Primary care provider expectations of addiction services and patients in Spain

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Primary care is key for addiction

- Many SUD patients enter or receive treatment exclusively through PC
- PC main setting of Screening Brief Intervention and Referral to Treatment (SBIRT) models
- addiction patients receiving also PC treatment have improved outcomes in many health areas, addiction and non-addiction related

Primary care and Addiction integration

- Reduced substance use
- Reduced expenses
- Improved physical health

Rationale

- Few studies have addressed the views of PC providers about SUD patients and their perceived needs.
- Few studies have targeted PC providers' views and attitudes towards the intricate and many-sided interaction between PC and SUD services .
- However, these studies were specifically focussed on integration experiences in the USA.
- A more general and geographically diverse inquiry into primary care providers views towards the interplay between PC and addiction services is needed to gain a deeper understanding and potentially improve their interaction

Objectives

- New addiction treatment facility that should provide specialist addiction treatment to a territory with three health areas (which included its three PC clinics)

- To explore the views and beliefs of PC providers towards SUD patients and the relationship between PC and addiction settings, as well as the perceived needs of PC providers regarding SUD patients.

Methods

- 27 GPs distributed in 3 focus groups (9, 7 and 11, respectively)
- April 2018 to September 2018
- Thematic analysis
- Semi-structured interview script

- What would you expect from an Addiction Treatment Facility covering your health area?
- What do you think about the possibility of addiction professionals visiting on-site in your GP facility?
- What addictive diseases would you consider the most relevant for your day-to-day work?
- What differences do you think exist between mental health and addictive diseases?
- Do you think addiction patients have significant differences and needs with regard the other patients you usually have at your practice?

Results

- 1. Differences and specificities of SUD patients
- 2. Interaction between providers of primary care and addiction services
- 3. Patient management
- 4. Addiction stigma

1. Differences and specificities of SUD patients

- PC providers seemed to clearly perceive SUD patients as having differential characteristics compared to other mental health patients
- erratic assistance to PC services
- low self-awareness as having a disorder
- importance of family members who might be more aware of the problem than patients themselves.

'Those ones that you might indirectly "spot" but don't come overtly for this reason [drug use] are very difficult…And they might repeatedly visit you due to somatic symptoms derived from drug abuse, but they don't want to acknowledge they have a problem' (female, 52 years).

- difficulties in referring SUD patients to specialized treatment
- the immediacy in the SUD patients' help request, the narrow margin of time for intervening and a low waiting tolerance

'It is almost like fishing in that moment… If the response is not given straight away, they can get lost again and they might beat around the bush' (female, 32 years).

- large history of failed treatments. This results in unmotivated patients, sometimes even angry patients with health providers.

'They have attended some programs, they have been repeatedly hospitalized and, well, they feel angry, they… it is difficult, taking control of such a patient is very complicated for me' (female, 40 years)

- unlike severe mental disorder patients, SUD patients can recover their daily adjustment if they remain abstinent

'And the differences are that in the case of serious mental disorders it [the social adjustment] is difficult to fix, whereas in the case of addiction if they quit alcohol or drugs it can work out, they can have a regular life' (female, 39 years).

‘To me SUD and mental health patients are obviously different in many aspects, so why should they have the same referral circuit?’ (female, 45 years).

2. Interaction between providers of primary care and addiction services

- GPs most expressed their dissatisfaction with addiction services
- poor feedback they receive about their referred patients.
- GPs repeatedly being unaware about whether referred patients finally arrived at the addiction treatment setting. Similarly, another outstanding worry was not communicating when patients left specialized treatment

'I think it would be fine if we knew those patients that do not attend anymore [to addiction outpatient facilities]. I have a patient and I refer it to you, and I think he's quitting alcohol, and then I wonder: "is he still attending?" I shouldn't wait until he comes and tells me himself' (female, 36 years).

- proposals were linked to breaking down communication barriers, making dialogue easier and enhancing the exchange between different professionals:

'I think that it is important that all of us understand each other, that we understand how you work and that you understand the way we run' (female, 40 years).

'the specialists that come here...it is something else. Because, of course, you knock on the cardiologist door: "Adeline, I have this patient that needs this", that's a different story—it is not the same that the ones there, you don't know them, you have never seen their faces before…' (female, 45 years).

3. Patient management

- lack of training regarding drugs other than alcohol and tobacco was clearly identified by all participants as one of the main barriers preventing proper interventions with SUD patients (low self-efficacy perceived)

'I think that we are lacked on some training, because you may remember some stuff, and you can be familiar with alcohol and tobacco, but when it comes to other substances it is more complicated. And you may follow some symptomatic treatment, but you don't feel like you master the issue. Then, they come very concerned, they ask plenty of questions and, honestly, sometimes you don't know how to guide them—and having more training would be nice' (female, 52 years

- necessity of training (motivational interviewing) and interventions to be tailored and suited to the reality of PC

'I think that communication and interview tools…to go deeper, instead of directly asking "do you rest properly?' (female, 59 years).

'To begin with, if I can use more tools…Maybe it is not as rigid as "point one, point two, point four"…If I have received more training, I can somehow do something…I will adapt them; each of us will adapt it on our daily work. But if you look closer, you wonder "which bureaucrat thought that this was viable in PC services?"' (female, 38 years).

4. Addiction stigma

- Crucial issue
- referral of a patient to a specialized addiction service cannot be separated from the social and personal implications of labelling the patient as "addicted".
- This prejudice can be experienced, both by the patient himself and by the GP, as a barrier for the patient in the face of his referral to the addiction setting.

'And you also have this strange feeling when referring them to the Addiction clinic, because you know what they will see at the waiting room. Not a long time ago I sent a young man and I was thinking "He may get frightened there"' (female, 52 years).

- some professionals the referral was also seen as an opportunity to precisely eliminate stigma

'Most probably you will see yourself there and the "I go where the yonkies go" myth will be torn down' (male, 56 years)

- the impact of relapse-induced shame or guilt in treatment abandonment

'Patients don't think of addiction specialists as "the guys with the addictions degree", they feel ashamed of having relapsed, they feel embarrassed to get in touch with them again' (female, 41 years).

Conclusions

- GPs consider addiction patients a specific group with specific needs, also yielding specific challenges to GPs themselves

- Addiction patients are differentiated from other mental health patients in their behaviour and care needs
- Key features that need to be specifically addressed not only at the specialized level, but also in PC
- A specific referral circuit would be more appropriate for them

- GPs feel they are well-equipped for alcohol and tobacco addiction in PC, but not for other substances

- GPs do not expect patients not to return to GP settings while they are doing specialized treatment, but they expect them to keep ongoing appointments with them
- GPs seem to highly value a fluid and efficient communication with the addiction specialist, be it in person or electronically

- All in all, it seems like GPs are requesting
  - a more shared model of care with addiction patients where
    - they receive more training,
    - have a more fluid communication with addiction professionals,
    - have more knowledge about addiction community resources and
    - readily receive feedback from their referred patients.