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Factors influencing recording of drug misuse in primary care:

a qualitative study of GPs in England

Abstract

Background
Drug misuse is a serious public health problem. Evidence from previous epidemiological studies show that GPs are recording drug misuse in electronic patient records (EPR). However, although the recording trends are similar to national surveys, recording rates are much lower.

Aim
To explore the factors that influence GPs to record drug misuse in the EPR, and to gain a clearer understanding of the gap between the amount of drug misuse recorded in primary care and that in national surveys and other studies.

Design and setting
A semi-structured qualitative interview study of GPs working in general practices across England.

Method
Purposive sampling was employed to recruit 12 GPs, both with and without a special interest in drug misuse, from across England. Semi-structured face-to-face interviews were conducted to consider whether and why GPs record drug misuse, which methods GPs use for recording, GPs' actions if a patient asks for the information not to be recorded, and GPs' actions if they think a patient misuses drugs but does not disclose the information. Resulting data were analysed using a combination of inductive and deductive thematic analysis.

Results
The complexity of asking about drug misuse preceded GPs' decision to record. They described how the context of the general practice protocols, interaction between GP and patient, and the questioning process affected whether, how, and in which circumstances they asked about drug use. This led to GPs making a clinical decision on whether, who, and how to record in the EPR.

Conclusion
When making decisions about whether or not to record drug misuse, GPs face complex choices. Aside from their own views, they reported feelings of pressure from the general practice environment in which they worked and their clinical commissioning group, as well as government policies.

Keywords
drug misuse; electronic patient records; general practice; primary health care; qualitative research; Read code recording.

INTRODUCTION

Large primary care databases are widely used to examine incidence and prevalence of disease diagnosis, symptoms, and health behaviours.[1] The key strength of primary care databases is that they provide a large amount of data from real-life consultations, which include rare exposures and outcomes, and enable us to study populations that may otherwise be difficult to study — pregnant women, those with severe mental illness, and those who misuse drugs.[2–4]

The UK has a number of primary care databases, incorporating electronic patient records (EPR; for example, the Clinical Practice Research Database — https://www.cprd.com/home/), which contribute to a longitudinal view about the treatment and care of individual patients, even if they do not always see the same GP.[5,6] General practice may be the first point of call for vulnerable and stigmatised individuals, such as those who misuse drugs. Drug misuse and dependence is defined as individuals who misuse illegal psychoactive substances and/or other recreational drugs, or are dependent on prescribed medication or over-the-counter opioids.[6] Drug misuse is a public health problem that can lead to poor health outcomes.[7] Consequences of drug misuse could necessitate a GP visit, which may provide an opportunity for drug misuse to be raised and potentially recorded by the GP. Previous quantitative work by the authors showed that GPs are recording drug misuse in EPRs and, although the rates are 25% lower, the time trends mirror those reported in the Crime Survey for England and Wales.[2,,8,9] Extrapolated rates from EPRs could therefore potentially be used to estimate the burden of drug misuse in the general population.

The rise in popularity of the use of primary care databases such as patient records, originally collected for administrative purposes, means that it is important to understand how and why information was recorded, and the consequences for what can be known, as Pope *et al*[1] argued. A semi-structured qualitative interview study was conducted with GPs in order to gain a clearer understanding of why, how, and in which circumstances GPs record drug misuse in EPRs, and to gain a clearer understanding of the gap between recording drug misuse in primary care and national surveys and other studies.

METHOD

Sampling and recruitment

Purposive sampling was used to recruit an equal number of GPs with and without a special interest in drug misuse from across England. The study attempted to obtain a spread of GPs working in inner- and outer-city neighbourhood practices, continuing recruitment until saturation of emerging themes was achieved. An expert on drug

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Submitted: 20 July 2017; **Editor's response:** 27 September 2017; **final acceptance:** 20 November 2017.

This is the full-length article (published online 27 Feb 2018) of an abridged version published in print. Cite this version as: **Br J Gen Pract 2018; DOI: https://doi.org/10.3399/bjgp18X695309**

How this fits in

Drug misuse is a public health problem, and information on the burden of drug misuse is important for policy on drug prevention and treatment. Previous epidemiological studies using primary care data have found that drug misuse is recorded, but at lower rates than in national surveys. This study examined factors that influenced recording of drug misuse in electronic patient records. There are currently no national drug misuse recording protocols. An anonymous drug misuse reporting system could be introduced, and existing recording templates could be rolled out nationally.

misuse e-mailed GPs a short summary of the study. If GPs were willing to participate they contacted the researchers directly. GPs that fitted the inclusion criteria were contacted by the researcher to arrange an interview. Before the interview, an information sheet and consent form were sent to the GP to sign. Each GP was given a £30 voucher for participating in the study.

Data collection

The authors used semi-structured face-to-face qualitative interviews following a semi-structured iterative topic guide (information available from the authors upon request) in order to explore and generate an understanding of the factors that determine GP recording of drug misuse in primary care. All except one interview was conducted in the GPs' surgeries, and they lasted on average 44 minutes (range: 35–66 minutes).

Data analysis

All interviews were audiorecorded and transcribed implementing data anonymisation. Data were analysed using a combination of inductive and deductive thematic analysis. The data analysis was initially conducted by the first author, followed by discussion with the wider research team.[10] The preliminary codes and themes were provided to the departmental data-analysing group, where the developing coding framework was discussed and refined. The authors used Atlas software version 7 to organise the data.

RESULTS

A heterogeneous sample of 12 GPs from different general practices were interviewed (Table 1). The sample ranged in terms of sex, years of experience, location, size of the practice, and special interest in treating patients who misused drugs. All but one of the eight GPs with a special interest had completed at least one module of the Royal College of General Practitioners (RCGP) Certificate in the Management of Substance Misuse. Two global themes and six sub-themes emerged from the data (Figure 1).

Global theme 1: Acquiring information about drug misuse

The GP accounts illustrated that the complexity regarding the decision to ask patients about drug misuse preceded the decision about recording. As drug misuse is a legislative illegal action that can lead to adverse consequences, enquiring is complex and often challenging. The sub-themes that emerged from global theme 1 were the context and the process of

Table 1. Demographics of GPs interviewed

GP participant	Sex	Completed RCGP substance abuse modules	Years of experience	Location	Number of GPs in practice (male:female)
GPs with a special interest in drug misuse					
1	Male	Yes	>15	Inner city	7 (3:4)
2	Male	Yes	>15	Inner city	4 (1:3)
3	Female	Yes	>15	Outer city	5 (2:3)
4	Female	No	5–10	Inner city	6 (2:4)
5	Male	Yes	10–15	Inner city	6 (1:5)
6	Male	Yes	>15	Inner city	4 (2:2)
7	Female	Yes	>15	Inner city	7 (1:6)
8	Female	Yes	>15	Inner city	7 (3:4)
GPs without a special interest in drug misuse					
9	Male	No	10–15	Outer city	8 (3:5)
10	Female	No	5–10	Outer city	7 (3:4)
11	Female	No	GP trainee	Inner city	9 (3:6)
12	Male	No	>15	Inner city	8 (3:5)

acquiring information about drug misuse, and the influence of the interaction between GP and patient (Figure 1). Quotes from GP participants (P) are given below to illustrate the themes. (Descriptive information is included for each participant).

Sub-theme 1. Context of acquiring information. The first sub-theme was divided into the organisational and individual context, and the financial incentives of recording drug misuse.

a) Location of the general practice: practices located in areas where drug misuse was more prevalent were, unsurprisingly, more likely to be accessible and have registered patients who misused drugs:

'We've traditionally been very keen, we've been very involved. Quite a lot of GPs, I think, are involved, particularly for maintenance, but also for reducing and stopping. So, I think we provide a very good place.' (P6, male, >15 years' experience, inner city, with a special interest in drug misuse [GPwSI])

The fact that patients who misuse drugs were regularly attending consultations in the practices seemed to desensitise the perception of drug use. In comparison, practices where drug misuse was less prevalent seemed to have fewer known registered patients misusing drugs:

'I think possibly we don't, just because we don't see that many [who misuse drugs].' (P10, female, 5–10 years' experience, outer-city neighbourhood)

b) Size of the general practice: GPs from larger practices reported that patients did not always see the same GP at each visit, which added to the challenge of asking about drug misuse:

'... because a lot of the time this isn't their regular doctor.' (P1, male, >15 years' experience, inner city, GPwSI)

However, the data suggested that some of these larger practices in locations where drug misuse is more prevalent had the capacity to appoint a lead GP for drug misuse, so that patients could experience more continuity of care:

'People who are specifically presenting with concerns [about drug misuse] *will get channelled into me.'* (P4, female, 5–10 years' experience, inner city, GPwSI)

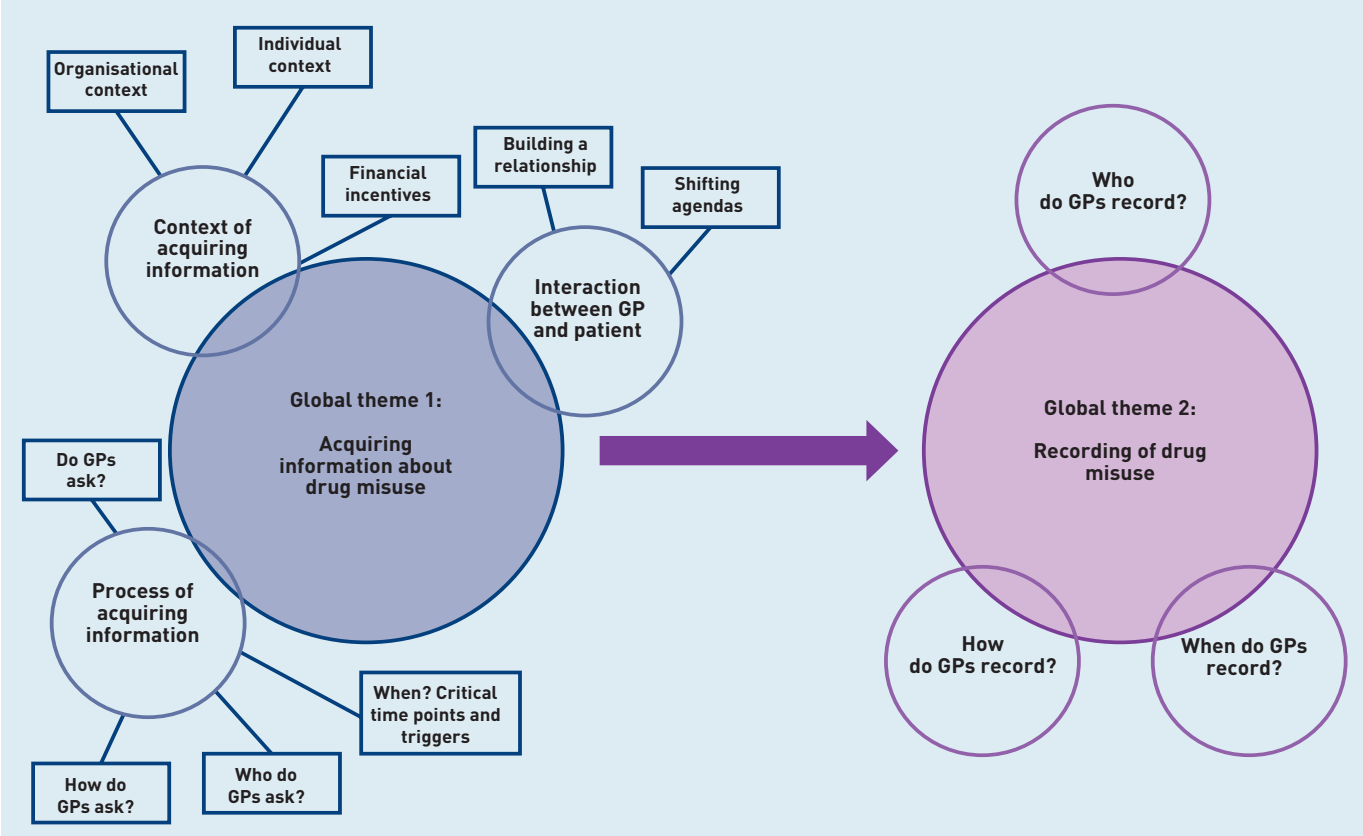

Figure 1. Global and sub-themes developed from thematic analysis.

Additionally, two of the inner-city large practices had an allocated weekly drug clinic, where patients could see the same GP and/or drug worker. This illustrates how the practice was working towards reaching the local enhanced service (LES) targets:

'We've been running a specifically dedicated substance abuse clinic, which is run in liaison with [local drug clinic].*'* (P7, female, >15 years' experience, inner city, GPwSI)

c) Financial incentives for GP practices: treating drug misuse is not in the General Medical Services (GMS) contract. However, practices in certain areas where the need has been identified have a LES for treating drug misuse, and are therefore financially incentivised to provide drug misuse treatment:

'Locally, the way our enhanced services have gone is that it isn't just for our own practice, it's actually for the whole of [named borough]. *We all have to reach that target for the whole group to be paid.'* (P7, female, >15 years' experience, inner city, GPwSI)

Consequently, recording of drug use was not only financially beneficial for all the practices in the area, but also facilitated continuity of care for the patient. Conversely, some GPs from practices without a LES expressed the opinion that the absence of Quality and Outcomes Framework (QOF) indicators for drug misuse influenced their decision to ask about and record drug misuse:

'It will be great if [recording drug misuse] *did* [get financially incentivised], *but it's always been resisted because drug treatment isn't part of the current GMS contract.'* (P9, male, 10–15 years' experience, outer-city neighbourhood)

This suggests that enquiring about and recording drug misuse would increase if a national QOF existed for drug misuse.

d) Individual context: GP experience and training: the RCGP training modules for management of substance misuse were seen as a positive way to gain experience, build confidence, and help improve the services provided:

'Well, I did it [RCGP modules] *specifically to set up a shared care service ... so, it was because we felt we weren't looking after the patients well that we decided, as a practice, we needed to develop more of an expertise.'* (P7, female, >15 years' experience, inner city, GPwSI)

In contrast, a GP trainee felt that she lacked confidence, but more experience would enable her to ask about drug misuse more frequently in the future:

'I'm not as confident as I imagine I will be in 10 years' time, when you've seen a lot more of this, and maybe as you get older you have more confidence to push an issue.' (P11, female, GP trainee, inner city)

GPs who worked in both general practice and drug treatment clinics found experience from the latter made them more aware of the signs of drug misuse, and therefore more confident about asking:

'[Working in the drug clinic] *helps me suspect things earlier and address them, I think, because a lot of people are nervous to ask.'* (P5, male, 10–15 years' experience, inner city, GPwSI)

This suggests that combining experience from working across both general practice and drug treatment clinics contributes to improved awareness of people who misuse drugs, and will therefore influence whether GPs ask about and record drug misuse in the electronic health records.

e) GPs' role in managing drug misuse: most of the GPs perceived that their role for managing individuals who misuse drugs was important:

'I think that GPs definitely have a role. I think one of the first things is actually uncovering that there's a problem.' (P11, female, GP trainee, inner city)

Their role seems to encompass identifying the problem and working together with other health professionals and services in order to manage and support individuals who misuse drugs.

Sub-theme 2. Interaction between GP and patient. The second sub-theme was divided into building a relationship and shifting agendas.

a) Building a relationship: GPs perceived that continuity of care was important to help establish a respectful relationship, as well as trying to remain non-judgemental:

'We do actually encourage a bit of continuity,

so they'd stick with one person, because then you build up a rapport and you're more likely to have an idea of what is actually going on at home, and with their drug abuse.' (P8, female, >15 years' experience, inner city, GPwSI)

It seemed as though this particular GP was trying to gain a deeper understanding of the patient's situation outside of the general practice. Furthermore, GPs discussed the need to balance clinically appropriate actions and maintaining the relationship:

'If I don't give them what they want, some of them will try to just test another doctor out, and whether or not they will be prepared to modify the prescription.' (P1, male, >15 years' experience, inner city, GPwSI)

The decision about recording raised a dilemma, with concern that recording may adversely affect patient disclosure:

'If they felt that to come and talk to you about something and that would require it being recorded would stop them coming to see you, then that would be detrimental to their care.' (P3, female, >15 years' experience, outer-city neighbourhood, GPwSI)

At times, GPs need to strike a balance between clinically appropriate actions and the established relationship, although GPs felt that, as occurs with the disclosure of alcohol use, people may minimise the extent of drug use in the accounts they presented to GPs:

'I think, generally, if people are willing to talk about it, then I've noticed people will talk it down, and say something like "Oh, well, I just sort of, you know, occasionally might use."' (P5, male, 10–15 years' experience, inner city, GPwSI)

Scepticism seems to creep in when patients disclose their drug misuse.

b) Patient's choice: some of the GPs discussed not recording misuse of drugs in the patient record following patient requests:

'... but if someone asked me specifically not to, then I wouldn't.' (P4, female, 5–10 years' experience, inner city, GPwSI)

GPs appeared to respect patients' autonomy and choice. Others, however, discussed circumstances in which they would urge recording, even when requests were made by patients to the contrary:

'I do think I would have the discussion with the person and make a judgement, and if it was really important I'd try to persuade them that it actually is important to put on their medical notes.' (P7, female, >15 years' experience, inner city, GPwSI)

GPs' actions depended on the circumstances, and GPs seemed more uncompromising about recording drug misuse if a woman was pregnant, or if there was someone else involved (for example, a child) and/or other agencies needed to be brought in:

'There are some situations where I would record, regardless of the use — if it was relevant to the consultation, or if there were children involved, or the person was pregnant.' (P4, female, 5–10 years' experience, inner city, GPwSI)

The consequence of GPs asking about drug misuse during pregnancy may have adverse implications for mother and child. Additionally, potential bias exists as GPs did not mention asking fathers about drug misuse.

c) Shifting agendas: there was the potential for a patient's original agenda and formulation of their problem to be superseded by a conversation about drug misuse:

'Also, social problems, work problems, I might ask them about [drug misuse] *if they present with these* [symptoms].*'* (P2, male, >15 years' experience, inner city, GPwSI)

However, the consultation may be sent in a different direction, with a risk of communication breakdown as the patient's agenda is not properly met. Patients presenting with common signs, symptoms, and comorbidities seemed to trigger awareness of drug misuse, and prompt the GP to ask about it:

'They generally come along with emotional difficulties — symptoms of depression and anxiety — and have just been unhappy with the way they are, really.' (P2, male, >15 years' experience, inner city, GPwSI)

Sub-theme 3. Process of acquiring information. The last sub-theme here incorporates whether, who, how, and when GPs ask about drug misuse.

a) Do GPs ask about drug misuse? GPs do not always ask about drug misuse. However, when the topic arises, it is usually during a consultation about a different problem. This

relates to the earlier theme about shifting agendas:

'It's more, kind of, mostly an incidental thing that will come up as part of questioning during a consultation.' (P4, female, 5–10 years' experience, inner city, GPwSI)

Mainly, GPs who did not have a special interest in substance misuse expressed the view that time was a barrier for enquiring about drug misuse:

'But I don't routinely ask. I mean, to be honest, we just don't have time.' (P11, female, GP trainee, inner city)

In contrast to GPs with a lot of experience, GPs with less experience seemed more hesitant and less confident when asking about drug misuse. Some GPs reported not asking about drug misuse as they may not have time within the consultation to help with the other emerging complex issues:

'Otherwise, a lot of people [GPs] *are just thinking they're going to open a can of worms, and it's going to make a consultation twice as long.'* (P7, female, >15 years' experience, inner city, GPwSI)

However, some GPs perceived that patients seemed relieved when asked, as they could then get the appropriate help:

'I think often people are relieved [to be asked], *and actually quite pleased to feel like there is some help.'* (P8, female, >15 years' experience, inner city, GPwSI)

GPs are in a good position to query about drug misuse, although barriers such as time, experience, and the complexity of the issue seem to have an impact on the number of patients that GPs ask, and therefore record information in electronic health records.

b) Who do GPs ask? Stereotypical versus atypical: GPs recounted that they did not have time to ask every patient about drug misuse, and therefore experience has taught them to direct their queries to individuals presenting with certain characteristics. These included those with mental health issues, young professionals, students, and homeless people:

'And anybody who comes in with depression or mental health issues we'd ask, regardless of age, in the same way as you'd ask about alcohol.' (P7, female, >15 years' experience, inner city, GPwSI)

It appeared that certain types of people were triggers for GPs asking about drug misuse. There was, however, an awareness that certain types of people, particularly those in a more privileged position in society, may not be asked:

'I think some of the party drugs male patients are not presenting, not being honest about it, and maybe that's because they're in, sort of, more professional roles, such as solicitors and barristers, than our typical drug misuser in the past.' (P7, female, >15 years' experience, inner city, GPwSI)

A key difference emerged between GPs who saw and GPs who did not see patients regularly who misused drugs. The former viewed that there was a risk of individuals being missed if the GP only focused on asking particular groups of patients.

c) How do GPs approach asking about drug misuse? GPs have developed different styles of questioning in order to ask about drug misuse. Accounts included both direct and indirect approaches:

'I don't ask people directly whether they are taking or misusing substances. I ask them permission to ask it first, and so they have a "get out" clause.' (P9, male, 10–15 years' experience, outer-city neighbourhood)

'I think you have to ask your question to the point, because otherwise you might not get the answer, and people might not understand your questions either.' (P3, female, >15 years' experience, outer-city neighbourhood, GPwSI)

Experience and reflection seemed to have shaped different questioning styles that fulfilled the purpose of acquiring information about drug misuse.

d) When were the critical time points for asking? There were distinctive and significant time points when opportunities for asking about drug misuse naturally fitted, such as new patient registration:

'This is our new patient health questionnaire, and on it, it has a section: "Do you misuse any of the following drugs or substances?" Alcohol is slightly easier than substance misuse, and, you know, in a questionnaire, I probably don't get the whole details of alcohol, and less of drugs.' (P6, male, >15 years' experience, inner city, GPwSI)

It seems that, although the patient questionnaire may be an opportunity for the GP to indirectly ask about drug misuse, there was some scepticism about the validity of the results. Although registration of a new patient may be a critical time for asking about drug misuse, it may not be the right time for an individual to disclose and therefore affects recording of drug misuse in electronic health records.

A GP trainee without a special interest in drug misuse described how she does not routinely ask about drug misuse on its own, but found it easier to ask about drug misuse together with sexual health issues:

'The other time when I would have asked [about drug misuse] *— people who'd come in for the morning after pill.'* (P11, female, GP trainee, inner city)

Consultations regarding other sensitive, but perhaps slightly less stigmatised, issues may present an opportune time for asking about drug misuse. Pregnancy was also seen as a timely opportunity, when other lifestyle decisions (for example, drinking and smoking) are discussed:

'The other area would be in pregnancy — so, for example, if I'm concerned that either someone might be smoking or could potentially be using drugs.' (P4, female, 5–10 years' experience, inner city, GPwSI)

Global theme 2: Recording of drug misuse

Once GPs have acquired information on drug misuse, they need to make a decision on whether or not to record in the EPR (Figure 1).

Sub-themes 4 and 5. When and who do GPs record? GPs' opinions differed with regards to when and for which patients to record drug misuse in the EPR. Some GPs did not feel that it was necessary to ask patients for their permission to record, and described how recording was an administrative issue, and did not appear to engage with the potential sensitivity:

'If somebody comes in about a drug issue, they would see me writing during the consultation. So, I guess that's implied consent.' (P8, female, >15 years' experience, inner city, GPwSI)

Other GPs expressed the view that the patient should be made aware of recording:

'I think that's something we'd have to discuss with the patient, because the problem is that once it's on their record, it's on their record forever.' (P3, female, >15 years' experience, outer-city neighbourhood, GPwSI)

In contrast to this argument, a female GP from an inner-city practice with a special interest in drug use perceived that it was important to record for insurance purposes:

'And, even if you don't do it, I would be liable if, say, it's an insurance report. It's still, if you know the information, then it would make their insurance thing null and void.' (P8, female, >15 years' experience, inner city, GPwSI)

These differences in opinion suggest that GPs may struggle between the role of providing care and that of a gatekeeper.

The issue of not recording could be explicitly raised in an attempt to gain an accurate picture of use:

'I've asked somebody about their drug misuse, and said to them that I'm not looking to record this, I think it'd just be useful to know 'cos it's potentially relevant to their stress or insomnia.' (P5, male, 10–15 years' experience, inner city, GPwSI)

In contrast, other GPs stated the need to record drug misuse in the interests of providing continuity of care across different clinicians:

'So, I usually say to them: "Look, if you're seeing somebody and they don't know something about you that's going to influence how they treat you, then it's in your interest to have it on the record."' (P7, female, >15 years' experience, inner city, GPwSI)

It seemed that the decision to record was a balancing act with regards to patient care and the existing GP–patient relationship.

All of the GPs were unanimous about recording in detail if a child was affected by parental drug misuse, as they viewed it as their duty and responsibility to record any adverse situations affecting a child:

'Usually, when I'm doing a consultation with someone who is pregnant, or if I was doing a consultation where I thought that it would be a social work [sic] *concern, I'd be more structured and detailed, I think, than just my usual rambling free text.'* (P4, female, 5–10 years' experience, inner city, GPwSI)

Recording may, however, not be via a Read code, but rather in the referral letter to the midwifery service:

'I can think of one woman recently who was a cannabis user, but she wasn't using any opiates. So, I put that in her letter [referral] *but I did not use a Read code.'* (P4, female, 5–10 years' experience, inner city, GPwSI)

Sub-theme 6. How do GPs record information about drug misuse? GPs described how time consuming finding specific Read codes can be, and that free text was often easier and quicker:

'So, yes, I think that's very true of EMIS, that it probably needs to be cleaned, but I guess there's often one [Read code] *to find.'* (P11, female, GP trainee, inner city)

GPs both with and without a special interest in drug misuse described how they usually use Read codes for the primary problem that the patient had consulted about, rather than drug misuse:

'In general practice, it would just be what you thought the main problem was.' (P9, male, 10–15 years' experience, outer-city neighbourhood)

Once a woman is discharged from the midwifery service, GPs receive a detailed discharge letter that is usually scanned, but not always Read coded:

'I would certainly record if I got that [drug misuse in the discharge letter] *letter back. I would open up the mum's and kid's records, and pick a Read code, and put it in.'* (P11, female, GP trainee, inner city)

Finally, some general practices have developed templates or protocols to use specific Read codes to record drug misuse:

'So, the only way you're going to get people to use similar Read codes is to make them use a template.' (P4, female, 5–10 years' experience, inner city, GPwSI)

The template offers more opportunity for auditing the information regarding drug misuse in their general practice, as the same Read codes would be used. Practices with more registered patients misusing drugs seemed more likely to have developed a template or protocol.

DISCUSSION

Summary

This study presents an understanding of the complexity of how, why, and in which circumstances GPs record drug misuse in the EPR. It is evident from the findings that some people who misuse drugs are consulting with their GP.

A confluence of factors affects both how GPs acquire information about drug misuse, and the management and treatment that influences various pathways that can lead to GPs recording drug misuse. The fact that drug misuse is still a stigmatised and sensitive issue could influence whether or not GPs follow RCGP guidelines, practice protocols, or templates.

Furthermore, the analysis identified and explored the four distinct levels that influence GP recording of drug misuse in the EPR — GPs' individual experience and training, general practice protocols, clinical commissioning groups' (CCG) service provision, and government policies. This study helps understand why there are gaps in recording drug misuse in primary care data.

Strengths and limitations

The main strength of this qualitative study was that it gives new perspectives about GP recording of drug misuse, using GP accounts to describe when and why they did not record drug misuse in EPRs. GPs were recruited and interviewed from a demographic and geographical spread, which allowed the authors to gain an understanding of different perspectives and practices in different regional areas. They were also able to recruit GPs in various stages of their careers; those who were leads in substance misuse, and those who did not see individuals who misused drugs regularly. This allowed the authors to explore if there were similarities and differences in the recording practices of GPs with more and GPs with less interest in drug misuse.

A limitation is that, in some cases, GPs referred back to the EPR to ascertain exactly how they had recorded, but this was not always the case. In addition, this study lacks opinions from other health professionals, including practice nurses and drug workers, and these are the views and perspectives of GPs alone. The voices of those who misuse drugs and consult their GPs are also not included in this study.

Comparison with existing literature

Primary care may be the first point of contact for individuals who misuse drugs, and these findings reaffirmed the RCGP recommendations that GPs should maintain a non-judgemental attitude towards patients and their behaviours.[11] Additionally, GPs' views and perceptions seem to be shaped by their experience and training.[12]

The findings support the importance of the RCGP guidelines, which recommend that practitioners with special interests should undergo specific training and accreditation, such as the RCGP training modules.[12,13]

The findings echo previous studies, where time was a barrier to GPs asking patients about complex issues, such as sexual health[14] and alcohol.[15] As in Gott *et al*'s work with GPs asking about sexual health, GPs from this study used the phrase 'opening a can of worms', indicating that they may not have time within the consultation to deal with additional problems relating to the adverse behaviour.[14] GPs may choose to only ask patients with particular physical, psychological, or social symptoms.[15] However, a key difference that emerged in these findings was that specialist drug misuse GPs argued that individuals may be missed if GPs only asked particular groups of patients.

The doctor–patient relationship is a crucial aspect of patient care, and possibly as important as therapeutic treatment.[16] This, together with GPs' recognition of the significance of trust when patients who may feel vulnerable disclose sensitive information, resonates with this study's findings.[16,17] This may be particularly evident if patients' original agenda shifts during the consultation, and/or if the presenting problem triggers GPs' awareness of drug misuse, leading the GP to focus on drug misuse rather than the original problem. In such circumstances, patients could become frustrated and deem the consultation unsuccessful.[17,18] When deciding whether to record sensitive issues such as drug misuse, shared decision making and a sense of partnership could help to maintain patients' trust in their GP.[18,19] Some health professionals seem to view coding as a complex sociocultural issue that could potentially impact the GP–patient relationship.[20]

Furthermore, evidence from studies examining GPs' recording behaviour of other sensitive issues suggests that GPs seem more concerned about building and maintaining a trustful relationship than recording alcohol misuse,[21] and were careful and cautious before using a permanent maltreatment code.[22] The definition of child neglect includes antenatal substance misuse,[23] which could partially explain why GPs in this study seemed more inclined to include drug misuse in the midwifery referral letter, rather than using a code to record it.

The location of the general practice could influence the need for a lead GP in drug misuse who could deliver continuous care. The Localism Act (2011) influenced a shift of responsibility from central to local public health bodies, leading to specific service delivery being informed by local population needs.[24] Treating drug misuse is not in the GMS contract. However, LES for drug misuse are incorporated in areas where the problem is more prevalent.[25] For areas without a LES, the model of shared care, where general practices work together with NHS and voluntary sector drug services, is available.[24] It is essential that GPs have a clear understanding of where to signpost or refer individuals for the most appropriate treatment.[24] Decisions and services provided by CCGs can indirectly influence GP recording of drug misuse in the EPR, and this study suggests that financial incentives may improve systematic recording.

These findings suggest that templates seem to be useful and efficient with regards to recording management and treatment of drug misuse in general practice. Maisey *et al* also reasoned that templates can help ensure quality assurance with regards to recording.[26] Furthermore, these findings suggest that having no QOF for drug misuse may affect recording, which reiterates that diseases included in QOFs usually have quality-assured protocols and are recorded more systematically.[26,27] Lock *et al* reasoned that the inclusion of alcohol misuse treatment should be included in both the GMS and QOF.[15] A similar argument could be made for drug misuse. Additionally, Dixon *et al* argued that current QOFs could be a barrier to the commissioning of suitable services for populations with social inequalities and complex needs, as the framework does not provide incentives for practices in these areas.[27] A pilot study of payment by results is currently evaluating incentives for delivery of recovery for drugs and alcohol in primary care.[28] If implemented, recording of drug misuse may improve. However, this could negatively impact the GP–patient relationship.

GPs, therefore, need to weigh up many factors and competing priorities before making a decision to ask about and/or record drug misuse in the EPR. GPs act at an individual level, but are influenced by wider structural factors, such as general practice protocols.

Implications for research and practice

Recording drug misuse with Read codes in EPRs may be challenging, because recording is permanent and may impact on the GP–patient relationship. A similar anonymous reporting system to that used

for HIV cases could potentially be introduced for drug misuse, to help understand the size and burden.[29] This is comparable to the eCHAT programme in New Zealand, where information about harmful behaviours, including drug misuse, can be collected anonymously using an iPad in the waiting room or via the internet.[30] Furthermore, the eCHAT program allows patients who want to discuss the issue with their GP to identify these behaviours and the impact they may have on their mental health before the consultation.[30] GPs will have access to this information and can initiate discussion about both the unhealthy behaviour and mental health impact in a holistic manner.[30] Additionally, new patient registration forms and previously developed recording templates could be used and rolled out nationally.

Furthermore, recording systems between services and general practices have been linked in some CCGs, and will be linked in Scotland by 2018.[31] If a patient gives consent, GPs can monitor and acquire a clearer picture of a patient's management and treatment in other drug services. The linkage of services using Read codes could also potentially be rolled out nationally. Finally, researchers using primary care databases to examine drug misuse should use an ontology-based process, as individuals may not be captured using Read codes alone.[32]

Funding

Hilary Davies-Kershaw had a PhD studentship with the National Institute for Health Research School for Primary Care Research (NIHR SPCR) (http://www.spcr.nihr.ac.uk/), reference number: HD2012. The funder had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript. This paper presents independent research funded by the NIHR SPCR. The views expressed are those of the authors and not necessarily those of the NIHR, the NHS, or the Department of Health. Hilary Davies-Kershaw conducted the work at University College London (UCL) but is now affiliated with the University of Surrey.

Ethical approval

Ethical approval for the study was granted by the UCL Ethics Committee (reference number: 5664/001).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

The authors would like to thank the GPs who participated in this study for their valuable time and accounts of recording practice. They would also like to thank the following researchers for their time and contribution with discussing emerging themes from the data: Dr Sonia Hill, Dr Kethakie Lamahewa, Dr Jamie Ross, Dr Rosie Webster, and Katie Yon.

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