Editorials

The opioid problem in primary care

RESPONSIBILITY, AND LEGALITY, OF PRESCRIBING

There are few areas within the profession of clinical practice that evoke more controversy, and at times anxiety and risk, than the prescribing and control of opioids. To cause harm or to be exposed to criticism by prescribing inappropriately has to be balanced against the unique responsibility to help the patient and relieve pain and distress. Many drugs prescribed in clinical practice are potentially toxic or dangerous, but the use of opioids assumes a position of heightened importance crossing into areas of dependency and misuse, legal complexity, and governance and control issues, bringing prescribers into the largely unfamiliar areas of contact with General Medical Council and Home Office regulations.

Prescribing for non-cancer pain has become an area of clinical practice under critical scrutiny.[1] Scott *et al*[2] draw attention to the complexity of the caseload and the multimorbid pathology driving consultations, as well as the range of interventions, investigations, and advice experienced over prolonged periods by this group who, by all standards, are dependent on opioids and other drugs. The range of drugs available and the history of repeated misuse of drugs such as barbiturates, benzodiazepines, antidepressants, gabapentin, pregabalin, and many others draws attention to the patterns of prescribing driven by concerns about overprescribing opioids and, quite understandably, attempts to search for alternative, less toxic (and less controlled) analgesics. The parallel increase in non-prescription interventions reflects the better understanding of the risks and limitation of the benefits of opioid analgesics, and the logical benefits of psychological and educational interventions. However, to many primary care practitioners, the enduring problems are of deprivation, adverse early life experience, and inequalities, which drive self-harm and self-medication in a population already at risk of health problems caused by smoking and heavy alcohol use.

A REASONABLE DEMAND FOR, OR EXCESSIVE USE OF, ANALGESICS

Scott *et al*[2] draw attention to the value and importance of interventions to reduce or mitigate opioid use but allude to the enormity of the task. Although popular culture and opinion of the characteristics of people who are dependent on drugs paints a clear picture of a rebel and criminal individual subculture driven by addiction to opioids, the reality is much more nuanced. Opioid-dependent people range from those who have, arguably, been established on opioids by well-meaning prescribers and who have become dependent and are experiencing adverse effects, to those who largely depend on the illegal market of heroin or other opioids. Within this spectrum are an extraordinary range of individuals all with an individual set of problems and circumstances. As ever, the primary care practitioner has to manage each case individually. The crossover between iatrogenic dependency generated by the use of prescribed or non-prescribed drugs is not simple, and the resulting caseload tests the ability of guidelines and teaching to make management clear. Alternative and specialist interventions are often in limited capacity, unacceptable to the patient, or unrealistic in their expectations.

> *"An illegal marketplace making an increasing range of drugs available challenges prescribing to be safe but accessible at a low cost."*

Government may take some comfort in a long-term downward trend in illegal drug use[3] but rising numbers of drug deaths, epidemic cocaine use, synthetic substance availability, and record numbers in custody and attending emergency departments are all alarm bells ringing loudly.[4,5] The apparent stability in overall drug use reported in England does little to reassure, and recent increases in cocaine and ecstasy use are alarming.

COMPLEX CASES AND MULTIPLE DRUGS

The opioid crisis in North America and warnings of similar problems with prescription opioids in Europe reach headlines, but not, apparently, resulting in clarity or vision of interventions for policymakers. The 2017/2018 survey estimated that, in the last year, 7.0% of adults aged 16–59 years had taken a non-prescribed, prescription-only painkiller for medical reasons.[3]

Drugs can be anything from cannabis, ecstasy, synthetics, and alcohol, to cocaine and heroin, and interventions range from decriminalisation to increased enforcement, and from simple harm reduction to expensive admission to heroin-prescribing facilities, acute care, detoxification, or residential recovery programmes. The problems for policy and for planning strategic action on drugs are the interactions between political expediency, legal and cultural opinions, and pragmatic action. In all this confusion, and with a tendency to divert into short-term solutions and vanity projects, the importance and central position of opioid use and its lethal complications is in danger of being lost. Therefore, the 'drug problem' is never stable and is invariably unpredictable, and responses are always required at political and operational levels.

The complexity of cases with multiple pathology demands an understanding of the interactions between mental health, social circumstances, and self-medication in an era of stress, unease, and inequality. This is increasingly an area of clinical practice requiring the involvement of a wider primary care team and a range of expertise from non-statutory agencies. Restructuring of the NHS to encourage competition and short-term contracting has been more obvious in England and Wales but is also emerging in Scotland, challenging the convention of personal care by GPs and the uniquely stabilising role of primary care for people with complex needs.

At one end of a spectrum of opioid use are those people using illicit heroin and, increasingly, a range and cocktail of drugs such as cocaine, atypical benzodiazepines, and synthetic drugs including cannabinoids. This presents to primary care in a bewildering array of clinical manifestations and in an increasingly diverse age and demographic range of individuals. Drug deaths are higher than ever; emergency department presentations are increasing; and difficulties in custody

and community situations demand inter-agency cooperation, with general practice occupying a key coordinating and informing role. Therefore, interventions are important and are both strongly supported by evidence of good practice and successful outcomes.[6–8]

ENGAGEMENT AND MANAGEMENT

Cases range across the age spectrum and have enormous variation in presentation in drug, or drugs, being taken, mode and frequency of use, and associated lifestyle problems. The concept of personal and recovery capital is useful in conceptualising the potential for short- and longer-term change, and this is likely to guide a plan of interventions. The presence of positive attributes such as education, social status, and family support are all indicators of better prognosis, as are the negative influences of past adverse childhood experience, experience of custody, and using multiple drugs over longer periods. The importance of injecting is a single and distinctively high-risk feature. Harm reduction and damage limitation becomes the initial and recurring driving force in the prevention of infection, overdose, and social disintegration, and this is inevitably driven by securing engagement by early intervention with opioid medication treatment. In a spectrum of treatments, rehabilitation and detoxification are familiar concepts and are an essential part of the experience of anyone who has become dependent on opioids (most long-term drug users will have several admissions similar to those who have relapsing alcohol problems).

At one end of the provision of medical interventions in the harm reduction model is the increasing interest in establishing a safe place for people to inject and for doctors and nurses to supervise heroin-assisted treatment. These are interventions that people who use drugs might need several times during a lifetime of dependency as they experience acute admissions and overdoses.

GPs have some problems with managing drug users. These are real and challenging, and should not be underestimated. Perceptions of high-risk or disruptive patients raise anxieties of medicolegal issues, confrontational situations, and prescribing in apparently controversial and divisive areas. These situations are not imagined but experience shows that engagement and purposeful management in a structured and evidence-based format can be rewarding for patients and doctors. Primary care increasingly includes nurse prescribers and pharmacists who can expand capacity in the team to manage people with complex problems including those involving inappropriate, illegal, or dependency-inducing medications.

Therefore, primary care has a unique and pivotal role today in the management of opioid use. It is located in communities; it is integrated with the wider team who are likely to share responsibility for people who use drugs (PWUDs), pharmacies, health visitors, social workers, and patient advocacy groups; and it has long-term perspectives in a condition that requires repeated supervision and varying interventions, often over many years. Perhaps of all health and social care organisations, primary care has a family and environment perspective that allows for GPs to judge and moderate progress in the context of an individual.

In a policy vacuum and surrounded by uncertainty about who is responsible for drug users, primary care should seize the opportunity to show its strengths. Opioid substitute treatment is not without its risk.[9,10] An illegal marketplace making an increasing range of drugs available challenges prescribing to be safe but accessible at a low cost. Prescribing methadone and buprenorphine, and maybe even benzodiazepines, in a climate of unfettered access to much more damaging quantities of less familiar and more toxic variations requires time and consistency. Evaluating interventions and providing the flexibility needed by a, sometimes disorganised, patient group is a responsibility to a vulnerable caseload and is surprisingly rewarding when organised with clear expectations for staff and patients. UK primary care is the envy of other countries in its potential for engaging and supporting PWUDs but at present is missing the opportunity to be the focal point of support for a much neglected caseload.

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Provenance
Commissioned; externally peer reviewed.

Competing interests
The author has declared no competing interests.

DOI: https://doi.org/10.3399/bjgp20X707741

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