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SMMGP

Substance Misuse Management in General Practice

PRESCRIBING INJECTABLE OPIATES Dr E Martin

In the 18th century in Turkey it was accepted fact that coffee was so dangerous that the appropriate sentence for possessing it was death. In modern day Saudi Arabia it is accepted fact that alcohol is such an evil drug that the sentence for possessing it is forty lashes. It was perfectly acceptable for Sherlock Holmes to have his evening cocaine, for Florence Nightingale to strengthen herself and Coleridge to seek inspiration using Laudenum. In the 1970's it was accepted fact that it was unwise for general practitioners to prescribe opiates to drug-using patients, whereas in 1982 the government published guidelines encouraging GPs to prescribe reducing doses of methadone to 'cure' them from their habit, but not to be involved with maintenance. In the 1990s this has again changed and maintenance is seen as a viable option. The next bogey prescription by GPs is injectables - are too many GPs prescribing injectables and should this activity only be undertaken by specialist clinics ? - though very few specialist clinics are actually undertaking this activity.

So what does one make of all this ? Perhaps the message is not to accept accepted fact. Instead of accepting dogma, perhaps one ought to think through problems including the problem of prescribing opiates. Perhaps two principles to start from are:

1. No doctor can, or has the right to make any patient do what they do not wish to do.
2. If a product that a patient wants is freely, though illegally available for sale and a doctor prescribes for that patient another marketable substance which the patient does not want, it is highly likely that the patient will sell the second substance prescribed by the doctor and buy the substance he or she wants. This is our experience in trying to 'persuade' patients to change from injectable to oral methadone.

Our Policy for Injecting Drug Users:

When dealing with an injecting drug user, we would establish that they actually are injecting by examining them and doing a urine drug screen. We would then accept them as they are and agree to supply injectable Methadone for them, if they want it to replace their street drugs. Our contract with them states that we will continue to care for them and prescribe for them unless they are violent to us, our staff, other patients or the building. No other clauses are included. The dose we prescribe is established by discussion, and then at times we ask patients to inject their Methadone in front of us, both to check their technique and also to check that the prescribed dose is well tolerated, i.e. they are not selling some of the drug on.

The patients meet regularly with the doctor and the practice drug support worker in an unhurried environment. The topics of discussion are usually to do with housing, nutrition,

money, personal problems, how they got to where they are and where they would like to be in life. The patient usually sets the agenda.

The methadone and how it is taken become almost a secondary issue. Perhaps this seems woolly and may sound irresponsible. We don't try to persuade patients to stop injecting or reduce the amount of drugs prescribed unless at their request.

The results seem worthwhile. Over ten years more than a third of patients we have engaged with have become drug-free. Our patients become much less likely to have new prison sentences when they are on our programme. Individual patients have re-established their relationships, been reunited with children taken into care, obtained jobs and celebrated as their children have given birth - all while still receiving a prescription of opiates. It seems less likely that patients who inject their drugs, can discuss this in an open way with their doctor and receive help and information about safer injecting, needle exchanges etc., will act in a way that will put them at further risk of hepatitis C, HIV or other infections that are waiting in the wings.

Our figures for the last ten years of caring for almost 200 drug users in general practice, without secondary care back-up are presently being collected and we hope to publish them soon. **From our experience, we cannot justify prescribing something that the patient does not want or 'pushing' patients to stop injecting drugs until they choose to do so!**
E.E.J. Martin MA, FRCGP.

The Task Force to Review Services for Drug Misusers: Re injectables

5.8.7 The prescribing of injectable opioids has been for a long time an almost exclusively UK practice, mostly in the form of injectable methadone maintenance or as a short term arrangement for weaning the entrenched addict off injecting (as described by the ACMD in 1988). Despite international attention to the prescribing of injectable pharmaceutical heroin, we note that prescriptions for injectable methadone in the UK far exceed those of heroin (by approximately a factor of 10:1) Furthermore we have found evidence of substantial increase in the extent of such prescribing over the last few years. Prescriptions of methadone ampoules now represent more than 10% of all methadone prescription.

5.8.8 In addition, we have significant evidence that injectable methadone and methadone tablets are more likely to be prescribed to be dispensed weekly or fortnightly, rather than daily, in private practice settings. The dispensing of large quantities of methadone ampoules has significant illicit value and contributes to leakage. Clinical evidence from established drug dependence clinics suggest that complex patients requiring injectable methadone should have regular (usually daily) instalment dispensing

5.8.9 We are not able to make robust evidence-based recommendations on the prescribing of injectable methadone, as the necessary properly controlled studies have not been conducted.

What do you think? Do you feel GPs should prescribe injectables? When we do prescribe do we offer a good service and create minimal problems? Is the problem that private prescribers prescribe both enough for the patient and enough to sell so the patient can pay for the script? Is this because most DDUs do not have anything to offer the most distressed and chaotic users and they are still intent on trying to make people do what they don't want to do? Write to us and let us know what you think.

Second National Conference on Managing Drug Users in General Practice
***'Embracing the Diversity'* Friday 25 April 1997**

This conference was over-subscribed last year - so book early! Details from Claire Manning, Conferences, RCGP, 14 Princes Gate, London SW7 1PU. Tel: 0171-581-3232

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