6.7 Outcomes from GP methadone maintenance in Britain match those from specialist clinics

Findings In Liverpool outcomes were similar after opiate addiction treatment at a drug dependence clinic and at a primary care practice supported by the clinic through a 'shared care' scheme.

Case notes from 36 patients who had entered methadone maintenance at the practice were compared with those of 89 from the local clinic. Outcomes were assessed at least nine months after treatment entry. There were no significant differences in the proportion of 'good' (56% primary care, 52% clinic) or 'bad' (33% and 40%) outcomes. Good outcomes consisted almost entirely of patients retained in treatment; bad were mainly primary care patients imprisoned (25%) and clinic patients who had dropped out of contact (20%). Over the initial nine months retention did not significantly differ. However, half the patients could be tracked for 20 months, when retention was significantly higher in primary care (69% versus 37%) and remained so when adjusted for differences between patients. Taking the same differences into account, primary care patients were six or seven times more likely to have been immunised or be immune against hepatitis B or tested for hepatitis C. The drug use profiles of the groups were similar, but the clinic saw many more pregnant women and female sex workers.

In context The study compares the clinic not against primary care as such, but against a *collaboration* between the clinic and primary care, with the clinic providing assessment, psychosocial care and referral options. Given this support, it reinforces limited evidence that primary care can deliver comparable outcomes to addiction clinics with in many ways similar patients. As in previous studies, outcomes might have been affected by remaining differences in the patients. Low average doses of methadone in both settings may have contributed to drop-out and continuing criminality.

LINKS Nuggets 5.9 2.9

UK evidence is that primary care can deliver reasonable or good retention and large reductions in opiate use, risk of viral transmission, crime and criminal justice involvement. However, nearly all the studies have involved GPs who specialise in addiction and/or receive support though shared care schemes. Shared care can help overcome GPs' concerns about treating addicts and addicts' concerns about the attitudes and competence of GPs, raise the quality of local practice, engage large numbers of GPs in addiction treatment, and facilitate the transfer of patients between primary and specialist care, helping to free specialist care for the most demanding cases. The result is increased access to treatment. But in most areas shared care has not been implemented or only poorly.

Practice implications Well run shared care schemes providing long-term methadone treatments create health and crime reduction benefits likely to match those from addiction clinics. However, this type of comparison suggests a competitive relationship between the two; current policy sees it rather as complementary. The issues are how to generate shared care and what constitutes a well run scheme.

Shared care is among the priorities for central funding of £50m over three years from 1999/2000 and is being strongly promoted by government supported by professional bodies, driven by the realisation that specialist clinics cannot expand sufficiently to meet national targets for drug users in treatment. A cadre of accredited GP specialists with their own national network will soon be created far greater in number than specialist consultants. New regulations have made it easier for health funders to pay GPs for addict patients

Shared care is complex with many potential failure points. Features of successful schemes include a sense of ownership by the primary care sector, support from drug clinics in the form of assessment and stabilisation and taking on complex cases, structured training, close links with specialist services and pharmacists, detailed practice guidance, and agreements on standards, who does what, and on how this will be monitored. In turn such schemes free up specialist addiction clinics, enabling them to play their part in shared care.

Featured studies Lewis D, *et al*. "General practice or drug clinic for methadone maintenance? A controlled comparison of treatment outcomes." *International Journal of Drug Policy*: 2001, 12, p. 81–89. Copies: apply DrugScope.

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