

Management of opioid addiction in primary care:

a pragmatic approach prioritising wellbeing not ideology

It would have been impossible to work in the substance misuse field for the past few years and have failed to notice the debate raging around 'recovery'. Recovery in substance misuse owes much to the development of the same concept in mental health services. Anyone involved in addiction may understandably embrace it, but it's important that the discussions and ideology around recovery don't distract general practice from developing the full potential of a primary care based substance misuse service. Some of the key points on recovery were laid out in a *BJGP* editorial by Rushforth and Wright. They also stated that: *'emphasising the concept of wellbeing rather than "cure" in the treatment of drug dependence is crucial to avoid the new centrally-driven recovery agenda being taken to mean that services should only look to support a drug-free status'*¹

RECOVERY CAPITAL AND IDEOLOGY

The latest milestone in the debate was the report from the Recovery-Orientated Drug Treatment Group, chaired by Dr John Strang of the National Addiction Centre.² The aim of the group was to guide the drug treatment field on the proper and optimal use of medications to aid recovery. Importantly, the report accepts the importance of opiate substitution therapy, while suggesting a framework to blend this with alternative and additional strategies. It should draw a line under the recovery debate, and primary care must look to the future. Methadone isn't going to be swept away or limited; neither is it the sole answer.

The Strang report lingers on the concept of 'recovery capital' and how this can be considered in terms of social, physical, human, and cultural resources. In short, someone who is homeless and jobless has less recovery capital and is less likely to achieve recovery. This won't come as a surprise to anyone; least of all GPs who are accustomed to working up close to the social circumstances of their patients. Recovery capital may be a useful notion when it comes to formulating wider social policy but it has little immediate benefit in the context of a 10-minute consultation. For the GP sat in front of a patient, with so many physical and psychological complications to manage, it's arguably a distraction.

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Political ideology and interference continue to haunt substance misuse services. The bald fact is that achieving full abstinence doesn't happen as often as policymakers would like. The most recent Parliamentary report continued with the angst and hand-wringing at this perceived failure. Their conclusions were as anodyne and uninspiring as ever.³ It may have bypassed most GPs but substance misuse services in England have been privatised. They have been subjected, almost in their entirety, to the forces of the market. Organisations now spend significant amounts of time and resources on tendering and re-tendering for services throughout the country. This has, in many areas, reduced the capability of organisations to deliver basic health care as they sit outwith the NHS infrastructure. General practice needs to be able to ensure it can meet this widening gap. The physical and mental health issues of those who use opioids are numerous and a number of areas are neglected, including: respiratory health; liver health and hepatitis C; and the management and sequelae of deep vein thrombosis. Nowhere can these be addressed as effectively and holistically as they will be in primary care.

PRIORITISING KEY PHYSICAL HEALTH ISSUES

Clinical experience has long suggested that lung health in opioid users is dire but until recently this was based on little firm evidence. A recent study analysed routinely collected data from general practices in Scotland.⁴ After controlling for multiple

factors (including smoking) they showed that more drug users than controls had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD) (17% versus 11%). In the drug misuse group 86% were either current or ex-smokers compared with 47% of the control group. Without the adjustment for smoking the risk of COPD was 10 times greater in the substance misuse group. There is an increasing appreciation of the need to blend harm reduction with promotion of abstinence when it comes to smoking in these groups. We may have to consider intermediate smoking goals; encouraging reduced consumption is valid and has been shown to be associated with an increased probability of future abstinence.⁵ There may also be a role for smokeless tobacco and long-term nicotine maintenance but these need further evaluation.⁶

Deep vein thrombosis (DVT) and its complications have been under-recognised and are often ill-managed. One specialist practice in England found a prevalence rate of 13.9% for DVT in users of opioids. Their risk of DVT is 100 times greater than in the general population. Treatment can be challenging but people with DVT reported significantly worse wellbeing with worse physical and psychological health status.⁷

There are estimated to be 216 000 individuals who are infected with hepatitis C virus (HCV) in the UK.⁸ Most of these are people who have injected drugs. Hospital admissions and deaths from HCV-related end-stage liver disease are on the rise. While testing has improved over recent years, over one-third of adult injectors in

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treatment are not recorded as having had a HCV test.⁸ Too many people live with the blight of chronic HCV infection and the significant, yet insidious, reduction in their quality of life.⁹

A PRAGMATIC AND PRACTICAL APPROACH

One of the challenges ahead for the management of opioid addiction in primary care is the changing pattern of substance misuse issues. The absolute numbers of injecting heroin users has fallen in recent years but those that continue are ageing.¹⁰ The prescription opioid medication misuse problems of North America are unlikely to be repeated quite so spectacularly in the UK but there are certainly indications that we are facing a steep rise in people with these problems.¹¹ Best practice and management in prescription opioid and over-the-counter medication misuse is far from clear at this point.

In order to make progress in the management of opioid addiction in primary care we need to move away from rarefied discussions on the nature of recovery. We need to push the strengths of general practice: we can do integrated care that is socially-savvy without blinking and we shouldn't waste time agonising over issues of recovery capital. We need to address wellbeing with good solid clinical management of a host of physical conditions. We should be supporting interventions that allow us to address inequalities: treating physical conditions in a timely fashion; supporting smokers to cut back or stop; finding people with HCV and helping them through treatment. They can be difficult groups to engage, but we need to do more to bring them into routine general practice. We certainly do not need to get bogged down in pseudo-political bickering over the exact definition of 'recovery'. As a profession we're too pragmatic to stand for that and the individuals who misuse substances deserve more practical measures.

Euan Lawson,

Director of Community Studies, Lancaster Medical School, Furness College, Lancaster University, Lancaster.

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ADDRESS FOR CORRESPONDENCE

Euan Lawson

Lancaster Medical School, Furness College, Lancaster University, Lancaster, LA1 4YG, UK.

E-mail: e.m.lawson@lancaster.ac.uk

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