emcdda.europa.eu

Minutes

Meeting • Réunion	European exchange on the practice and current issues in opioid substitution treatment (OST) in General Practitioners' Setting	Date	22 September 2010
Venue • Lieu	CDS 107		
Present • Présent(e)(s)	Alessandro Pirona (EMCDDA), Dagmar Hedrich (EMCDDA), Tim Pfeiffer-Gerschel (DBDD), Richard Haumann (Germany), Linda Harris (United Kingdom), Vlastimil Necas (Czech Republic), Michael Soyka (Germany), Tiphaine Canarelli (OFDT), Hans Haltmayer (Austria), Venija Cerovecki (Croatia), Jakub Minarik (Czech Republic), Thomas Clausen (Norway), Claude Magnin (France)		

Minutes

1) Aims:

- To bring together general practitioners (GPs), experts and scientists working in the field of OST across Europe
- To create a platform for exchange of experiences of GPs in the provision of OST
- To increase awareness and knowledge about GPs experiences with OST
- To establish partnerships and discuss future involvement of EMCDDA and National Focal Points in documenting GPs experiences with OST

2) Agenda / outcome:

The meeting comprised of two thematic sessions, namely:

Morning Thematic Session: **'Experiences and issues in the management of drug, health and social co-morbidities among clients in opioid substitution treatment with GPs'** (chairs Dagmar Hedrich, Tim Pfeiffer-Gerschel). This session included four communications, followed by a round table discussion. The first three were presented by professionals coming from Germany (Dr Richard Haumann -RH), United Kingdom (Dr Linda Harris - LH) and Croatia (Dr Venija Cerovecki - CN), who shared their national experiences in the provision of OST. To integrate GPs practices with the research field, research findings in this field were also presented (Dr Michael Soyka - MS). An overview of the presentations / topics discussed is provided below.

- **'German experience and issues in opioid substitution treatment in GP'** (RH) – Dr Haumann started with a brief overview of more than 20 years of opioid substitution in Germany. Currently in Germany, 50% of OST patients receive their treatment from specialised GPs and 30% from regular

GP practices (Cobra Study, 2004). About 2700 physicians (GPs) are involved in the provision of OST although about 7000 physicians are certified for the provision of OST. Some of the reasons mentioned for the reluctance of certified GPs to engage into the provision of OST is the fear of losing large parts of their other clientele, conflict between legislation and medical decisions for the patient, avoid 'difficult' patients in their practice and the payment for treating opioid dependent clients is too small for encouraging doctors to engage in this type of treatment. counselling and psychosocial support for OST clients is mandatory but health insurance only covers the pharmacological treatment and not the counselling which can create a barrier for the client and reduces optimal treatment provision. Also, practices with more than 50 OST clients have to have a counsellor integrated in the GP practice, but here again; the costs of this counsellor are not covered. Other barriers and issues in Germany are for example divergent national coverage of OST with clients having to travel everyday about 60km to access the nearest GP practice providing OST; decrease in interest for OST among new generations of GPs, lack of interest in drug addiction and care for drug dependent individuals from other relevant specialists (infections specialists, psychiatrists, etc), the negative perception of substitution treatment among the population, decision makers and some professionals, heavy and complex regulatory measures.

- **'The British Model'** (LH) – In 2002, a plan was set to further involve GPs in the provision of OST. Aims of this plan: to establish a multi-agency party to develop a training package / substance misuse certification scheme; to encourage wide participation; to de-mystify working with drug users; to promote good standards of care; to mainstream the treatment as part of the other many of long term treatments and managements. In 1999, the department of health published the 'orange book' (UK clinical guidelines) which was provided to every GP and a sizable investment has been made to train GPs in the provision of OST treatment. Different types of certifications have been established depending on the level of training. For example, E-learning courses with a one-day face to face training plus information packages trains the GP to work in a shared care arrangement with the specialist system. Further training (9-day training) specialises the GP in their field. In 1999, only 3% of GPs were involved while in 2005, it was estimated that 31% of GPs were prescribing OST. GPs' core contract requires them to deliver basic harm reduction and manage other comorbidities. If they choose to provide OST, additional remuneration and incentive payments for this additional service. Current challenges: widening the already existing multidisciplinary team operating from the GP practice, measurement of benefits (improved wound care, reduced DVTs, HCV treatment, etc leading to cost savings), payments / incentives to GPs, lack of interest from younger GPs.

- **'Experiences and issues in the management of drug, health and social co-morbidities among clients in opioid substitution treatment with GPs – Croatia'** (VC) – More than 50% of GPs have clients in OST. GPs get specialised support and education from experts and are allowed to prescribe OST only after indication from psychiatrists in a treatment centre. Overall, addiction is considered and treated as a chronic disease. GPs supervise, follow-up and monitor, on a daily basis, the overall health status of clients in OST, in a shared-care strategy. Barrier: part of GPs do not follow national guidelines. Current challenges: payment scheme to GPs; education to GPs and nurses.

- **'Opioid maintenance therapy – research issues'** (MS) – Several research findings were presented and discussed regarding pharmacological therapies for substance misuse and related disorders (e.g. Connock et al, 2007; Kamien, Branstetter & Amass, 2008;), as well as the 12-month OST outcomes of the PREMOS study, which also included OST provided by GPs with focus on the following indicators: retention in treatment, ASI scores, psychiatric morbidity, mortality risk, causes of death.

Topics raised during the morning thematic session

- GPs as potential **"gate-keepers"**?
- **Ageing clients**, leading to an increase of drug-related complications AND ageing GPs, challenging new generations of GPs to get involved with OST
- The importance of **training / supervising / supporting GPs** in the **provision of OST**
- Decision making based on **clinical vs. political** concerns. Also, effectiveness of treatment is affected by the funding schemes of treatment, not only OST. For example, health insurance may cover the costs for 8mg of buprenorphine only (e.g. in Hungary) and may result in under-dosing and thereby affect effectiveness.
- How should **polydrug use / comorbidity** be addressed? A number of GPs in different countries have specialised in OST alongside the management of comorbidities (BBV). Also guidelines for comorbidities exist, but implementation and usage is still a big challenge. Also, in the UK and Croatia, training which includes the management of comorbidities is provided to GPs. But also effective referral mechanisms, back up and collaboration with other professionals is crucial.
- **Counselling / psychosocial support** is recommended but constrained by **limited funding** opportunities.
- The **shift of therapeutic success indicators**: abstinence vs. psycho-social-health improvement (e.g. being engaged in OST and other treatments, employment). Success indicators vary between countries and over time.
- **Limited funding for long-term OST and acceptability of long-term OST by different stakeholders:** opiate addiction as a chronic disease that can be treated but may not be cured?
- **Financial incentives / payment schemes to GPs** providing OST vary between countries. The examples of some countries were discussed: in the UK and Croatia, each GP is paid a certain amount of money per patient / per year (capitalisation regimen), e.g. in the UK the payment that a GP receives for providing shared care is on average 150 pounds per patient per year (on top of the basic salary); in Germany, GPs receive per each contact (a flat rate, not on top of basic salary but is part of the salary) with the client in OST but is not given any incentives for unsupervised OST prescribing (take home). Problems mentioned with the latter system are that some doctors will be reluctant to prescribe take home doses in order to maintain the patient within the practice and get the payment for that contact. In Vienna, 75% of clients in OST are prescribed by GPs which receive 21 euros per contact with a limit of 10 contacts every 3 months. This is paid by the general health insurance.

Afternoon Thematic Session: **'Experiences and issues regarding access to opioid substitution treatment through GPs and risk of diversion and misuse of opioid substitution medications'** (chairs

Alessandro Pirona, Tiphaine Canarelli -TC). The afternoon session comprised of five communications was followed by a joint discussion, similarly to what occurred during the morning period. Four professionals representing Austria (Dr. Hans Haltmayer - HH), Czech Republic (Vlastimil Necas - VN, Dr Jakub Minarik - JM), Norway (Dr Thomas Clausen – TCl) and France (Dr Claude Magnin -CM) presented their national experiences in the provision of OST, in addition to the presentation of a research project conducted in France (TC). A summary of the communications and discussed topics is given in the following paragraphs.

- **'Oral substitution treatment in Austria – the role of GPs'** (HH) – The Austrian framework for OST provision varies between regions, from e.g. Vienna, where GPs may initiate OST (in this region, 75% of OST is covered by GPs) to regions where OST can only be initiated by specialised centres (e.g. Upper Austria) or by specialised centres and specialised GPs (e.g. Styria). In terms of training provided to GPs, there are two licensing schemes in Austria: 1) license to start / change dosage and type of medication and 2) license only for maintaining OST. Benefits of OST in GP practice: early / rapid access to OST; high coverage rate; opportunity for basic treatment and examination. Barriers: suboptimal treatment of patients; lack of psychiatric back up; diversion of medications; overprescription of benzodiazepines.

- **'Substitution treatment in the Czech Republic'** (VN, JM) – In Czech Republic, under the Act Prevention of Harms Cause by Tobacco, Alcohol and Other Addictive Substances (379/2005), all medical doctors are allowed to prescribe methadone or buprenorphine and are obliged to report it to the ST National Register. The guidelines by the MoH define two different forms of OST: "basic ST", provided by GPs in addition to a contract with an external therapist and "complex ST", specialised treatment centres with psychotherapy included. Strengths: OST widely accessible; 3 medications available; existence of professional standards for OST; GPs allowed to prescribe. Weaknesses: high risk of diversion, unlimited prescriptions; low law enforcement; computer literacy of GPs, affordability of OST medication for the patient seen by GPs.

- **'European exchange on the practice and current issues in opioid substitution treatment in GP settings – The Norwegian experience'** (TCl) – In Norway, 65% of OST is currently prescribed by GPs after induction and stabilisation of treatment in a specialized OMT centre. In the Norwegian setting there is a three-party collaboration between OMT centres (specialist health services), GPs and social welfare offices. According to a recent survey conducted with GPs, this collaboration scheme is appreciated by the majority; GPs feel that handling complex challenges posed by OMT patients are best covered by this three-party scheme. Concerns: OMT patients in GPs settings may be time-consuming and risk of diversion of take-home prescribed doses.

- **'Primary care medicine and substitution treatments in opiate dependency – the French experience'** (CM) – In France, maintenance prescriptions with methadone are allowed within GP settings after initiation by a specialist care centre, while maintenance initiation and provision with buprenorphine is allowed by any GP. GPs in France do not receive general trainingregarding this specific treatment. Overall, the prescription of buprenorphine is considered to be more flexible than methadone and its positive impact within GP practices has been acknowledged: e.g. reduction in the number of overdoses, increase in the number of entries in the care process. Barriers: lack of training to GPs; inexistence of evaluation / monitoring of practices and patient outcomes;

heterogeneous practices between GPs; insufficient psychiatric / psychological support to clients. Current challenges: encouragement of linkages between GPs / patients / pharmacies; development of guidelines for treatment provision; accreditation system for OST prescribers.

- **'Opioid substitution treatments through general practice in France: a French study based on reimbursement data'** (TC) – This communication aimed to discuss the situation of OST in France, the frameworks for OST prescribing and the impact which OST has had in the last 15 years (e.g. reduction in the number of drug-related deaths; cost savings; improvement of social conditions), as well as its limitations, namely, heterogeneous access to treatment and misuse / diversion of prescribed medications. The trafficking / misuse of buprenorphine has been declining since 2006, nevertheless, different measures are adopted in such situations (according to seriousness level): patients 1) receive information letters stating that reimbursement of medications may be suspended, 2) may be convoked in order to establish a medical protocol and 3) a complaint may be registered against the misusing patient; staff members 1) physicians and pharmacists receive information letters about the misusing situation, 2) sanctions of medical and pharmaceutical associations may occur and 3) complaints against health professionals involved in trafficking may be registered.

Topics raised during the afternoon thematic session

- The **mutual influence of countries regarding policies, regulations and market supply**. The example of Finland and France was discussed, namely, how the widespread of buprenorphine prescription within the French territory may have affected the misuse of this medication in Finland.
- The **lack of professionals with a background in psychiatry / psychology in the provision of OST**. Reasons for this were discussed, for instance, lack of willingness / interest among these professionals about OST.
- The policies regarding **funding for treatment / reimbursement** of clinical expenses may **limit the access to OST**, similarly to other factors previously discussed (e.g. dissimilarity of geographical coverage).
- **OST provision to clients enrolled for treatment in foreign countries** (e.g. short-term immigrants, tourists). In this matter, the reality of some countries was discussed, for instance: in Austria, overall, any tourist / foreigner prescribed with OST is provided with the medication but must pay and get reimbursement from his country of origin (methadone might be occasionally provided free of charge); in the UK and Cyprus, OST is provided free of charge to all tourists / foreigners (in the UK, a temporary registration with a local GP is also encouraged).
- **Registration of OST clients into local / national databases**: how to manage data collection in this context (e.g. length of forms, time)? With whom should information be shared and for what purpose? How should data protection be assured? The cases of Croatia, Czech Republic, Austria and Germany were discussed. In Croatia, there is a national database which is updated on a daily basis; in Austria, there is also a computerised registration system containing data about initiation / ending of OST per each enrolled client, avoiding situations of e.g. double prescription. The examples of Czech Republic and Germany are dissimilar to those, since in the former the reporting of information by GPs is not always performed and in the latter, even though GPs are obliged to

systematically collect data about their clients, this information is of very limited access e.g. to national agencies and therefore potentially underused.

3) Conclusion:

The meeting constituted an opportunity for European scientists, experts and GPs to exchange experiences regarding the provision of OST in primary care settings. The main goal for this meeting was, therefore, to stimulate and develop a common European-wide platform of knowledge about the regulations, practices and challenges faced by GPs in the provision of OST to problem opioid users. Overall, the data and the professional experiences presented by the GPs provided grounds for discussion:

- The experiences of GPs in OST provision
- The guidelines / professional standards of GPs involvement with OST
- OST training / educational programmes for GPs
- Collaboration between GPs and other professionals (e.g. psychiatrists) and services (e.g. pharmacies)
- OST prescribed by GPs within Europe: similarities / differences in political and clinical frameworks between countries
- The management of complexities associated with OST: e.g. comorbidity, polydrug misuse, diversion of medications, ageing population, health tourism
- Concerns surrounding the registration, management and usage of information regarding OST clients (e.g. time-consuming task for GPs? confidentially of data? level of accessibility?)
- Financial incentives and payment schemes for GPs providing OST

It is the aim of EMCDDA, with the collaboration of National Focal Points, to promote and expand this initiative into regular meetings gathering European professionals involved in the treatment of problem drug users in General Practices. Ultimately, these joint discussions would potentially improve the knowledge about OST provision across Europe, stimulating a cooperative network of professionals working in this field.

All presentations of the meeting are available online at
http://www.emcdda.europa.eu/html.cfm/index2062EN.html

EMCDDA, November of 2010