

Managing crack users in primary care – a personal learning experience

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Background

- 2.5 GPs 4,000 patients PMS Pilot 4.02
- Took over 1,400 patients from failing practice 4.02 'inner city' type demography
- Personal interest in sexual health & HIV, equal opportunities for health care access
- RCGP drug certificate course 02-03
- Shared care clinic in planning stage
- Crack cocaine training day 28.1.03
- Member RGCP Task Group Sex, Drugs & HIV

“Greg” 43year old male

- Unknown to present practice staff
- Presented no appt. midmorning 30.1.03
- (Later learnt from him 3rd attempt to get to practice)
- Triaged by practice nurse -> Dr as extra at end of morning surgery
- PMH
 - 1969 appendicectomy
 - 1992 duodenal ulcer
 - 1995 OD paracetamol
 - 1995 drug user – cocaine and ecstasy

Presenting complaint 1

- “In trouble doc”...“in a mess”...“need help with my crack problem”
- Crack use 10yrs – smoking £100/day (previous injecting heroin) pipes or cans
- Unemployed painter/decorator
- Lives c girlfriend (not user) & 3yr daughter
- Domestic/relationship problems due to use
- Paternity issues brought up

Presenting complaint 2

- Not eating/sleeping, cough, chest pains, sore mouth
- Paranoid (?real) ideas – vendettas, people out to get him
- Low mood – “hit the bottom...no point carrying on but won't let them win”
- Last used last night
- Also smokes cannabis

Examination

- Thin, unkempt
- Agitated, restless, verbally angry
- Pressure of speech & thought, flight of ideas
- Scratch marks on arms, no injection sites
- Wt 71.6Kg, BP 161/103, Pulse 80 bpm reg
- Occ. coarse wheeze, HS normal
- Poor dentition

Discussion with patient

- Motivations to reduce use
- Effects of crack
- Harm reduction – pipes not cans
- What I can and cannot offer (no substitute prescribing)
- Explored referral to specialist drugs service
 - ?Can support worker see him in practice not centre (“I won’t go there – too many smack heads I know there – I’ll end up back on heroin”)
- Given script for nutrient supplement drinks

Plan

- See 1 week or SOS
- Contact specialist service
- Reminder notes for me or other Dr
 - Avoid SSRI (d/w me before any prescribing)
 - CXR & ECG
 - Bloods including BBV screen
 - Urine for drug screen – for us and him

6.2.03

- Using less
- Eating a bit better “beans on toast”
- Poor sleep
- Concerns re health/chest
- Happy to see drugs worker in practice
- Agrees to CXR,ECG and urine not sure re blood
- See 1w
- Arrange meeting with drugs worker

13.2.03 - 1

- Now homeless, sleeping rough
- Able to stay off crack 3 days but heavy use when using
- Wants to stop crack but needs it to escape
- Very low “bottom of pit” suicidal thoughts but “wouldn’t do it because of daughter”
- Seeing support worker – taking him for CXR, ECG and arranging urine

13.2.03 - 2

- Motivational interviewing re use and wishes to reduce
- Discussed why antidepressants won't help
- Think further about bloods
- Discussion re his chest symptoms and poor health in general
- Note to me – need slow approach to keep him engaged and feel safe with us

20.2.03

- Still sleeping rough
- Eating out of skips (couldn't tolerate drinks - offered different – declined)
- Using less
- Chest pains, bad cough
- Discussed need to get CXR (TB, crack lung)
- Further discussion re bloods - agrees
- Urine shows cocaine only
- Sick note given 1m “stress, chest pains under investigation, drug misuse engaged in services”

27.2.03 seen with support worker

- Much improved
- Not used 10 days
- Chest pain less
- Appetite a bit better
- Still living rough but beginning to get benefits sorted
- Still some paranoia but not unrealistic, less pressure of speech and more settled
- Got investigations done at hospital
- Further motivational interviewing – positive outcomes in adversity

7.3.03 with support worker

- Still not used
- Fleeting thoughts of suicide – only on bad days, not preoccupied/troubled by them
- CXR, ECG, BBV, biochem – normal
- FBC – Hb 167, MCV 103, MCH 35.3 – needs further investigation
- Wants to see smoking cessation nurse!
- Plan to see fortnightly, alternating with support worker

14.3.03

- Used last night, felt particularly low
- Reassured OK to be honest with me about his use
- Motivational interviewing
- Wants referral to community dentist
- 1st hepatitis B vaccine given
- Further sick note

4.4.03

- Still occasional use
- Staying on friends floor
- Much of the same

15.4.03

- DNA!
- Out of contact with support worker
- Personal disappointment – not surprise

13.5.03 seen with support worker

- Not used 7 days but smoking much cannabis
- Resulting in “out of it most of the time” but better appetite (wt 72.6Kg)
- OE “out of it”, singing our praises, “pissed off with council re housing”
- Discussed heavy cannabis use
- 2nd hepatitis B vaccine
- Sick note – “drug dependency – engaged in services”

10.6.03

- Binge use of crack again precipitated by
 - Loss of access to daughter
 - Being “pissed about” by housing and “social” who had lost his sick note
- Further motivational interviewing
- Duplicate sick note (“please do not allow your bureaucratic inefficiencies to prejudice this man’s recovery”)
- Letter to housing dept – in confidence to Dr not housing officer
- 3rd Hepatitis B and blood for repeat FBC, B12 & Folate

8.7.03

- Not used for 11 days, cannabis 3x in last week, but drinking half to bottle of brandy to help sleep
- Just moved into flat in next town (4miles away – pleased but will not stay there if has to change GP and support worker – not manipulative)
- B12 & Folate low normal – recheck with HBV surface ab next month
- Wt dropped to 68.3Kg – dietary advice, verbal written, pictorial
- Motivational interviewing re continued abstinence from crack and harm re alcohol

Learning points 1

- From Crack Training Day – use & effects of crack, harm reduction, triggers
- Dr's knowledge of problem helps patient's confidence
- Can prescribe - but not medication
- Difficulty with time, writing full history on computer, focussing consultation – tensions between letting him talk and feel empathy and getting the information I needed
- Assessment of mental health in presence of drug use
- Contact details – NFA – mobile phone

Learning points 2

- Rules of engagement
- Whole staff training and attitude
- Receptionist – first impressions
- Equal opportunities statement in waiting room – (red ribbons in window), other posters in waiting room
- Feed back to staff re progress with him
- Good quality basic principles primary care

Equal opportunities statement

- Our aim is to provide high standards of care to all our patients regardless of the nature of their illness
- We intend never to discriminate against people on the grounds of gender, race, social class, age, ability, religion or sexual orientation
- No matter how young or old you are we will not tell anyone else what you tell us, unless you give us our permission first

Learning points 3

- At bottom of learning curve but not as scary as I thought – I can do some of this
- Very rewarding – danger of failure or disappointment if doesn't stay engaged
- Learning more about drug sub-culture
- Shared care, support from specialist service
- Whole staff training re shared care and DUs
- Normalising care – specific users' clinic or normal surgery appointments?
- I'm very lucky!