Pharmacotherapy is an extremely effective treatment for the management of opioid dependence, and medical practitioners who are active prescribers play a critical role in addressing a significant public health issue. Sam Lawry talks to two GPs about their own experience.

While only a tiny proportion of the Australian population engages in illicit opioid drug use, a much larger proportion is affected by it. Illicit opioid drug use is connected to increased crime rates, and carries a social cost, impacting on family and employment and resulting in increased medical costs. In comparison, effective maintenance of patients on legal opioid substitutes (such as methadone or buprenorphine) coincides with decreased use of illicit heroin, and an increased reintegration into community life, including through employment.¹

This is therapy for a chronic condition through daily medication, in this sense much like treatment of other conditions such as diabetes, which also requires daily dosing, and carries equally high risks for non-compliance.
Pharmacotherapy prescribing requires clinical skill, as well as the capacity to manage sometimes difficult patients.

Dr Monica Cooper, a GP practising in Carlton for 19 years, has 35 per cent of her practice dedicated to pharmacotherapy patients, and says patients can be difficult for a range of reasons: “They can be quite rude and demanding, they often have co-morbidities and some just don’t understand how to behave.”

The circumstances of many pharmacotherapy patients can be very challenging too, some of whom face housing or legal problems. “Each time I see them I go through their other issues,” says Dr Cooper, who also has a social worker attached to her practice.

“Often, too, I may be the first person they have seen who isn’t ripping them off.” A lack of access to prescribers means her patients come from all over Melbourne. Yet once patients are stabilised – which can happen quite quickly – they may only need to see their doctor every four to six weeks, while their doctor has regular contact with dispensing pharmacies.

Lack of access is a particular issue for those wishing to start treatment, perhaps for the first time. “If a practice only has doctors only available for a few hours a week, this is difficult. When someone in crisis calls they need to be seen within 48-72 hours, otherwise we lose the opportunity.”

Ballarat GP Dr Wayne McDonald has also treated pharmacotherapy patients for many years. He believes more GPs could take on a role treating opioid dependent patients, and makes the point that many clinics often have these patients in their waiting rooms already, but only for crisis treatment.

“When you only see patients in crisis you are not addressing other drug issues, as you can when prescribing legal opioids. People may use drugs for five, eight, or even 10 years before seeing a doctor for management. This management is then very rewarding, because you are working towards an outcome.”

Dr McDonald is also concerned about the changes in drug-seeking behaviour; the rise in poly drug use, including prescribed drugs like oxycodone.

“Some doctors have contributed to this problem…these drugs are prescribed for pain, often legitimately, but the reality is that these are often sold on the black market.”

Addiction to licit drugs is also an increasing problem, in Australia and overseas. In the United States, for example, the number of people dependent on prescription opioids is four times as great as those dependent on heroin. The National Drug
Strategy household survey from 2007 reported that more than 1.2 million Australians had used a pharmaceutical drug, “for a non-medical purpose”\(^2\).

Pharmacotherapy can also be used to treat addiction to legal opioids.

“Real time” prescribing systems, which allow for doctors to see at a glance what has been prescribed for a patient, and when, are in development. Trials are underway in Tasmania, but there are questions around who will hold the data, and privacy.

One of the challenges for pharmacotherapy is that, unlike with other medications, patients bear dispensing costs for opioid substitutes, which can be $5 a day. This can be difficult for patients, many of whom are on social security benefits, must pay travel costs in order to receive treatment, and are trying to introduce some stability into their lives, as well as for pharmacists, who must collect these costs. It has been argued that subsidising these fees, while ensuring pharmacists are fairly paid, would be a cost-effective strategy, as well as a more equitable one. The longer patients remain in opioid maintenance treatment, the better their health outcomes, with corresponding benefits for the community. Failure to continue treatment, for cost or other reasons, can often mean a return to heroin use.

An issue for prescribers is the requirement that prescriptions are handwritten – a historical requirement aimed at reducing fraud. AMA Victoria has recently been asked to advocate for changes to regulations, to acknowledge the reality that records are now primarily electronic, that patients are mobile and do not just see the one pharmacist, and to allow for chart-based prescribing.

The Victorian Auditor-General’s report, *Managing Drug and Alcohol Prevention and Treatment Services* ([http://wwwauditvicgovau/reports_publications/reportsbyyear/2010-11/20110302_aodaspfx](http://www.audit.vic.gov.au/reports__publications/reports_by_year/2010-11/20110302_aod.aspx)) was released in March 2011. The review was critical of the fragmentation of the drug and alcohol system, and the fact that previously identified issues – such as a lack of alcohol and other drug (AOD)-specific qualifications – had not yet been fully resolved.

The fragmentation of services, and lack of clear referral pathways, has a direct impact on medical practitioners trying to assist their patients, particularly in regional and rural areas. This is changing – some areas have addiction medicine specialists working closely with local services, in a support or mentoring role, and some metropolitan services, such as DAS West Footscray, work with practices in regional areas. Mental health nurses can also be utilised to support pharmacotherapy prescribers, where there is a mental health plan. Yet there is a great deal of pressure on GPs in country areas who currently prescribe to carry the load, leaving their patients – who require long-term, ongoing treatment – to wonder what will happen when their doctor retires, or moves on?

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The Victorian Government, as part of the recent budget, has committed additional funding to pharmacotherapy services over the next four years, and states that it is working to address pharmacotherapy issues. AMA Victoria recently attended a pharmacotherapy roundtable consultation, which looked at some of these.

Proposals being considered by the government include scholarships for addiction medicine training, additional support for specialists, additional support services (especially for rural and regional services) and increased support and training opportunities for GPs and pharmacists, including training (for medical students) in dealing with difficult behaviours. Other models include hospital-dispensing, such as in New South Wales and Queensland, and pharmacists managing prescribing.

Each model has its own challenges, and opponents. Ultimately the success of treatment can depend very much on the quality of communication between patients, treating practitioners, pharmacists and other services, and a better coordination of all services.

Dr McDonald sees drug and alcohol use squarely as a public health issue, which could be addressed within a public health model. “There is no current capacity within the current Division structure to address drug and alcohol issues. There is no public health focus through Divisions. We need more specialists in drug and alcohol, as well as other coordinated services (housing, crisis, client support), for GPs to refer to.”

In the meantime, Dr McDonald would like to see GPs as part of the solution, developing and utilising a new skillset.

Training is offered through General Practice Victoria, in collaboration with the Department of Health – a one-day workshop focusing on problematic pharmaceutical opioid use, drugs, dependence and harm minimisation, clinical assessment, medication and legal issues.

Treating GPs can have a significant impact on the lives of those pharmacotherapy patients they see.

Dr McDonald: “I like to see the change in people. For example, one patient, who had previously been a heroin user, moved from living in a motel to stable housing, and was now in training to become a personal trainer. These people need continuity of care. All GPs see a range of problems; D&A is just one area. The alcoholic patient, for example, is much more difficult to deal with than the opioid-addicted patient. We are just seeing patients, writing scripts. You can take on just five patients, as part of your practice, form long-term patient relationships that make a huge difference for those patients.”
Dr Cooper understands why some are unwilling to take on pharmacotherapy patients. “Some can be quite intimidating. But 85-90 per cent of them are really nice, write notes to say thanks, and respect you for how you help them.”

The proposed measures, in combination with additional support for GPs, would make a difference. Doctors who treat opioid-dependent patients are a vital component of a treatment program with demonstrated success, yet the value of their role is underappreciated. Most, like Dr McDonald and Dr Cooper, see these patients because they are committed to caring for other people. As Dr Cooper wryly notes, “Someone’s got to look after them.”

### Pharmacotherapy statistics at a glance

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<th>13,666 (as at 1 April 2011)</th>
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<tr>
<td>No. of pharmacotherapy clients in Victoria</td>
<td>13,666 (as at 1 April 2011)</td>
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<td>Amount of pharmacotherapy need being met</td>
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<td>No. of doctors prescribing</td>
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<td>No. of doctors approved to prescribe</td>
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From the Department of Health Victoria


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