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Editorial

Family Practice substance use disorder theme issue: commentary

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Both substance use and substance use disorders (SUDs) are common problems suffered by patients seeking primary care. Since its second volume in 1985,[1] Family Practice has continually highlighted research related to detecting and treating legal, illegal, and prescription substance use, abuse, and dependence. Twenty-five years later, many of the same research questions and clinical challenges still face family medicine and primary care, with the potential exception that there seems to be a growing acceptance that SUDs can and should be treated in primary care.

Many patients with SUD do not seek treatment. It has been shown that approximately 60% of persons with opioid use disorder (OUD) in the United States do not receive any treatment and that the delay from onset to first treatment is close to 4 years.[2] A similar picture is seen in alcohol abuse, where the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported that in 2019 only 7.3% of adults ages 18 and older with an alcohol use disorder in the past year received any treatment in the previous year.[3] The role that stigma plays is probably a large contributor to suboptimal identification and treatment of SUD in primary care.[4] This theme issue is dedicated to the full spectrum of SUD in primary care and includes problems that result from a single occasion to repeated use, of substances that have psychoactive properties, including certain medications.[1]

The prevalence estimates of SUDs in primary care vary greatly, depending on the country where it is measured and the methods used (e.g. medical records registration, or waiting room screening). When using a screening method for multiple SUDs in the United States, John et al. found that over one-third (35.8%) of participants had at least 1 SUD (tobacco, alcohol, or drug) in the past year.[5] However, actively screening for SUDs gives a very different estimate than analysing registration by physicians using medical records. In this theme issue, Metz et al.[6] report on the prevalence of SUD in primary care using electronic health record data from northern California, where screening on alcohol was implemented as standard care. The prevalence rates in their study illustrate the under-registration of SUDs in primary care. The prevalence of any SUD (excluding nicotine) in their sample was 1.8%, alcohol use disorders 1.1%, nicotine use disorders 5.2%, and drug use disorders ranged from <0.1% (sedative/anxiolytic) to 0.4% (cannabis). They also report about the co-occurrence of SUD and alcohol use and show that many patients with drug use disorders actually reported not drinking at all, but those who reported drinking were more likely to exceed recommended limits.

There is clearly an increased need to manage opioids and OUD in general practice, consistent with the fact that 6 of the 14 manuscripts in this theme issue are related to opioids. Du et al.'s review of medical records revealed that the clinical characteristics of patients receiving office-based opioid treatment (OBOT) were similar to the general population.[7] Thus, the authors argue, this patient population's clinical needs are within the scope of general practice and patient complexity should not be a barrier to OBOT. But as demonstrated by St Louis et al., providers continue to face challenges when treating patients with OUD.[8] Specifically, for pregnant patients with OUD, stigma, lack of trained providers, and social determinants of health were all relevant barriers to care. Abbott et al. interviewed Australian women who had been in prison and who had a history of SUD.[9] These women strongly perceived that they were not as welcome as other patients to visit a GP, and they experienced a lack of skills and interest among the GPs.

Managing opioid withdrawal was investigated by Quattlebaum et al.'s[10] case study and Langejan et al.'s[11] systematic review. The case study reports the use of rapid administration of high-dose buprenorphine for buprenorphine precipitated withdrawal in a patient who did not respond to recommended dose escalation.[10] Remarkably, the systematic review of controlled trials of interventions for opioid withdrawal during opioid tapering, found only 1 study meeting inclusion criteria.[11] This study found no between group differences in opioid withdrawal symptoms between

varenicline vs placebo. There is a great need to develop improved strategies for treating withdrawal in opioid tapering. There remains concern about the safety of medications for OUD during pregnancy, which was investigated by Sujan et al.[12] In this retrospective cohort, the risk of neonatal abstinence syndrome was more than 4 times greater when pregnant women received methadone compared with buprenorphine.

Parallel to opioid taper, reducing benzodiazepine dose is a major challenge in primary care. Fernandes et al.[13] report on a 14 site intervention designed to improve successful benzodiazepine taper and cessation. Using a mix of motivational interviewing, patient education, and standardized protocols, nearly 60% of patients with benzodiazepine dependence tapered off and another 85% reduced dosage, an outcome maintained at 12-month follow-up. There are tools to improve safe opioid prescribing but not all are regularly utilized. Harocopos et al.[14] conducted qualitative surveys with 53 providers to understand attitudes to one of these tools, the mandatory prescription drug monitoring program (PDMP). Results indicated a range of daily to intermittent PDMP use, but identified a lack of knowledge that the PDMP is in part intended to help identify SUDs and provide or refer to treatment.

The complexity of care is a major challenge when dealing with patients with SUD. Family doctors are often the first point of contact for patients. However, the problems of the patient with SUD are often complex and frequently too complex for the family doctor to manage. This creates subsequent challenges, from finding the right place for specialist care (and making sure the patients actually enters specialist care), to keeping contact with the patient and providing good continuity of care. Andreu et al.[15] give an overview of the challenges GPs face in Spain when dealing with SUD patients and the management of care with addiction services. They show that GPs feel they are well equipped for alcohol and tobacco addiction, but not for other substances. Another challenge, described by Scott et al.[16] is the co-occurrence of SUD among adolescents with mental health disorders. These adolescents often receive pharmacological treatment for their mental health, but Scott et al. find that the reviewed pharmacotherapies are quite often not very effective in reducing mental health problems, and generally do not reduce alcohol, cannabis, or other drug use, which suggests that SUD needs targeted interventions.

Olickal et al.[17] provide insight into the impact of alcohol use on family life in India. Such reports are crucial for our understanding of the magnitude and impact of alcohol use in different settings and parts of the world. The impact of substance use on family could be very different in different cultures. Is the patient rejected or supported, and to what extend are family members affected by the alcohol use and associated problems? Of course, this will also have consequences for the way the patient and his family are managed by the family doctor. Sturgiss et al.[18] investigate the challenges in primary care in Australia in dealing with harmful alcohol use. One of the challenges observed was that it has become difficult for the public to see the dangers of alcohol use, considering the inconsistent health messaging around alcohol intake (small intake often considered healthy). Primary care is an excellent setting to educate patients about unhealthy alcohol use and can be a source of care for problematic alcohol use, but Sturgiss shows that many aspects hinder a full adoption of effective programs in primary care.

When it comes to improving services in the near future, the study of O'Malley et al.[19] gives a good insight into the challenges and opportunities of improved SUD services provided in primary care clinics in the United States. They observed and interviewed providers in clinics that were either innovative, or relatively avoidant in expanding the SUD services. They conclude, among other things, that there is a need for widespread provider training, care should be coordinated between the different services and primary care should better integrate behavioural healthcare.

This issue highlights persistent challenges in primary care that are related to substance use and use disorder, yet identifies where progress can be made to improve detection, treatment, and safer prescribing of medications with abuse potential. Stigma remains a huge challenge for both patients and physicians. It is a complex care problem that needs ongoing research to find the possibilities for improvement. Hopefully, through this theme issue, we are able to add a small piece to this puzzle.

Conflict of interest

None declared.

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