PRACTICE OBSERVED

Practice Research

Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers

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Abstract

With the recent unprecedented growth in the spread of drug misuse in the United Kingdom the role of the general practitioner has become more and more prominent, both in response to demands for treatment and as the focus of national policy on drug misuse. Although general practitioners may be the first contact, few data are available on the extent of their contact with drug misusers.

A postal survey was carried out in mid-1985 of a 5% national sample of general practitioners in England and Wales concerning their role in and views on the treatment of opiate misusers, including the extent of their contact with such patients during a four week period. Of the 1166 general practitioners surveyed, 845 replied, a response rate of 72%. The results show that roughly one in five general practitioners in England and Wales attended an opiate misuser during this four week period, seeing an estimated 5000 to 9000 patients, one third of whom were "new" to the general practitioner. A cautious estimate of between 30 000 and 40 000 new cases of opiate misuse presenting to general practitioners in a year is suggested, with some adjustment necessary because of double counting. A wide variation in the prevalence of consultations among regional health

authorities was found, and several of the regions with a high prevalence are outside the London area.

The scale of contact thus confirms the importance of the general practitioner in the national response to drug misuse.

Introduction

A major strand in the policy response of government to the unprecedented scale of current drug misuse in the United Kingdom is to strengthen the provision of care under the Health Service by encouraging general practitioners to treat drug misusers. Thus the Department of Health and Social Security has issued *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* to all doctors and has drawn the attention of family practitioner committees to the need for action on drug misuse.

There is some indication that general practitioners are already seeing many drug misusers. Of all first time notifications of drug misuse made by doctors to the Home Office, general practitioners notified 15% in 1970, 29% in 1975, 49% in 1980, and 55% in 1984. This trend may reflect the fact that the growth in the prevalence of drug misuse has generally outstripped the capacity of specialist treatment facilities to respond. Long waiting lists for first appointments at hospital drug dependence clinics and the uneven distribution of specialist facilities in the UK have meant that in some areas general practitioners are the only source of help. For many people, of course, the family doctor is the natural first contact.

Nevertheless, the DHSS has acknowledged that information about the numbers of drug misusers who are treated by general practitioners in England is not available. Indeed, as Edwards¹ observed several years ago, general practitioner services to drug misusers remain largely unexplored and unrecorded. To help fill this gap a research project was designed, and the findings are reported here and in two further papers.

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Methods

A postal cross sectional study was planned, with the aim of obtaining descriptive information on the scale of contact which general practitioners currently have with opiate drug misusers, in how such cases are handled, and in the views that general practitioners have on issues of policy on practice connected with drug misuse. It was decided that the study should cover only opiate drug misusers in order to focus on the particular problem that these pose.

A postal questionnaire was designed in three sections. The first section, which is discussed in this paper, referred to the four weeks before the questionnaire was completed and concerned the number of patients seen by the general practitioner for problems associated with misuse of heroin or other opiate drugs, excluding patients who were being treated for painful or terminal illness. Each general practitioner who was selected was sent a questionnaire with a covering letter explaining the background to the study, the aim of opiate drugs, and a request to return the questionnaire. Three follow up letters, with return envelopes, were sent out to remind non-respondents. The survey was conducted during the period May to August 1985.

RESULTS

Over the four mailing waves 845 (72%) general practitioners returned usable questionnaires. There was a significant variation in response rate among the regional health authorities: 37-84% (table 1). The overall response rate tends to be lower in urban regions, perhaps with general practitioners under less pressure to respond at a higher rate (table 1). The overall response rate

TABLE 1—Number of general practitioners and response rate by regional health authorities

Region	No. of general practitioners in 5% sample	No. responding	%
Northern	71	53	75
Yorkshire	101	77	76
East Anglia	36	28	78
North West Thames	40	30	75
North East Thames	40	30	75
South West Thames	40	30	75
South East Thames	40	30	75
Wales	40	30	75
Wessex	40	30	75
South Western	40	30	75
West Midlands	40	30	75
Mersey	40	30	75
North Western	40	30	75
Wales	40	30	75
All regions	1166	845	72

compares well with that achieved in other large scale surveys of general practitioners—for example, 67% in Cartwright and Anderson's survey covering 20 parliamentary constituencies.² The response rate for individual regions is satisfactory—for example, Oxford's 78% response rate compared with Anderson's survey of all general practitioners in two Oxford health districts with a 67% response. The profile of responding general practitioners is closely similar to the national profile in respect of average number of patients on their list (1166 patients for respondents in regional health authorities in England compared with the national average of 2089) and practice structure (13% singlehanded doctors among all respondents compared with 13% single handed for the UK).³

Results

EXTENT OF CONTACT WITH OPIATE MISUSERS

The general practitioners were asked to report how many different patients they had seen over the past four weeks for problems associated with misuse of heroin or other opiate drugs. They could also indicate whether they had never seen such a patient. Thus general practitioners can be classified into three contact categories: those who had never attended an

TABLE 2—Extent of contact with opiate drug misusers by regional health authorities: all regions, percentage based on total sampled sample

Region	No. of patients seen	No. of patients seen	No. of patients seen	No. of patients seen
	Never	Not in past four weeks	In past four weeks	In past four weeks
Northern	28	48	17	21
Yorkshire	24	41	16	19
East Anglia	24	41	16	19
North West Thames	24	41	16	19
North East Thames	24	41	16	19
South West Thames	24	41	16	19
South East Thames	24	41	16	19
Wales	24	41	16	19
Wessex	24	41	16	19
South Western	24	41	16	19
West Midlands	24	41	16	19
Mersey	24	41	16	19
North Western	24	41	16	19
Wales	24	41	16	19
All regions	28	48	17	21

1. Percentage that responded.

2. Percentage adjusted for non-response, see text.

opiate drug misuser, those who had at some time but not in the past four weeks, and those who had attended at least one opiate drug misuser in the past four weeks.

Table II gives data on general practitioners in England and Wales, by region, according to these contact categories. The two sets of figures are: 1. the percentage distribution of the total sample and 2. the percentage distribution after allowing for the non response. To take account of possible non-response bias, these latter figures have been calculated in a more refined way than simply basing the percentages on the number of responding general practitioners. As expected, an analysis of the four response waves in respect of the proportion of general practitioners in each of the contact categories confirmed that there was a significant difference between earlier and later mailing waves in the pattern of responses. Since non-respondents are likely to be more similar to later respondents percentages based simply on population of general practitioners would not adequately reflect the whole population. Consequently, our refinement uses a log linear model technique which adjusts for this possible similarity by weighting the percentage distribution towards the two later waves of response. This adjustment results in a more realistic, though not greatly dissimilar, picture than would be obtained by the straightforward percentage calculations.

For England and Wales as a whole roughly one in five general practitioners came into contact with an opiate drug misuser during a four week period (table II). There was a wide variation among regions in the experience of general practitioners in this respect, and it is interesting that of the six "hotspot" regions, in terms of the proportion of general practitioners who reported having contact in the past four weeks, four are provincial: Mersey, East Anglia, North Western, and Wales, whereas the London area which is partitioned into four regions of North West, North East, South East, and South West Thames, is represented by just two regions: South West Thames and North West Thames.

Such findings immediately raise questions of interpretation. The extent to which general practitioners in different regions come into contact with opiate drug misusers does not in itself indicate the relative magnitude of the population of opiate misusers. Apart from the level of misuse, many factors may influence the probability of consulting a general practitioner within a particular region, including the availability of alternative services, the treatment policies of the specialist clinics, the diligence of the local drug squad, and the accessibility and attitude of general practitioners. Our data show only the regional variation in the "burden" on general practitioners presented by this population and in the scale of consultations with general practitioners by opiate drug misusers; they do not directly testify to a commensurate scale of opiate drug misuse in the community.

PROFILE OF OPIATE MISUSERS AND REASONS FOR CONSULTING GENERAL PRACTITIONERS

Table III shows that a total of 329 opiate misusers were seen in a four week period by all responding general practitioners. Of these, 107 (32%) were women. The female to male ratio is roughly the same as that found in a study of intravenous heroin users who attended a Scottish group practice (39% women)⁴ and is close to the ratio in Home Office statistics of narcotic addicts⁵ who were notified during 1984 (29% women), and of addicts who

TABLE III—Number of opiate drug misusers seen by general practitioners in a four week period, by regional health authority

Region	Total No. of opiate misusers seen by sample of general practitioners		No. of opiate misusers new to sample of general practitioners		Estimated No. of opiate misusers seen by population of general practitioners	
	1	2	1	2	1	2
Northern	10	13	5	6	200	270
Yorkshire	26	34	12	16	400	514
East Anglia	17	22	8	10	340	456
North West Thames	17	22	8	10	340	456
North East Thames	17	22	8	10	340	456
South West Thames	17	22	8	10	340	456
South East Thames	17	22	8	10	340	456
Wales	17	22	8	10	340	456
Wessex	17	22	8	10	340	456
South Western	17	22	8	10	340	456
West Midlands	17	22	8	10	340	456
Mersey	17	22	8	10	340	456
North Western	17	22	8	10	340	456
Wales	17	22	8	10	340	456
All regions	329	479	114	169	6580	9595

1. Number for all respondents.

2. Number adjusted for non-respondents, see text.

were recorded as receiving notifiable drugs at the end of 1984 (30% women).⁵ Roughly half (52%) of patients seen were reported by general practitioners as being under 25 years of age compared with 45% of narcotic addicts who were notified to the Home Office during 1984 and 21% of addicts who were receiving notifiable drugs at the end of 1984.

Roughly a third (35%) of opiate misusers who were seen in a four week period were first time consulters to that general practitioner for this problem, with considerable variation between regions in the ratio of "new" to "total" misusers seen (table III). What kind of help are these opiate misusers seeking from general practitioners? In the questionnaire general practitioners were asked to allocate first time consulters to categories according to the type of help which, in the general practitioner's view, they were primarily seeking. More than one reason per case was sometimes given, and so the following percentages do not add to 100. Almost two thirds (61%) were reported to be primarily seeking help concerning withdrawal or rehabilitation, or both. This is almost twice the number reported to be primarily seeking a prescription for opiate drugs (35%), with 25% primarily seeking treatment for medical complications of drug misuse and 20% other kinds of help.

This suggests that, at least in this view, general practitioners are not approached principally as a source of opiate drugs. The apparent substantial demand by opiate misusers for help in coming off their drugs emphasises the important position of the general practitioner as both provider of and gatekeeper for key services in the response to this problem.

SCALE OF CONSULTATION FOR OPIATE MISUSE

Table III gives the aggregated total for each regional health authority of the number of opiate drug misusers who were reported by general practitioners in the four week period before the questionnaire was completed, together with the number in this total whom general practitioners reported as new consultations to them for this problem. Table III also gives the estimated numbers for the general practitioner population of total and new opiate drug misusers consulting in a four week period, which are calculated from the 5% sample, with 25% primarily seeking help concerning withdrawal or rehabilitation, or both.

The data show the actual figures produced by the general practitioners who responded to the questionnaire, columns headed 1. The figures generated from the survey respondents may be regarded as the minimum parameter since the implication here would be that not responding general practitioners had seen no opiate misusers in the past four weeks. This, however, is unlikely to have been the case, and consequently figures are included columns headed 2, based on the adjusted percentage distribution presented in table II. These figures provide a more realistic alternative to the minimum figures.

The figures in table III indicate the scale of consultations with general practitioners by opiate misusers in each region. For England and Wales as a whole, a minimum of roughly 6000 opiate misusers, and possibly around 9000 individuals will consult general practitioners in a four week period for problems associated with misuse of opiate drugs. Roughly one third of these consultations will be new patients to the general practitioner for this problem. Assuming a steady four week rate, this implies that over a 12 month (13 x four weeks) period general practitioners throughout

England and Wales will see a minimum of 30 000 (more realistically around 40 000) new cases of opiate drug misuse.

It is necessary, however, to take into account several qualifying factors. For all the figures there is the inflationary effect of double counting, which results from some individuals presenting at more than one general practice. There is no evidence available upon which to estimate the size of this effect. Also, in the case of the 12 month projection for new cases the summer seasonal rate of consultations which is obtained in this survey may not hold for other times of the year. No specific evidence is available on this point for opiate drug misusers, though in a study of general practitioner consulting patterns over a year in a large urban area there was no evidence of seasonal variation.⁶ A further uncertainty concerns possible instability of the boundary of the four week recall period, which may result in overinclusion and so that period and hence also an inflation of the 12 month figures, may also, however, result in underinclusion.

The estimated number of new persons consulting for opiate misuse—that is, new to that general practitioner—for the 12 month period is substantially greater than the 5415 new notifications of addicts made by all doctors in the UK to the Home Office during 1984. It is, however, not wholly legitimate to make such a comparison since the definition for the two groups is not identical—addition for purposes of notification as opposed to problems associated with misuse of opiate drugs in this survey. The problem model of drug taking as a water and will include cases which fall outside the remit of the notification regulations. Under notification to the Home Office by doctors must also be taken into account. Given the qualifications on these data, the results of this survey nevertheless indicate that Home Office figures are a considerable underestimate, even for notifiable drugs, of the scale of drug misuse.

PREVALENCE AND INCIDENCE OF PERSONAL CONSULTATIONS

The raw figures in table III have limited value for assessing the relative scale of this general practitioner patient population. Table IV gives standardised data for period prevalence, "total" cases, and incidence, "new" cases, of personal consultations in each region, based on the population aged 15-54 years in each region. This age range was chosen by Hartnoll et al.⁷ to include almost every case found in their epidemiological study of opiate misuse in North London community. These figures provide a more realistic picture of the scale of consultations with general practitioners for opiate misuse. The position of East Anglia in the list for consultations for opiate misuse. These consultation rates, however, do not necessarily reflect important levels of prevalence of opiate misuse in the population. The figures for Mersey and Wales should be considered with caution since these regions had the two lowest response rates. East Anglia, on the other hand, had one of the highest response rates.

Given the incidence of 204 "new" consultations per 100 000 population aged 15-54 years for England and Wales, Table IV, it can be estimated that in the typical general practice with a list of 2000 patients, of whom 1000 are aged 15-54, the general practitioner will have about 20 new cases of opiate misuse in a year. The total workload is difficult to estimate since the rate of

consultation for established cases is unknown. The actual burden on general practitioners of such cases will vary considerably from region to region, and table V gives the breakdown of the number of hours for personal consultation for the number of general practitioners in each region. These figures represent, of course, the average burden among general practitioners. Within some regions, however, these consultations may be concentrated at a few general practices only.

TABLE 5—Estimated period prevalence and incidence of personal consultations for opiate drug misuse per 100 000 population aged 15-54 year

Region	Period prevalence per 100 000 population aged 15-54 year		Incidence per 100 000 population aged 15-54 year	
	1	2	1	2
Northern	17.1	20.4	96.8	113.9
Yorkshire	22.1	26.4	128.1	149.3
East Anglia	17.1	20.4	96.8	113.9
North West Thames	17.1	20.4	96.8	113.9
North East Thames	17.1	20.4	96.8	113.9
South West Thames	17.1	20.4	96.8	113.9
South East Thames	17.1	20.4	96.8	113.9
Wales	17.1	20.4	96.8	113.9
Wessex	17.1	20.4	96.8	113.9
South Western	17.1	20.4	96.8	113.9
West Midlands	17.1	20.4	96.8	113.9
Mersey	17.1	20.4	96.8	113.9
North Western	17.1	20.4	96.8	113.9
Wales	17.1	20.4	96.8	113.9
All regions	17.1	20.4	96.8	113.9

1. Official of Population Census and Survey and 1984 population estimates for local population and health authorities, areas of general and Wales.

2. Number for all respondents.

3. Number adjusted for non-respondents, see text.

TABLE 6—Number of personal consultations for opiate drug misuse per 100 general practitioners

Region	No. of personal consultations per 100 general practitioners		No. of personal consultations per 100 general practitioners	
	1	2	1	2
Northern	14.1	19.0	40.5	122.7
Yorkshire	22.1	30.4	112.4	149.3
East Anglia	14.1	19.0	40.5	122.7
North West Thames	14.1	19.0	40.5	122.7
North East Thames	14.1	19.0	40.5	122.7
South West Thames	14.1	19.0	40.5	122.7
South East Thames	14.1	19.0	40.5	122.7
Wales	14.1	19.0	40.5	122.7
Wessex	14.1	19.0	40.5	122.7
South Western	14.1	19.0	40.5	122.7
West Midlands	14.1	19.0	40.5	122.7
Mersey	14.1	19.0	40.5	122.7
North Western	14.1	19.0	40.5	122.7
Wales	14.1	19.0	40.5	122.7
All regions	14.1	19.0	40.5	122.7

1. Number for all respondents.

2. Number adjusted for non-respondents, see text.

Discussion

The recent report of the Advisory Council on the Misuse of Drugs suggested that the current policy of providing services to drug misusers is strained and cited as evidence "the unparalleled increase in involvement by doctors in general practice."⁸ The results of this national survey show the national pattern of "articulated demand" by opiate drug misusers for general practitioner services. The data show that substantial numbers of opiate misusers are approaching general practitioners in England and Wales for help. A realistic estimate is that 9500 person-consultations for opiate misuse take place in England and Wales in a four week period. Roughly one third of these are cases that are new to that general practitioner, which suggests an

annual total of around 40 000 "new" cases. Those who present in general practice represent a particular subpopulation of opiate misusers and constitute an unknown fraction of the total number in the community. The diversity of seeking help from general practitioners have been little explored, and local factors, in particular, availability of other sources of help will influence the scale of consultations with general practitioners in different regions.

It is apparent that opiate drug misuse is now widespread outside the London area. In particular, the "growth areas," in terms of a high rate of numbers of new to total number of cases seen in the four week period, are in provincial regions. Certain regions where the problem is already substantial face high growth rates: Mersey 57% new cases, Wales 48%, and others with a relatively low base rate of consultations by opiate misusers also appear to be experiencing high growth levels: Wessex 60% new cases, Northern 50%.

These regions may be ill equipped to handle this recent demand for health care, particularly if these trends continue or rapidly increase. During 1984 general practitioners in the UK notified 4000 new and former addicts to the Home Office. The substantial discrepancy between Home Office figures and those generated by the national survey can be partially accounted for in terms of different case definition, undernotification of addicts on the part of general practitioners, and duplication of cases in general practitioners reporting in this study, eliminated in Home Office figures by crosschecking of names. The results nevertheless show that this source is an inadequate indicator of the real demand for general practitioner services by opiate drug misusers: not all of whom are addicts. Furthermore, the finding that, on average, one in five general practitioners throughout England and Wales will attend an opiate misuser in a four week period suggests that the role of the general practitioner should indeed be given serious consideration in the development of a strategy for responding to the current drug problem.

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