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EDITORIAL

Now is the Time to Address Substance Use Disorders in Primary Care

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Although over 21 million people in the United States have substance use disorders, most individuals with addiction do not receive treatment.[1] Of those who are fortunate enough to receive treatment, less than 7% access it through their doctor.[2] In addition, fewer than 10% of people with opioid use disorder in specialty care receive buprenorphine.[3]

Primary care physicians are on the front lines of this epidemic and we see it in the faces and stories of our patients: in the night sweats or gastrointestinal symptoms that are due to alcohol or opioid withdrawal; in the anxiety symptoms that are associated with cocaine use; in managing chronic pain that raises concerns about possible addiction. We are good at managing people with many coexisting conditions, and at prioritizing and knowing when we and our patients need specialists. The current opioid epidemic and marginalization of substance use disorders away from primary care has been a disaster,[4] however, and it is a marker for the under-attention to primary care. The most complex functions in health care—the much needed integrating, prioritizing, and personalizing care across prevention, acute illness care, mental health care, and management of multiple chronic illnesses—crammed into 10 minutes.

This issue of *Annals of Family Medicine* contains several studies that address substance use disorders and may point to a way forward for primary care physicians. The study by Anderson and colleagues found that primary

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care training and support in alcohol screening and brief advice had an impactful effect on patients who received the intervention that was sustained after 9 months.[5]

In addition, Dopouy et al[6] report a hazard ratio for death—the likes of which we haven't seen since discovering that smoking causes lung cancer—among those with opioid use disorder when they are out of treatment with a general practitioner. The French generalists have figured out how to treat opioid use disorder with buprenorphine, no doubt saving numerous lives. Over the past 20 years, many randomized trials in US primary care settings have found buprenorphine, with minimal counseling, to be highly efficacious; even methadone—though only with legal exception—has been found so.[7-10] Yet most primary care physicians are not waivered to prescribe buprenorphine, and most who are, choose not to prescribe it.[11-14]

The research brief by Andrilla outlines the multiple barriers[14] that rural physicians face in prescribing buprenorphine for opioid use disorders, such as regulatory requirements for a waiver to prescribe buprenorphine.[15] There are resources to promote the confidence and skill of the practitioner. For example, the Physician Clinical Support System (PCSS)[16,17] provides consultation and mentoring while the ECHO model[18] is becoming more widely available and may be particularly well-suited for rural physicians.

Both the Anderson and Dupouy studies address the other issue that commonly arises with randomized trials and general practice: the applicability of clinical trials to our real-world practices. Although extant studies of opioid agonist treatments may be limited in this way, so too are many of the trials for many other diseases that we treat. The observational evidence of treatment success in less selected patients in primary care settings is now accumulating.[19,20] It is important to note that the limitations in the evidence are insufficient to preclude a wider dissemination of medication treatment of addiction in primary care, particularly given the current dismal state of access to care and the mortality from the disease.

The Point/Counterpoint in this issue speak to the major barriers and challenges in the treatment of substance use disorders in primary care.[21,22] From our perspective, the primary barrier is the difficulty in obtaining targeted services, due to the limited availability of providers and programs, the reimbursement challenges in paying for such services, and the difficulties patients face in selecting and navigating an array of treatments. For example, one-half of addiction treatment programs do not have a prescriber.[23] Despite addiction medicine becoming an American Board of Medical Specialties specialty, these specialized physicians are insufficient in number to assume responsibility for the initial and longitudinal care of all patients with substance use disorders.[24] Primary care needs to be a better point of entry to care for these patients, and specialized services need to be more widely available and accessible as part of the wider health care system. Fortunately, the rise in care management and co-located behavioral health in patient-centered medical homes can provide the organizational infrastructure that can be responsive to effective treatment.[25,26]

The essays by Lathrop and Gastala give voice, in different ways, to the physician perspective on engaging and caring for patients who have substance use disorders. Lathrop notes the changing roles and expectations of physicians, particularly around grief and burnout.[27] Physician burnout comes from many sources, mainly from doing tasks that seem unimportant and from not having control.[28] But if you speak to any primary care clinician that has begun prescribing buprenorphine for opioid use disorder, you will invariably hear that it is among the most satisfying roles they have taken on—a good anti-burnout prescription.[29]

Gastala calls out the professional and community aspects of denial in the opioid crisis and our response should be multipronged.[30] We need to expand the framework of chronic care management to include substance use disorders and other mental health conditions under the same roof as congestive heart failure and other chronic conditions.[25,26] Attention to mental health, in the context of being accountable for the care of populations (eg, accountable care organizations), should be expanded and implemented to manage people who also have addiction.[26] The treatment of opioid use disorder in primary care has efficacy and is feasible, and published clinical experiences, such as those in this issue of *Annals*, are adding to the information base. Finally, we can no longer deny that substance use disorders impact our patients' lives and our communities. Our nation will not be able to adequately respond to the current epidemic without addressing it in primary care and there is no question that the time to do it is now.

To read or post commentaries in response to this article, see it online at http://www.AnnFamMed.org/content/15/4/306.

Key words: buprenorphine, naloxone drug combination; opioid, opiate substitution therapy; opioid-related disorders; prescribing patterns, physician, primary health care

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