CATEGORY II – SPECIALITIES & SETTINGS: GENERAL PRACTICE

1.0 Introduction

A large proportion of the population who misuse substances are cared for in general practice which is able to deliver services from a community base. Thus, general practitioners are in a pivotal position to create a non-stigmatising environment in which to screen and detect substance misusers. GPs and their teams can provide comprehensive care: advice, information, support, as well as identification and diagnosis, brief interventions, management of substance misuse, management of physical and mental health, improvement in social functioning, and onward referral where appropriate. Some doctors working in primary care have undertaken specialised training to support them in delivering specialist care to substance misers in primary care.

Vignette One

Ryan, aged 35, has been registered with his GP several years ago. He has a long history of drug misuse and has been injecting into his groin and has a poor history of engaging into treatment. His GP has discussed with him rotating sites for injecting as he is concerned about the risks of his continued injecting into the groin. His GP manages to encourage him to commence a treatment programme of methadone, but Ryan refuses to go to the "drug clinic". He also drinks alcohol at the level of harmful limits. The GP has asked Ryan to keep a drink diary and when he visits each week, so Ryan and the GP calculate the units. Over the last few weeks Ryan has managed to reduce his units of alcohol to 24 units a week. He presented yesterday with a deep vein thrombosis (DVT) in his left leg.

What are the risks associated with injecting and are there any particular risk of injecting into the groin? What concerns do you have about the harmful level of alcohol consumption and what tests would you undertake?

2.0 Common presentations

2.1 Special/distinctive features

- General practice is the first port of call for about 90% of the population and as such GPs are in the position to address substance misuse and dependency.
- As GP support is not perceived as stigmatising, patients may prefer to visit their GP than attend a specialist drug or alcohol clinic.
- The patients initial or main contact with substance abuse treatment is likely to be through primary care.
- A patient of any age may have substance problems though the presentation may not be typical.
- Patients tend to present in primary care with problems overtly or covertly related to substance problems. Thus, substance problems may not be immediately apparent.
- GPs will normally see patients even if they are in specialist care.

LEARNING OUTCOMES

Medical students will:

1. Appreciate that the patient is entitled to the same health care as for any other patient in addition to that required for substance misuse.
2. Understand that substance misuse is common and can present with a multiplicity of features.
3. Appreciate how to differentiate between substance use, misuse and dependent use including the signs and symptoms of acute and chronic presentations and withdrawal.
4. Appreciate the relevance of primary care to the prevention, detection, and management of substance misuse and its complications in primary care.
5. Recognise that substance misuse is often part of a complex picture of physical, psychological, family, relationship, legal and financial factors.
6. Identify opportunities for detection and treatment of substance misuse in primary care.
7. Identify the relationship between common presentations and substance misuse.
8. Be aware of a holistic approach to the physical, psychological and social assessment and management of patients in partnership with healthcare professionals, specialists, voluntary and criminal justice sectors.

- GPs usually have a longstanding relationship with patients and their families, are easily accessible within the community setting and are familiar sites for care.
- GPs are likely to know the patient and family background and are able to place the difficulties in context and manage the patient, partner, carers and dependants.
- They are able to provide a very wide range of care and access to services directly or through referral.
- Primary care is expert at signposting to services that are not available 'on site', and working with care pathways between agencies.

- GPs often see patients and families 'in crisis' e.g. suicidal, domestic abuse, and threatening behaviour during intoxication.
- Young people are likely to present to general practice with common general symptoms other than substance use problems e.g. problems with anxiety, depression, sleeping and eating.
- Patients may need to visit the GP to receive a Fit Note.

2.2 Ensuring appropriate treatment and access

- Although most GPs will provide some services to substance users, there may be some who may not have the same degree of special expertise or experience in managing substance misuse in general practice.
- All are expected however to provide general care as for any patient on their list.
- Patients with complex needs who present as high risk usually also require support from a specialist substance misuse service and may not be suitable for care in general practice without this support. However, the GP can direct them to the relevant service and monitor care, as well as provide other elements of a wrap-around service through their primary care team.

3.0 Assessment

A large number of patients present to primary care with difficulties which are directly or indirectly associated with substance problems. The GP should always have a high index of suspicion that any presenting problems could be substance related.

Thus the GP and team is likely to:

- Be aware of the atypical as well as typical presentations of acute as well as chronic conditions associated with substance use.
- Be aware of comorbid mental and physical health problems and clinical signs and symptoms.
- Be aware of the effects of different patterns of substance use with special attention to urgent medical emergencies and safety issues.
- Take a history
- Utilise appropriate screening tools
- Offer screening for BBV and hepatitis immunisation.
- Undertake biological investigations if required.
- Make an assessment of the patient's understanding of the impact substance misuse in having on their lives and the motivation to change their substance use in order to offer a positive alternative plan for recovery.

GPs will be able to consider substance misuse in patients with illness that has not been explained, or that appears treatment-resistant. GPs are experienced in recognising that

- Patients may under report their consumption due to guilt and shame.
- Patients with alcohol problems may present requesting a fit note for their employer or the DWP, or have pressures in their relationships, at work, housing, social services or be in trouble with the police or have court appearances pending.
- Patients may seek repeat prescriptions of sedatives or opiate-containing medication, or may have recently registered at the surgery and are requesting these for the first time; some seek help as temporary residents.
- Patients with refractory low mood and dyspepsia may be a candidate for a careful alcohol history.
- Patients with mood swings and repeated presentations with headaches may have a stimulant use problem.
- Frequent accidental injuries may be related to alcohol misuse.
- There are signs of intoxication.
- Referral to occupational health is appropriate because of post-weekend sickness absence.
- Raised mean corpuscular volume (MCV) may be a marker of alcohol misuse.
- Abnormal liver function tests, usually Aspartate aminotransferase (AST, "transaminase") and/or Gammaglutamyl transferase (GGT), are markers of alcohol misuse
- Patients with frequent mood swings and/or poor sleep may be using stimulants, such as weekend Ecstasy with midweek depressions.
- Some patients present with problems from heavy cannabis use, particularly if using 'skunk', which may cause some psychosis and delusions, as well as dependence.
- Excess alcohol use is very common.

Common presentations include gastro-intestinal problems (constipation, diarrhoea, vomiting, weight loss and gain); psychiatric difficulties (anxiety, depression, self- harm, memory dysfunction; neurological problems (headache, blackouts, memory loss, loss of consciousness); cardio-respiratory conditions, musculo-skeletal pain, and infections. Individuals with psychiatric disorders have higher rates of substance use disorders, and those with identified substance use disorders have higher rates of psychiatric disorders. Hypertension, anxiety and psychosis can be induced by stimulant use; and pupillary constriction, and sedation are signs in opiate users. Solvent abuse can be a cause of intoxication with blisters around nose and mouth. Likewise, withdrawal from opiates may present with yawning and irritability whilst withdrawal from stimulants may present with low mood, and lethargy.

As part of routine practice all new patients should be screened for substance use problems. A high index of suspicion is required. Apart from a thorough history, brief alcohol screening questionnaires (e.g. 'AUDIT' or 'CAGE') are examples of validated screening tools for alcohol misuse. Ensure that potential indicators of substance misuse are not missed.

When patients present with substance use problems, there are a number of biological tests as well as the screening tools described above that can be used to assess drug problems eg DAST 10 and severity of the problem, SDS (Severity of Dependence Scale).

4.0 Treatment

Ryan did agree to attending an outpatient appointment for a Doppler scan which confirmed a new and an old clot in his leg but he refused to go into hospital. His GP started him on low molecular heparin after advice from the hospital. Careful monitoring is required as heavy alcohol use can cause liver dysfunction and may potentiate the effect of warfarin, but drinking within safe levels has little effect. The GP therefore is working with Ryan to reduce and control his drinking. Post thrombotic syndrome is common following DVT, can be significantly reduced by wearing appropriately fitting compression stockings, so this may need to be considered for Ryan.

Withdrawal from high levels of dependent alcohol use can be risky and the GP needs to balance the risks of prescribing vs not prescribing. Any prescription should not be stand alone and be in the context of psychosocial interventions. Withdrawal from drugs may be very unpleasant, but is rarely life threatening. However, drug misusers are at greatest risk from accidental overdose usually using a cocktail of street drugs and alcohol, particularly upon release from prison, when tolerance is lowered, but desire is high.

Many GP services provide substitute prescribing for opiate addiction, usually in association with shared care services. At least one or more of the GPs in such settings will have an RCGP level 1 or 2 certificate in the management of drug misuse. In association with specialist workers form a shared care service they will undertake an assessment, discuss and negotiate management options, provide and titrate substitute medication then proceed to maintenance or detoxification regimes, whilst providing care for general health, immunisation against, screening for and information about BBVs. Some practices provide BBV treatment services. They will also provide general care and support for the physical and mental health of the user. As for all services there will be regular reviews of progress and motivation, reassessment and negotiation about progress along the recovery pathway.

Management of patients will be determined by the local care pathway. Shared care arrangements in general practice involve general practitioners having an awareness of and experience in working with local secondary care services as well as non-statutory/charitable sector providers. General Practitioners have a central role with every patient in delivering opportunistic brief interventions around alcohol, smoking and prescription drug use. In addition to paying attention to physical aspects of substance misuse such as blood-borne virus screening, immunisation provision and maintenance/detoxification prescribing, the GP may provide a substitute prescription for the patient or supervise a detoxification regime for community alcohol detoxification while the providers of social care and support in their locality supports the patients social and emotional needs.

Patients with substance use problems may present with a partner, family member or friend. The style of the consultation is crucial to engagement and building trust and rapport. Sometimes information is disclosed about the patient's problem in their absence. Depending on the level of risk to themselves or others the GP needs to take appropriate action, possibly after an appointment organised by the informant. Occasionally, careful ethical guidance may be needed from a senior colleague of defence organisation (e.g. heavy goods driver who won't disclose this information to their employer or a fellow health professional admitting to using cocaine at weekends).

The primary care team may undertake pharmacological and psychological treatments, and the former should only be undertaken in conjunction with the latter.

Detoxification from mild to moderate alcohol dependence can be undertaken in the community but it is advisable that local protocols are in place so that the team consists of trained personnel e.g. GPs, psychiatric nurses, primary care nurses, and pharmacists.

Admission is required for the following situations

- Patient is confused or hallucinating
- Patient has history of complicated withdrawal
- Patient is at risk of suicide
- Patient is vomiting and has diarrhoea
- Previous unsuccessful home detoxification
- Withdrawal symptoms uncontrollable
- How environment unsuitable e.g. unsupportive, lives alone, chaotic

Psychological interventions

- The most common intervention is a 'brief' intervention which can range from 5-45 minutes.
- The essence captures in the FRAMES acronym as follows:
- Feedback about personal risk or impairment
- Responsibility for change
- Advice to cut down or abstain
- Menu – of alternative options for changing
- Empathic interviewing – listening reflectively without confronting and exploring patients' reasons for change
- Self-efficacy – an interviewing style which enhances people's belief in their ability to change

There is consistent evidence that brief intervention in primary care can have a positive impact on harmful substance use but not severe substance dependence.

5.0 Network/referral/services

The needs of those with substance misuse problems change and patients may benefit from relapse prevention. They may also benefit from mutual aid such as Alcoholics Anonymous. Physical health, psychological problems, social issues may resolve but the GP should maintain contact with patients treated by the specialist addiction, medical and psychiatric services in case difficulties do develop. It is important to ensure that there are clear pathways between primary care and other services so that those who may require more specialist input can be referred to be managed in specialist services, and also those in specialist services, who become more stabilised, can be transferred to the

care of the GP.

It is important to plan that in any local area and system, that there is provision and pathways for the needs of the most severe and complex patients. There are clearly advantages for patients in having access to a range of provision, from GPs with a range of competencies, and from secondary care specialists across an integrated system of care, including social care.

6.0 References

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7.0 Resources

Addiction to Medicines Factsheet 1 Prescription and over the counter medicines misuse and dependence http://www.rcgp.org.uk/bookshop/eresources/addiction-to-medicines-factsheet-1.aspx

Addiction to Medicines Factsheet 2 Steps to avoid misuse of and dependence on prescription only and over the counter medicines http://www.rcgp.org.uk/bookshop/eresources/addiction-to-medicines-factsheet-2.aspx

Addiction to Medicines Factsheet 3 How are patients who are misusing or dependent on prescription only or over the counter medicines identified http://www.rcgp.org.uk/bookshop/eresources/addiction-to-medicines-factsheet-3.aspx

Addiction to Medicines Factsheet 4 How are patients who misuse and or become dependent on prescription only or over the counter medicines treated http://www.rcgp.org.uk/bookshop/eresources/addiction-to-medicines-factsheet-4.aspx

Alcohol Identification and Brief Advice e-Learning course http://www.alcohollearningcentre.org.uk/eLearning/IBA/

Misuse of Drugs and Alcohol e-learning courses http://elearning.rcgp.org.uk/mod/page/view.php?id=3927

Royal College of General Practitioners Certificate Courses Substance Misuse and Associated Health http://www.rcgp.org.uk/learning/substance-misuse-and-associated-health-landing-page.aspx

Substance Misuse Management in General Practice (SMMGP) website. Library of Guidance Documents http://www.smmgp.org.uk/html/guidance.php

Substance Misuse fact sheets Cat III Assessment and Screening tools http://www.addiction-ssa.org/factsheets/assessment-and-screeningtools

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