methadone.

Tom was able to reduce his illicit use of heroin. Although he still used once a week, he could stop to give a drug-free urine sample. He finally stopped using heroin altogether and the clinicians involved in his care considered alcohol detoxification, managed by primary care, coordinated via the primary care drugs nurse and nurse consultant.

Tom completed his alcohol detoxification plan with primary care services and was returned to his primary care worker nurse. He was started on disulfiram, which reacts to any alcohol consumed by the patient and therefore acts as a deterrent. Tom initially remained abstinent from alcohol, but after eight weeks he stopped taking the disulfiram and returned to drinking, although at a reduced rate. He also reduced his dose of methadone from 100mgs to 90mgs daily by working with primary care services. His aim is to reduce and slowly move to abstinence and recovery.

**CONCLUSION**

The case report illustrates what is possible in primary care and how patients with complex needs can be treated effectively by becoming less dependent on substances such as alcohol and heroin. Some patients are able to become non-complex and achieve stabilisation just by using methadone, while others need high dose substitute prescribing to achieve stability.

In addition, a tiered system of treatment need not focus on its treatment criteria too closely. Flexibility between services is useful and valuable for some patients, particularly those who have found it difficult to engage with services. However, it should be acknowledged that this cohort of patients take longer to stabilise and reduce their substitute prescribing.
The next phase is to examine those figures in 2013 to see if stabilisation and then the idea of recovery can be introduced earlier. However, it can be seen from the work carried out at the authors’ clinic that primary care can play a valuable part in treating, stabilising and reducing drug abuse in patients with complex needs, and enabling better engagement without the need for referral to the specialist service.

REFERENCES

KEY POINTS
- Primary care services have become an increasingly prominent part of substance misuse delivery in the UK.
- The combination of methadone and buprenorphine is to help drug abusers quit heroin, continue with methadone/buprenorphine (‘stabilisation’), and ultimately work towards abstinence through structured recovery.
- In Islington, GPs, supported by nurse liaison services, provide substitute prescribing for drug users in a place which is accessible and near their home.
- Primary care can play a valuable part in treating, stabilising and reducing drug abuse in patients with complex needs, and enabling better engagement without the need for referral to the specialist service.

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