Primary care medicine and substitution treatments in opiate dependency

The French experience

Dr Claude Magnin
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Overview

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I. Context (1)

- Debate is clear on the benefits ++ of substitution treatments

- But:
  
  - firstly, patient management cannot be reduced simply to drug prescription: social and/or psychological support and harm reduction are an integral part of Opioid Substitution Treatment (OST)
secondly, new questions arise:

- Treatment duration
- Side effects and misused treatments
- Primary dependency on Opioid Substitution Medicines (OSM)
- Access to treatment for users with major psycho-social difficulties
II. Prescription of OST in General Practice (1)

- **Initial prescription:** HDB (Subutex®) since February 1996

- **Maintenance prescription after initiation by a care centre:** Methadone since 1995 (capsule form since April 2008)

- **Approximately 130,000 patients treated (95,000 HDB and 35,000 Methadone) in 2008**
Prescription of OST in General Practice (2)

- **Breakdown in the paradigm in 1995**

- **General practitioners are not trained in these new treatments**

- **Departmental OST monitoring committees are set up: these operate very unequally**
Specific French feature subtended by the:

- Prevalence of HIV and HCV in IDU
- Need to provide a rapid response because of France’s tardiness in adopting OST
- Low cost of the system relying on general practitioners
Ill. Prescription of HDB in General Practice (1)

- More flexible prescription framework than Methadone
- Good accessibility because of geographical distribution of prescribing doctors
- Merits of a “partial agonist” molecule of opiate μ receptors => relative safety in terms of risks of overdose
Prescription of HDB in General Practice (2)

- **Main positive impact:**
  - reduced number of overdoses
  - and gradual distancing from heroin use
  - entry into the care process
IV. A specific case of OST

Prescription of OST in General Practice

**Morphine Sulphate:**

- **When** HDB and Methadone have failed
- **No official OSM status**
- **But tolerated** with the agreement of the health insurance system physicians
- **Approximately 1,200 to 1,500 patients**
- **Disadvantages:** injection practices ++
- **Advantages:** keeps patients closely linked to heroin in the care system.
V. Medical practices (1)

Dominated by:

- Lack of training or skills required to prescribe OST
- No evaluation of professional practices
- No evaluation of patient outcome
- Therefore: very heterogeneous practices among physicians
Medical practices (2)

- Involvement of General Practice
  - 97% of prescriptions (HDB and Methadone) are issued by GPs
  - But approximately 50% of GPs never prescribe
  - 8% to 10% are extensively involved, including a group who have become “implicit specialists” in OST
Medical practices (3)

Practices in multi-disciplinary care networks provide:
- support for isolated doctors (regular visits and meetings)
- free total care (psycho-social) for users
- specific training for young doctors or students in their final years of study
Medical practices (4)

But also:

- systematic refusal, occasionally ideological
- lax, emotional or inappropriate practices
- routine mechanical renewal of drug prescriptions without real patient management
VI. Difficulties encountered with these drugs (1)

**HDB:**

=> sniffing and injection practices associated with effect-seeking, social and/or psychological difficulties or poor understanding of sub-lingual dosing

=> skin and subcutaneous lesions: hand and forearm oedema, necrotic lesions at injection spots, distant infectious lesions
Difficulties encountered with these drugs (2)

**Methadone:**

- Difficulty in accessing treatment
- Difficulty in moving from maintenance treatment to primary care
- Consequences: care centres overloaded, with very long waiting times for patient management
- Existence of a methadone black market
VII. Difficulties encountered with prescribers (1)

- **Persistent inadequate training**
- **No requirements for management of patient treatment**
- **Harm reduction culture restricted to:**
  - needle exchange,
  - harm reduction training with regard to injections,
  - systematic screening for viral infections insufficient
Difficulties encountered with prescribers (2)

- Difficulty in establishing formalised content for the treatment renewal consultation
- Inadequate psychiatry support for GPs in opiate dependency-related psychopathologies
- After many years of prescribing: Thoughts? Questions?
VIII. Avenues for improvement

What has been realized or is in process:

=> **Decree of 1st April 2008 aims at favoring links between patient / GP / pharmacist:**
   - Name of pharmacist printed on the prescription
   - Improving links between the Health Insurance system and prescribing doctors in terms of appropriate doses, medical nomadism, questionable drug associations HDB/Benzodiazepines through a medical protocol

=> **Strengthening the GP / Pharmacist link:**
   telephone call at first prescription

=> **Ongoing study on the possibility of initiating methadone prescription in Primary Care ("Méthaville study")**
Avenues for improvement

What has been proposed and should / could be done?

In order to improve physicians ability to prescribe OST

=> To incorporate addictology and OST into the medical curriculum and into continuing medical education programmes

=> To produce a reference good practice document particularly for HDB (ongoing)

=> To refer to a second, more expert, medical opinion for high doses of HDB (>16 or 24 mg/D)

=> To establish an accreditation system for prescribers?
Avenues for improvement
What has been proposed and should / could be done?

In order to improve the patient management:

=> To increase monitoring of patients during the period when treatment is initiated
=> To perform more systematic somatic examinations
=> To propose urine analysis when HDB treatments are started?
Avenues for improvement
What has been proposed and should / could be done?

In order to improve OST pharmaceutical forms:

=> To develop other galenic forms
=> To develop other form of HDB (injectable or nasal form? mouth-dissolving tablet form?)
=> To give an official status of Morphine Sulphate when Methadone and HDB have failed?
=> What about the marketing of Suboxone®? debated benefit in terms of medical service provided because of the long-standing existence of HDB
Thank you for your attention