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Evaluation survey of a Methadone Treatment share care programme between a specialized clinic and a network of GPs

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Summary

Emergence Espace-Tolbiac is a methadone treatment clinic. Over the last 5 years, EET has initiated methadone treatment with 738 patients, including 548 who have been referred to a network of 220 GPs The way of service functions is defined by the French regulations for methadone treatment. Such treatment must be initiated by specialized clinics, but once patients have stabilized, can be referred to GPs. Our service initiates the treatment, and patients stay at the clinic, where methadone is administered every day by a specialized team. During the first few weeks, the patient's needs are evaluated and he or she is referred to various professionals, such as social workers, doctors and psychiatrists, according to whatever is appropriate in each case. Patients are referred to GPs when the evaluation is made that they no longer abuse drugs such as heroin or cocaine, or other substances such as alcohol or benzodiazepine. They must have social resources and available accommodation. Patients suffering from a psychiatric disorder do not receive referrals until their condition has been stabilized by any kind of treatment. So far 40% of our patients have received a referral after an average of 2 months at the clinic, and 30% after an average of 9 months, while 18% have stayed at the clinic for over 2 years. A follow-up has been conducted on 296 patients referred to GPs (32 GPs failed to answer) After an average of a year and a half on treatment, 5% were no longer available for follow-up, and 85% are still being advised by their GP. Of these, 95% are still being treated with methadone. Most of the others (9/13), are being treated with high-dosage buprenorphine (Subutex). The mean dosage is 60mg/day, 15 mg less than at the end of the stay at the centre. Relationships with other professionals are frequent (67% of patients). 20% are still in contact with the centre.

Key words: Methadone Treatment - GPs network

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The Emergence Espace-Tolbiac programme began in June 1995. The choices we made were determined by the Paris context. At that time GPs were not officially allowed to prescribe substitution treatments. Methadone had been recognized as a substitution treatment in April 1995, subject to a regulation that only specialized services could begin treatment with methadone. These services might, however, refer a patient to general practice if they considered that the patient' condition had been stabilized. The Ministry of Health had not wanted GPs to prescribe methadone in the first place, because it considered that a prescription of methadone required specialized knowledge. One of the reasons given was the risk of overdose. For prescriptions in general practice it was decided to use high dosage buprenorphine (Subutex); this received legal sanction in January 1996.

In June 1995, however, several Paris GPs found themselves dealing with many patients who obviously needed access to methadone. These doctors had begun substitution treatments during the 1980s, using low dosage buprenorphine (Temgesic). When patients were unable to stabilize with Temgesic they used morphines, which, in principle, are reserved for the treatment of pain (Skenan / Moscantin). It is difficult to say today why stabilization through the use of Temgesic proved unsatisfactory, or whether dosages were inappropriate. The fact remains that these patients achieved stability more satisfactorily by using morphine, and they should therefore have been given access to treatment using methadone. The number of patients then being treated with morphine was estimated at between 2000 and 3000 in the Paris region alone.

We therefore chose to work in collaboration with a network of these doctors, most of whom had had several years of experience with substitution treatments. We considered that our role was to stabilize the patient and then refer the patient to his or her GP as soon as the patient was able to cope with the treatment without our direct help. Past experience of substitution treatment in medical practice showed that a proportion — as yet unknown — of patients do not need the kind of daily care that is provided in a specialized unit. It also showed, however, that certain patients had needed sustained care by a multidisciplinary team (medico-psycho-social). After reflection, our working hypothesis was that some patients might benefit from specialized care over relatively short periods with clear objectives, such as access to secure housing, or giving up the use of drugs by injection. We therefore chose to individualize treatment periods in the specialized unit, in line with the patient's progress.

Given the situation in Paris, we wished to refer patients to general practice quickly, whenever possible.

We adopted the following criteria:

— Stabilization in terms of dosage, which, if there are no other problems, can be achieved rapidly (in one week).
— Control of legal and illegal psychotropic drug abuse: alcohol, psychotropic medicines, cocaine and other drugs.
— Social stabilization: either access to social security resources, which may include a job, or social security benefits (the minimum social security

benefit, a pension or other benefits).

— Absence of major psychiatric disorders.

The needs of employed patients could be met more quickly. We also took into account the patient's relationship with the GP. Some poorly stabilized patients, patients with psychiatric disorders, or those suffering from multiple drug addiction, were dealt with more quickly if the GP was willing to take on the responsibility, and had a good relationship with the client and an experience of patients with drug addictions.

Considering the whole of 1999, we began methadone treatment on about 800 patients, that is, over 10% of all patients treated with methadone in France (7,500 patients).

A survey was conducted by Dr. Charpak (EVAL) among GPs in 1997, on cases where one and a half years had passed since they had taken over responsibility. Eighty-eight doctors were questioned about the progress of 239 patients.

The profile of patients was comparable with that of other patients treated with methadone in France: 67% were men and 33% women, with an average age of 36; 25% lived alone, 44% cohabited, and 23% were living with their families. 93% had a fixed abode (patients are not referred to general practitioners if they have no fixed abode). 34% had a job when they were referred to their doctor (Table 1).

Table 1. Socio-economic background

Age (M)	36	
	N	%
Sex (Males)	161	67.4
Home circumstances		
single	61	25.5
cohabiting	106	44.4
living in family	56	23.4
institution	2	0.8
missing	14	5.9
Housed		
yes	151	93.2
no	3	1.9
missing	8	4.9
Financial resources		
employment	55	34.0
benefits	71	43.9
family	13	8.0
no resources	3	1.9
missing	20	12.2

From a physical point of view, 22% were HIV-positive (52), 64% HIV-negative (154), and 13% unknown (33), 110 were hepatitis-positive and 62 unknown.

The first result of this survey is the rate of retention (patients still monitored one and half years after going into care). 92% (222) were still under treatment by doctors and 88% (211) were still being treated with methadone. Two patients were under treatment with Subutex, three with a morphine sulphate, and two had been disintoxicated.

In all, 12 patients had given up treatment (nine dropouts, one death and one relapse) (Table 2).

Table 2. Retention rates

	N	%
Patients still in treatment	222	92.9
Patients on methadone treatment	211	88.3
Patients no longer on treatment	9	3.8
Patients on "Moscontin" or "Subutex" treatment	3	1.3
Patients who had died	1	0.4
Detoxified patients	3	0.8

These results are comparable with those obtained in our unit. The results confirm our clinical experience by proving the feasibility of treatment by general practice.

The duration of treatment at Emergence Espace-Tolbiac is extremely variable (Table 3).

61 patients (37%) were referred to general practice following a single consultation. Various criteria justified this rapid referral:

— patients already under general practice treatment and already satisfactorily stabilized; patients with jobs and without any other special difficulties;
— patients living a long way from Emergence, for whom monitoring on a daily basis is ensured by the GP and the pharmacist;
— patients suffering from a physical pathology, those unable to travel, and so on.

These are the patients who had been referred to general practice, but 25% of those staying in the centre had been under care for more than two years in 1998. The latter were faced with at least one of the following problems:

- multiple addiction (alcohol, medicines, cocaine...)
- social alienation
- psychiatric disorders.

These patients require care over a long period. In the case of patients who show

Table 3. Time spent at emergence before referral to GP		
Time	N	%
< 1 week	61	37.4
< 1 mounth	35	21.5
< 3 mounths	17	10.4
< 6 mounths	22	13.5
< 12 mounths	8	4.9
> 12 mounths	20	11.3
TOTAL	163	100.0

strong social alienation, like those with multiple addictions, we achieve positive progress through long term care. Psychiatric disorders are a major obstacle for which we try to organize double care, together with the psychiatric sector.

For the evaluation of drug use while under general practice care, questions were asked about drug use during the previous month.

The main results were as follows : 67% of patients were not using heroin; 9% were using it occasionally, and 7% every day.

68% were not using cocaine and 5% were, while the doctor had no information about 26% of cases.

Crack is only rarely used; it is a problem for 2% of patients.

Lastly, 67% of patients no longer take drugs by injection.

It must, however, be noted that doctors do not use urine analysis. This may mean that cocaine use, for example, is underestimated. However, patients with a major cocaine problem are not usually referred to general practice.

As to alcohol consumption, 46% of patients do not drink, 24% drink regularly, and 20% have alcohol problems (Table 4).

As to changes in patients' social situation, progress was relatively slow. In some cases there were rapid changes at the beginning of treatment, prior to referral to general practice, after which the situation remained stable. This was the situation with housing and long-term shelter, or with returning to work in the case of patients who were previously employed. As regards financial resources, 54% of situations remained unchanged, 19% had improved situations, and 14% were in a worse situation. In the case of those were employed, jobs were usually kept, which was a good result in itself. Those who had never worked found it very difficult to find jobs. Worsening financial situations mainly involved those in irregular jobs, who alternated between good and bad times.

One of the important results of the survey is the GPs' involvement of other health care professionals. 61.25% of patients were referred to another professional, including 17.7% to psychiatrists, 12.65% to social workers, 7.85% to dentists (which, however,

is too flow a proportion), 9.5% to infectivologists, and 8.75% of patients are referred to a drug addiction specialist who ensures double monitoring.

Table 4. Drug use last month, after one and a half years

	N	%
Injection		
yes	38	15.9
no	161	67.3
missing	40	16.8
Heroin		
yes	48	20.3
no	150	62.6
missing	41	17.1
Cocaine		
yes	12	5.0
no	163	68.4
missing	64	26.6
Alcohol		
moderate drinker	57	24.0
heavy drinker	46	19.2
abstainer	110	46.0
missing	26	10.8

The involvement of various health care professionals bears witness to better access to both physical and psychiatric health care. It also shows that doctors are not isolated, and work in a network with other professionals (Table 5).

We consider that these results justify the choices we made at a general level. Referral to general practice is desirable, and the results obtained are comparable to good programmes of methadone treatment. In considering these results, the following factors must be taken into account:

1) The duration of treatment in the centre and referral to general practice are not unconditional; they are based on clinical criteria. Some referrals may have been premature, others unnecessarily long, but a clinical survey requires other means. In particular, it is impossible to know what results might have been obtained without treatment in a specialized unit.
2) The network of doctors we are working with is particularly experienced; many of these doctors have had patients under substitution treatment since the end of the 1980s. In addition, they are organized in networks that offer training. These, then, are motivated doctors who are prepared to devote a large part of their time to their patients and who all work in a network with various specialists.

In a more general way, the results we obtained in France with substitution treatments

Table 5. Referral to various professionals		
	N	%
Psychiatrist, psychologist, psychoanalyst	42	17.8
Drug Addiction Specialist	21	8.7
Social Worker	30	12.7
GP	17	7.1
Dentist	18	7.8
Gastroenterologist	17	7.2
Invectiologist	23	9.5
Internist	14	5.7
Other	18	7.6
TOTAL	146	61.2

must largely be attributed to the mobilization and involvement of GPs. Between 1994 and 1998 the reduction in fatal overdoses was 70%, and this figure indirectly reflects the improvement of health and lower mortality in drug-addicted patients. This corresponds precisely with the years of growth in substitution treatment (that is about 80,000 patients under Subutex treatment and 7,500 under methadone treatment at the end of 1999). During these four years the situation of drug addicted patients has changed radically. These patients were formerly rejected from hospital units as a matter of course. Today there are specialised teams in hospitals for taking patients into care. Of course progress remains uneven according to place, but now drug addicts do have access to care, which is also reflected in the fall of numbers of deaths from AIDS (this can be stated, even though we do not yet have any precise figures).

In assessing results of substitution treatment, context and the quality of professional practice, which are difficult to evaluate, are rarely taken into account. From the point of view of context, we would certainly not have obtained such results at the time of a steep rise in heroin use, such as that occurring in the 1980s. Another contextual element is the advent of treatment for HIV, which certainly motivated drug users to take more care of themselves. Professional practice seems to me to have played a major part, which is not entirely reassuring: doctors mobilized at a time when the situation of patients was very serious, and at which substitution treatment had to be introduced and people convinced of its usefulness. Today these treatments have official status, and drug addicts have

become patients just like other kinds of patients who do not justify any particular effort. It is quite possible that in the years to come we may find it difficult to maintain such good results.

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