LDN / 800 / 010218

The working Addict

A clinical case study

Aims of project

- To find out how physical, psychological, and social elements of a patient's life interact and give rise to a clinical problem. I wanted the project to fulfill two primary aims , broadly speaking, to be educative for me and to be helpful to the patient.
- To find out more about Drug Addiction, and improve knowledge of ways to help drug addicts.
- To find out more about the drug Dipipanone.
- To increase proficiency in using Information Technology.
- To find out if it was usual for drug addicts to maintain themselves in gainful employment throughout their drug-taking career as I was unfamiliar with the concept of 'The Working Addict'
- Is there a role for the GP in treatment and management of drug addicts or should it be left to Specialist drug treatment centres?
- To look at this patient in a holistic way and try to make sense of what had happened to him / influenced him over his drug-taking career.

Method

I chose the clinical case study as my preferred vehicle on the basis that a detailed assessment is `vital to the continuing care of the patient and that it can begin a process of change even before a **full** assessment is completed' (Drug Misuse and Dependence: Guidelines on Clinical Management (1999) HMSO. As noted in this document, the method itself is thus an integral part of the therapeutic process.In so doing, I would be fulfilling my first aim to simultaneously obtain information and engage in meaningful therapy with the patient.

This idea of the ` Process as Therapy' interested me a great deal. I adopted a patient-centred approach in sessions and advocated a feedback time after each session for both patient and doctor to point out what each had considered beneficial and not so beneficial about the session. The patient was aware that what he divulged was intended not just to inform me but also to benefit him.1 was there to facilitate him taking charge of his own recovery.

Information was obtained from several interviews , formal history-taking sessions with patient, the notes, doctor interviews, and hospital letters. Corroborative information from patient's wife was obtained .

The Working Addict

Mr B., 48 year old Catholic, white male, self-employed builder, married, two children. A referral for initial specialist inpatient treatment for safe withdrawal from drugs was made and he awaits assessment and admission.The bulk of follow-up will be with the GP (me) and self-help services, and specialist service involvement is still to be decided.

Reason for referral

Self referral requesting detoxification from drugs after years of poly drug abuse. "I've had enough, want to stop, but need help". Fed up with routine of having to take drugs daily, unable to make savings in spite of working regularly and wants to give family better life.

History of present illness

Use of amphetamines, sedatives, cannabis for about 33 years and opiates including heroin, methadone, dipipanone for about 26 years. Receives prescription of DICONAL (dipipanone and cyclizine) from psychiatrist for last 16 years, which he uses i.v. Had not injected for 6 days, was taking 50 mls methadone each day experiencing mild withdrawal symptoms. Never experienced more than 24 hours withdrawal except in treatment.

Family History

Biological father

B. made persistent attempts to trace but unable to see or get information. A married Army officer having several affairs resulting in numerous children. Paid allowance to B's mother till she married. Apparently drank `too much alcohol'.

Step father

Died aged 75 Ca prostate. Did not drink / smoke. Served in Army. Became postman after retirement, then married patient's mother. `Looked after me as well as any father' but not emotionally close.

Mother

Aged 80 reasonably healthy, lives Worthing. Married pt's step-father aged 36 (4 years after pt's birth). Continued marriage till husband's death. No other children. Simple hard-working waitress, secretary and other jobs until 1976. A worrier, ineffective in disciplining son. Drinks `once in a while'. Does not smoke/ take drugs of any kind. Not emotionally close.

Other relatives

No other siblings that he knows about. One maternal aunt probably dependent on alcohol. No other family history of note.

Personal History

Early development- Normal milestones.

School : 5 to 11 years. Grammar school till 15 yrs. Not interested in studies, but did not fail any class. Lots of friends. Spent much time out of house. Did not like teachers- frequent minor conflicts. Refused to go to college against parent's advice. No exams.

Sports: Good footballer- represented school for several years. Joined men's amateur team - played for two years after school.

Work: Worked in factory immediately after school- left after 3/12 `didn't like working indoors'. Became construction worker- worked regularly for 4 years and saved lot of money ` to travel to foreign place'. Aged 19 bought ticket to Australia (`farthest away I could think of') There worked on railways, 2 promotions in 10 months. Then asked to serve in Army,-refused -had to leave country. Returned U.K.

Worked as builder regularly since.Age 37- left job , became self employed - works 5-6 days, earns £300+ per week

Marital: Married aged 24 (wife aged 16) after 5 months friendship. Wanted companion to share interest in travel dancing and music. Plans upset when 1st child born within one year. Wife trained as teacher- worked regularly. Currently 3 part-time jobs (total 60 hours), earns £700+ per month. Describes wife as supportive, -dislikes his drug habit but never seriously considered divorce or separation. Used cannabis and amphetamines in first two years of marriage but never after that. Does not drink /smoke.

Children: Daughter (24yrs) Son (20yrs). Suspected son not his but one of his friends. Wife accepts this to be true also. Son is not aware of this - have not allowed it to become a major conflict. Very fond of son - trained him to play football. When daughter aged 18 and about to go to college -became pregnant by boyfriend who refused to marry her. Had baby- lived at home with parents. Daughter emotionally closer to mother than father.

Sexual history: Had sex with girlfriends before marriage. No contact with prostitutes. No homosexual contacts. After marriage realised sex drive was low and decreased further in following years. Now have sex occasionally, (about 5 times last year) Attributes this to use of drugs -not concerned .

Present social situation: Lives with family, semi-detached house. No outstanding arrears on rent or bills.

Previous medical history

Occasional mild infections but no serious complications of drug abuse until 1989 - DVT right leg -treated conservatively for 6 weeks. Nil else of note.

Previous psychiatric history

1978 sought treatment for drug problem- with intention of obtaining prescription. Visited 2 psychiatrists and found a third who was willing to prescribe Diconal,- has been under this prescription since. Admitted

to hospital 1982 on South Coast for detoxification and afterwards to London hospital- self discharged against medical advice - couldn't stand sickness any more -went back to drugs. No records from admission. Not attempted detoxification since despite occasional suggestions from psychiatrist.

Personality

Describes as active, outgoing , likes excitement and novelty hates routine of any kind.

Social Relationships: Had many friends but dwindled over years. Now left with 2 close friends, an addict and an ex-addict.

Hobbies and Interests: Was keen football player. Enjoyed loud music, dancing, motorbikes. Also wanted to travel and see world. Now hardly any interest left in these activities.

Attitude to work -Work essential to keep him busy and earning money. No higher ambitions. Would still be builder if given choice again.

Attitude to authority: Dislikes authority/ being given orders. Did not like teachers . Refused to join Army.

Mood: Generally happy. No major mood swings. Usually free of worries and tension.

Coping with stress: Tries to avoid problems by ignoring them. Escapes family problems by staying away. Will pay money to wife to avoid shouldering responsibility.

Drugs

Amphetamines: from age 15. Helped increase energy level, made music more enjoyable. At 19 years 15-20 tabs per day 4-5 times weekly. Amphetamines i.v. started in Australia- injected daily for about ten years. Gave way to regular opiate use. No amphetamine since 1986.

Sedatives: Needed `downers' after 2 years amphetamines. Took Tuinal , Mandrax to sleep, take edge off amphetamines and when nothing else available.

Cannabis: commenced age 16 - use moderate and irregular to date. Last 10 years not smoked more than twice per week `A drug for kids'.

Opiates: First used age 22. Smoked morphine, heroin . By 24 years injecting occasionally. By 28 years injecting daily. Experimented with Diconal orally, then by crushing and using i.v. Bought illicitly, consuming as many as could, sometimes up to 40 per day. 1978 saw psychiatrist -regular `script for Diconal - 6 tabs od. Managed to get month's supply of 180 tabs. together and inject these in about 1 week. Had to buy more for rest of month -used heroin, methadone, codeine linctus. Patient's wife requested psychiatrist to prescribe weekly for last few years. Takes it i.v. except when no veins, then takes it orally. Shared needles occasionally in past- not for last 10 years.

Withdrawal : 6-8 hours after opiate use - restless, anxiety, yawning, lacrimation, aches/ pains, rhinitis, sneezing, weakness. Never more than 24 hours of withdrawal.

Other drugs: Occasional use LSD, cocaine - never formed liking /dependency.

Alcohol: Aged 15 years started drinking beer - never became heavy/ dependent drinker. Takes alcohol 4-6 units every 2/52 with friends. Smokes 15-20cpd since 14.

Drug -related disabilities

Physical: minor infections. 1989 -DVT

Psychiatric: short-lasting paranoid symptoms with amphetamine use. Nil else significant..

Accidents: *3* major car accidents last 15 years all under effect of drugs / alcohol. No serious injuries to self / others -retains driving licence. No accidents at work.

Financial: Bought drugs from wages and sale of household goods. Most things now bought by wife which in general he will not dispose of Never borrowed. Never indulged in crime for financial gain.

Legal: Aged 17 - arrested - assault on policeman - father arranged for him not to be prosecuted. Nil else.

Marital: Strained - no threat of divorce.

Physical Examination: NAD except healed fistulous track right groin.

Mental State Examination: NAD

Management Goals: (i) Complete Abstinence, (ii) Relapse Prevention, (iii) Rehabilitation

DISCUSSION AND HOW CHANGE MAY BE EFFECTED AND IMPLICATIONS

(i) Dipipanone Dependence

Dipipanone is opiate used as treatment in severe organic pain. Available only in tablet form for oral use as Diconal,- contains 10mg dipipanone , 30mg cyclizine (Wellcome). Has high dependence potential . Number of new dipipanone addicts reported to Home Office in the last 20 years up until the Home Office addicts index ceased to exist, showed the largest increase in percentage terms of all addictive drugs. Advisory Council on Misuse of Drugs in its report on Treatment and Rehabilitation (ACMD 1982) recommended its inclusion in list of drugs specified under Regulation 4(3) of the Misuse of Drugs Notification and Supply to Addicts Regulation, 1973.

Now dipipanone prescribed to addicts only by doctors licensed for this purpose. Main danger of dipipanone - injected intravenously after crushing tablets. Often leads to DVT (as seen in our patient), pulmonary embolism and bacterial endocarditis. If injection made by mistake into artery, gangrene can result. It is believed that iv dipipanone gives very pleasant `rush',which remains in spite of many years of use. B. also reported this as reason for dipipanone being his drug of choice.

Editorial in Lancet (1983) drew attention to use by addicts having gone up by 'leaps and bounds', and recommended more strict regulations. Bewley and Ghodse (1983) were among first to express concern over excessive Diconal prescribing by private practitioners while Ghodse et al , as early as 1985 reported deaths caused by diconal injections..

(ii) The Working Addict

Some addicts are able to `integrate their drug habit with the world of work' (Caplovitz 1976). He states ,working addicts were found to be more often older, married, and less often criminal; all characteristics true for B. Study also revealed that contrary to expectations, working addicts were highly dependent on heroin and were often using multiple drugs. (B. also severely dependent on opiates and polydrug user). Working addicts are in minority in most clinic populations; a study by Sheehan et al (1986) found only 10% full time employed and another 14% in casual or irregular work.

How Chan es ma be ffected and implications

a. In view of high dependence potential of dipipanone, its relatively easy availability and its highly dangerous parenteral use, following suggestions may be worth considering:

1) As a number of other opiate analgesics are available, Diconal may be taken off the market.

2) In case 1) not feasible, dipipanone may be combined with another drug which produces unpleasant side effects when taken in excessive dosage. This method of combination marketing has a precedent and has been found to be of value against misuse of diphenoxylate by combining it with atropine.

3) Alternatively, the pharmaceutical company may be asked to find some way of rendering oral preparation unsuitable for injection . Marketing only linctus may be one possible step

With regard to the Working Addict, there is a continued need for more research on factors which facilitate an addict to remain employed; especially because it can be strong mediator for better outcome. This may also have increased importance in the future if drug laws are relaxed and greater numbers of drug users make up the working population.

b. Long-term prescription of opiates to addicts

Provision of long-term prescription of drugs has been one of components of `the British system' of managing addicts. This was recommended by the Rolleston Report (1926), and accepted with certain limitations by the Second Brain Committee (1965). A few safeguards are however essential before prescribing long-term opiates to known addicts. These should include some method to ensure that the addict is not consuming other drugs obtained from the illicit market and also that he/she is administering the prescribed opiate as advised.

In our case Diconal has regularly been prescribed by a private psychiatrist for ten years, and both these safeguards have been violated. Patient was consuming variety of other drugs and was injecting all Diconal tablets. Even a single physical examination and urine drug profile would have proved these beyond doubt.

A re-examination of long-term opiate prescribing by private psychiatrists and others is necessary. There are currently insufficient regulations/ guidelines both to ensure lack of abuse by patient addicts and unscrupulous prescribers, and to protect genuine prescrrbees from adverse criticism.

CONCLUSIONS (RELATING THESE TO AIMS OF PROJECT-SEE PAGE 2)

1. Within this framework of a case history, I was able to chart physical, psychological, social and emotional growth/ experience of patient and plot this against significant events in his life. I made a Life Chart (word limit precluded inclusion here) which we used in therapy to help with understanding of the past and planning change for the future, which patient reported as helpful in that it gave him longitudinal view of his life course and choices. A Life Chart used in this way has been recommended by many workers in the Addiction field as an adjunct to other therapies.

A holistic approach is the only approach - I became convinced through this study that we must look at whole person to understand causes and context in which illness or' dis-ease' occurs.

In this instance, I did very little, ostensibly `for' the patient but he was grateful both for the time I had spent listening, and for opportunity he'd been given to review his life in this way.

He had been unaware of the options for treatment and was amazed at the cognitive/ behavioural methods of treatment and how powerfully effective these could be. His fear was that he'd be' locked in padded cell to do cold turkey' - that there would be nothing else available to help him.

I wanted the patient to benefit from the case-history approach (Process as therapy). Although I was not able to evaluate results scientifically, patient reported that he had grown in confidence by being encouraged to set his own agenda and take a responsibility in facing difficult issues. To my knowledge, he was never late, nor missed appointments and had always completed tasks that we had agreed at end of each session. He reported finding it painful to hear views expressed by his wife but said it was therapeutic as he had never taken time to listen to her point of view before. He felt it had helped create a closer relationship between them and he had recognized her feelings as valid for the first time.

21 found out about Dipipanone, a drug I had not come across previously. And learnt many cognitive/behavioural methods of helping drug addicts. (unable to include due to word limit.)

Another aim was to a) Increase my knowledge of drug addiction and did this by extensive reading of both books and seminal papers, as listed in bibliography and referred to throughout the text:- some of the older papers are recognized as the main authority on subject and remain unsurpassed by later work, if such work exists at all.

Also used Internet resources which fulfilled another aim of b) increasing proficiency in using Information Technology, leading to greater confidence in this area.

Of greatest benefit was `listening to patient tell his own story.' This was invaluable `education' not only in terns of finding out about dipipanone from point of view of an addict but helping me see patient and his family in a holistic way- not just as, eg a patient requesting methadone or presenting with a DVT.

Discovered many of my previous prejudices surrounding drug addicts were invalid - Were not all liars or under-estimators of their drug use, or unwilling to help themselves.

This exercise helped me to shed concerns re. being ineffective as a therapist working with addicts. Found many ways in which I could as an informed individual, help someone bring about beneficial changes in their life and discovered this was crucial as opposed to doing things for the patient.

3. Was illuminating to discover paper by Caplovitz, after which this study was entitled -see heading'The Working Addict'.

4.13ecame convinced there is role for GP's in treatment and management of drug addicts, having previously believed only specialist services provide the help needed. Work with addicts and alcoholics (Drummond DC et al. 1990), have shown that there are no significant differences in outcome measures between GP's and specialist treatment services.

Clare Gerada (Oct. 2001) as advisor to the Department of Health on drug abuse policies says ` the aim is to ensure that Primary Care Services no longer abandon responsibility for this vulnerable patient group'

My view would differ from this in that I believe practitioners who are interested and wanting to be involved in treatment and management of drug addicts should be encouraged and helped to do so, but should not feel pressured into doing so, apart from offering their obligatory general medical services My belief, backed up by extensive reading around the subject is that a genuine interest and understanding is essential to success in working with addicts. However, an appreciation of the pitfalls in therapy is essential too. Work is challenging, time -consuming and chronic relapsing nature of addiction problems is not everyone's cup of tea.

My research has led me to appreciate importance of dealing with these problems as part of a team with a variety of resources at one's disposal. To this end, a GP must feel they have back up of specialist services,

regular seminars/meetings with other professionals and opportunities to increase professional development and expertise.

It is hoped that recent measures to introduce specialist courses for GP's will encourage greater numbers of family doctors to take on this field of work.

Relevance to my own Practice

In our own Practice, we hope to look more closely at how we manage drug addicts and monitor their prescription drugs.

In addition, hope to offer those interested, opportunity to attend training courses to equip themselves with skills to undertake work with addicts with greater confidence.

Also hope to establish firmer links with specialist drug unit, by arranging meetings, ie. `meet the department' to develop supportive / educational links. Although only preliminary soundings have been made, may be feasible to undertake joint therapy sessions with some patients involving primary care and specialist service workers. In this way, it is hoped communication will improve and consistency of approach will be achieved.

In first instance, we are planning an audit to commence September 2002.

3000 WORDS

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