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Tensions and changes in the substitution practices in the community

Monitoring drug-using patients in general medicine - Qualitative approach

This study constitutes the qualitative part of an evaluation work set up at the end of 1996 by a group of general practitioners who had already monitored the progress of drug users before the substitution regulations (1995-1996). The first phase of this evaluation system was quantitative in nature. It was carried out between 1996 and 1998. Its second phase, presented here, was carried out in 1999. Its objective was the qualitative evaluation of doctor/patient relationships built up around the issuing of substitution drugs (high dose buprenorphine, methadone, morphine sulphates).

The objective was, on the one hand, to put these relationships into perspective within the broader context of their legal and social environment; on the other, to analyse the concrete details of the "care" and the treatments, together with the intentions and arguments justifying the practices, as they emerge at least from talking to the patients and doctors.

The material consists of around twenty semi-directive interviews carried out with fourteen patients, then with their doctors (seven of them were met). The same topics were tackled point by point with the patients then with the doctors. The content of the interviews was then cross-referred.
Out of the 14 patients encountered, 7 were being treated with buprenorphine at the time of the interview, 3 were on Moscontin®, 2 on methadone, and 2 had withdrawn themselves from methadone after one course of treatment (of two years for one of them, of nine months for the other). Their treatment had started between two and four years earlier (with the exception of one person, who had begun his treatment one and a half months before the interview). More than half (8 people) had begun their treatment before the change in the regulations.
These patients were recruited from among the clients of doctors who were relatively experienced in monitoring the progress of drug users. Consequently, the group of doctors and patients encountered presents particular characteristics: the patients may appear to be more "stable" than the average, and the doctors more motivated or committed than other general practitioners. However, even in this case, difficulties can be observed in agreeing on the same objectives. These difficulties reveal the complexity of the relationships entered into around substitution treatments, and without doubt suggest even more difficult relationships, in the most common situations.

From this series of interviews there may emerge elements of reflection involving the uses of substitution treatments and the practical logics which underpin them in this particular context of two-fold care, care of the body and care of the use of psychotropic drugs, which general medicine proposes.

"Substitution" does not exist

Caring for drug users through the system of issuing substitution drugs "in the community" brings complex relationships into play, intermingling three types of logics or determinations:
- The public health objectives of the health authorities;
- A medical logic of accommodating and monitoring drug users;
- Logics derived from cultures of non-medical use of psychotropic products, which can, on occasions, lead to the use of substitution drugs within objectives concerned with "tripping" or managing illegal use.

As a result, the treatments usually have disparate objectives, for the patients and for the doctors. To such an extent that it can be said that "substitution" does not exist, in the sense that it constitutes a therapeutic strategy of clear and unambiguous objectives. Or again that substitution only exists such as the protagonists (re)design or (re)construct it each time they confront it. Each of

them, in fact, approaches it not only from his or her own culture, but also through the interaction of tensions which to varying degrees are contradictory.

To begin with, the official philosophy of substitution imposes its determinations. Not only does it designate official objectives for the treatments; it also proposes pharmaceutical tools and a prescription framework which corresponds to its principles of controlling and curbing illegal practices. But it remains pierced with unresolved tensions between "substitution" objectives and "maintenance" objectives. It is split between resorting to pharmaceutical products and mobilising medical, psychological and social support. Finally, it is still unsure as to the range of products authorised for prescription for substitution purposes.

The doctors, for their part, are subject to three series of tensions.
Firstly, some struggle to rebuild a carer position based on what is asked of them: issuing substitution opiates. The objectives are often perceived as falling more within the social arena than the medical arena. Moreover, they have very restricted room for manœuvre, since the choice of prescriptions remains extremely limited.
On the other hand, the objectives concerned with medical care of the drug users remain divided between two philosophies for approaching the problem. The one is aimed at a reduction in the health and social risks linked to the use of drugs, the other at a strategy of care for the drug addict.
Finally, the two-fold activity of controlling use and caring for the patients sometimes leads to conflicts which are perceived as insoluble (should one sanction parallel use at the risk of seeing patients disappear in a worse state of health, or tolerate the maintenance of illegal practices at the risk of seeing a degradation in their social situation in particular?), as does the contradiction between simultaneously adopting both the "macro" public health point of view and the "micro" scale of the individual problems.

In short, the patients carry different demands which the doctors often have difficulty in identifying: the desire to stop using drugs assumes varying meanings from one person to another.
Nearly all the patients have already had experience of substitution drugs. They have often used all sorts of drugs, in particular opiates, to alleviate craving pains, to arrange breaks in their use, to "kick their habit" temporarily, to reduce their expenditure or, sometimes, to "get high". As long-standing habitués of automedication, they have knowledge of using substitution drugs which will interfere, sometimes on a long-term basis, with the "therapeutic" use strategies proposed to them by their doctors.
It is in this context that "treatment" strategies must be constructed or negotiated, like so many processes for switching from one logic of product use to another.

The inventions of substitutions

If one believes the testimonies of the fourteen patients encountered here, none of them initially came in search of a "substitution treatment": some were looking for a doctor to sort out somatic problems, others wanted a product to help them "come off drugs", but none of them, strictly speaking, were looking for treatment for their "drug addiction" problems or treatment which would allow them to be free of drugs.
Consequently, nothing appears fixed at the beginning: neither the treatment objective nor the treatment strategy, nor even the medical nature of the relationship entered into around the substitution drugs.
Moreover, the in-depth research into the details of setting up treatments reveals that the impetus is, in effect, provided by the patient. In nearly all cases, in fact, it is the patient himself who chooses his treatment – according to the issuing conditions offered to him and the pharmacological efficacy he attributes to the products. Ignorance of the doses of heroin actually consumed before the start of the treatment, moreover, usually leads to him being entrusted with determining the original dosages, through a process of gradual adjustment of the doses which the doctor himself cannot appreciate.
Unbalanced at the start, the doctor/patient relationship is restored, when it succeeds in doing so, through gradual correction of the situation, with the doctor endeavouring to make the progressive adjustments which, throughout the treatment, will enable logics of automedication or of non-medical use of psychoactive substances to be converted into therapeutic logics. In the negotiation, doctors and patients will strive to adjust their respective expectations and worlds. Sometimes for the benefit of a medical logic, sometimes for the benefit of a user logic, they will continuously reinvent substitution or rather the practices of substitution.
The detail of these negotiations is observed from three angles.

The dosage angle. The investigation here reveals a codification which is in progress but unfinished. The evaluation of the initial dosages seems to comply, at least for this group of doctors, with a more or less stabilised, although extremely precarious, technique. On the other hand, the problem of evolving the treatments is far from being resolved, or even confronted. The doctors often resist the idea of reducing the dosages, out of fear of destabilising and compromising the treatment. The patients sometimes resign themselves to a *status quo* which to varying degrees is difficult to accept, and sometimes take the initiative of a reduction by themselves, with variable results. A significant uncertainty remains over the issue of treatment. The moment of withdrawal from substitution drugs seems, essentially, to be still ignored.
The dose rate angle. According to the doctors, the deconditioning of the "drug addict" behaviour is what is at stake in taking doses regularly. The objective is to encourage the patients to abandon consumption habits which are often closely linked to the management of their emotions or to the ups and downs of daily life. This involves playing on the "long-term" effects of the substitution drugs in order to avoid an increase in the number of doses. However, this behavioural concern sometimes has a tendency to overlook the side effects of the treatments and strategies implemented by the patients in order to bypass them.
The angle of parallel uses and indirect uses of substitution drugs. These "transgressions" of the treatment rules seem to be the norm in the doctor/patient relationship. Apparent here is the objective deprivation of the community doctors who are usually forced to defer to the words of their patients in order to appreciate the situation. But this situation also highlights their attitude of relative tolerance, as long as the treatment seems to them to be balanced overall. Sometimes even, on the margins, the doctors who are most experienced in monitoring drug users invent methods of intervention, allowing themselves to take advice on managing these parallel uses. Their perspective is that of a "reduction in risks" which is gradually forced to acknowledge the persistence of "tripping" uses alongside the treatment.

Conclusion

The evaluation of the substitution programmes poses various problems. The principal one lies perhaps in the absence of a definition of the notions of "failure" or "success" of the treatments. Some carers or political or social players are in fact preoccupied first and foremost with insertion into the care system, others with reducing the health and social risks linked to the use of drugs, others again with controlling practices or suppressing illegal use.
The specialist centres (CSST) (drug addiction treatment centres) take up the challenge of playing on the complementary nature of the pharmacological, psychological and social treatments of drug addiction. The dispensing of substitution drugs "in the community", for its part, plays on the two-fold plan of treating both somatic problems and "drug addiction". Consequently, the issuing of substitution drugs by general practitioners must be evaluated according to these two criteria. This must also be done given the alternative it offers to issuing in a specialist centre. Access to the specialist centres is in fact restricted, both by a limited capacity for accommodation and by the conditions imposed on issuing the products, and by a not insignificant proportion of drug users deemed too strict to have recourse to this.
The detailed examination of the practices of a small group of relatively motivated and experienced general practitioners – particularly through the appreciation shown by their patients for the monitoring they receive – reveals the complexity of the relationships entered into between doctors and patients around substitution drugs are numerous interferences, with the social and legal environment of these therapeutic relationships: the weight of the regulatory constraints surrounding the prescription process, interferences sometimes with the legal system (in the event of a therapeutic injunction, for example), the evolution of the black market and "tripping" practices, can rarely be disregarded.
However, under the pressure of this environment, new methods of monitoring and intervention seem to be invented continuously.
With the combination of their medical expertise and their experience in monitoring drug users, some doctors today seem to evoke something which may well constitute a third generation of substitution: after the "risk reduction" of the pioneers, then the "care for drug addiction" designed by the regulations in 1995-96, comes a medicine for bodies under the effect of psychotropic drugs .

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For further information

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Psychotropic drugs and dependence:

User profiles and behaviour patterns

There are numerous determining factors in the use of psychotropic drugs. Therefore, to broach this topic on the social uses of the users, we have favoured an approach which links researchers in different fields (sociology, public health, epidemiology) and uses complementary research methods. This collaboration has enabled us to describe the practices of use and to explore the attitudes with regard to both psychotropic drugs and the dependence they engender.
Part 1 confirms the major factors associated with the use of psychotropic drugs, the predominance of use by women, the role of socio-professional factors in men and medical factors in women, and this in a population of volunteers (belonging to the Su.Vi.Max cohort) who are mindful of their health and consequently not representative of the French population.
Part 2 highlights 2 types of pattern, occasional and continuous - 53% (149) of the users have a continuous pattern (TC), in other words they have used at least one psychotropic drug every month for 5 years. Of these, more than two thirds have taken them every day.
Part 3 shows that the attitudes of users towards psychotropic drugs and dependence cannot be differentiated on the basis of their socio-demographic characteristics (gender, professional activities), but according to the duration and regularity with which they take them. This observation leads us to pose two hypotheses. The first, methodological, concerns the relative homogeneity of our sample which may explain the low degree of spread in the variations observed. The second, more sociological, concerns the period when one is in one's fifties which, packed with life events (divorce, children leaving home, increasing responsibility at work, retirement, etc.) would harmonise the social conduct of men and women towards this drug and the dependence it can generate, and this all the more so since these individuals themselves, as users, have experience of use.
Psychotropic drugs procure well-being while containing a risk of dependence. There is consensus on help to live better, but also on the wish to live without this help. In the attitudes stated with regard to psychotropic drugs and dependence, two major ideas prevail.
The first evokes the users' submission to psychotropic drugs which is associated with the desire to be better. They perceive their attachment to these drugs, but affirm that they would like to be able to manage without them, but one in two do not do so because their use follows a continuous pattern. The increase in the use of psychotropic drugs would be dependent on this quest for "super-health". But the users remain divided over the fact that: "taking these drugs means being ill"; uncertainty about the status of the illness is aroused.
The second places the role of the doctor and the drug back into a relationship which above all tries to be therapeutic. The medical establishment occupies a position of guarantor, the doctor is the legal prescriber of this use. The public's trust in medicine in general would reinforce the widespread nature of this use.
Part 4 confirms the originality of this approach which is not focused on an occasional user status, but has considered a pattern of use, a combination between a period of time and a regularity of dose recorded here over a 5-year period; indications of a dependence behaviour. The users moreover are aware of it, the perceptions of their use (continuous or occasional) are for a large majority in keeping with their objectively defined patterns of a continuous or occasional type based on the records of use.
More than 50% of the users have a rather positive view of psychotropic drugs; of these, 75% "have rediscovered the joy of living". These results reaffirm the role of psychotropic drugs in the quest for a better quality of life. To justify their use, the continuous users assimilate their reasons to pathologies or to symptoms of a medical nature (in order of importance: depression, insomnia/sleep problems, stress, anxiety) which are already well described in the literature, and to the effects of dependence. They have a fatalistic view of their use of drugs: "desire to manage

without them or to reduce them, but it's a necessity". The occasional users liken their taking of psychotropic drugs to an occasional need (life events, problems with friends and family) which implies a limited duration; they are therefore in favour of "moderate use". There seems to be a *continuum* between the endogenous and exogenous reasons, between the etiopathological causes defined by the doctor and the life events evoked by the patient which often make it possible to justify continuing with a prescription.

The more favourable their experience of using psychotropic drugs has been, the more the users are tempted to continue using them, and this with a certain degree of medical justification. The discrepancies between the attitudes which surround the initial taking and the current reasons for the relapse or the reasons for perpetuating show the extent to which the problems have become medicalised. Today, even a recognised risk of dependence no longer proves to be a sufficient reason to bring about a halt in use.

Although the users, in particular the occasional users, recognise positive effects in psychotropic drugs, they do however find that the public holds a somewhat negative view of these drugs: their principal arguments are the dangers of dependence and the undesirable effects. These declarations corroborate those obtained in other European works undertaken in the general population.

More women than men emphasise the fatalistic attitude surrounding this use: "it's an obligation, a need", which agrees with the conclusions in the literature: the family circle contributes, in certain cases, to increasing the amount of psychotropic drugs being taken. They are said to use these drugs because the probability of them being in unrewarding family environments seems higher than for men and/or because they are more sensitive to the lack of family support.

"Not being able to manage without them, being incapable of living without them" is the definition of dependence, in particular for the women and the occasional users. The continuous users admit their dependence, emphasising "that they have the impression that they use them too much" and "that their family and friends make comments to them on this subject". Half of the users recognise that they are dependent. More than 8 out of 10 users with a continuous pattern perceive themselves as dependent, and, conversely, more than 8 out of 10 users with an occasional pattern do not declare themselves to be dependent. These findings put into context the notion that dependence remains difficult to accept, even if objectively the users cannot manage without drugs.

The principal prescriber is the general practitioner, in particular for the occasional users, followed by the psychiatrists; which confirms the known data: 85% of psychotropic drugs are prescribed by general practitioners, and only 11% by psychiatrists or neurologists. Automedication through family and friends remains marginal, including the first time the drug is taken. It has perhaps been underdeclared as the literature stresses, or else quite simply this generation has resorted to it to a lesser degree.

There are many users who find out about the side effects of psychotropic drugs; the information received has altered their behaviour "by encouraging a reduction in use" or "by strengthening the desire to stop". Nobody stressed the fact that they felt ill-informed or that they felt the need for information. The continuous users say that they do not ask for information because they have "faith in the doctor and the treatment". Is this faith called into question by the other users who do ask for information or rather is it the expression of the fact that this particular use is not widespread?

Speaking of their use, few do so "without difficulty". The individuals who do dare to talk about it say that it is "something normal", "that there is no reason to hide from it", because "it may serve as advice for others". We still need to find the right person! It is therefore to the close circle of family, friends and neighbours that they turn first of all. On the other hand, for those who do not talk about it, it is because "it's a private, personal subject" and "they don't find it interesting". For them, there is "a genuine difficulty in talking about it" because "it's a subject tainted with shame", "devaluing in their eyes". To recognise the use of psychotropic drugs is to reveal *in situ* psychic difficulties which have certain similarities with weakness.

Three types of attitude have been highlighted with regard to psychotropic drugs and dependence. In this, our results are close to those of a qualitative study carried out with 50 English users.

1st type of attitude. The continuous users have faith in the drug and the medical establishment. They believe in the positive impacts that the drugs can have on their quality of life and accept the dependence; force of habit is evident. Psychotropic drugs help them to feel well and to retain a joy of living and play a part in their stability.

2nd type of attitude. The continuous users recognise the therapeutic efficacy of psychotropic drugs. They put into context the positive impacts that the drugs can have on their life and their health. They are aware of the side effects, the dependence. Their strategy of acceptance is formalised by favourable attitudes towards automedication in order to make an attempt at control. They feel obliged to take psychotropic drugs in order to face up to suffering and events. They use these drugs for other people, to preserve or maintain social cohesion.

3rd type of attitude. The occasional users have a more homogeneous attitude. They deny that they are dependent and practice automedication in order to have control over their use. They admit that they are not able to manage without psychotropic drugs when faced with certain situations.
These factors should be useful to clinicians and health professionals. The strategies for prevention and health education might be able to emphasise the risks linked to:
- the habit rather than the dependences denied by the occasional users and accepted by the continuous users;
- the side effects which are often neglected in the practices of adaptation or autonomy.
The importance assumed today by the medical response through the prescribing of psychotropic drugs is probably a combination of:
- an increase in psychological problems;
- a lowering of the tolerance threshold: doctors faced with the complaints of patients and/or patients faced with what they term the necessities of life.
What is worrying is that the use of psychotropic drugs is considered by the users as all the more legitimate since it leads to the remedying of moderate or major shortcomings in the functioning of the individual in the exercise of his family and business roles or in his ability to face up to life events. In fact, the quest for a better quality of life would appeal to the user of psychotropic drugs in his role as a player in his health and a joint manager of his care. "Non-compliance through excess" (increase in doses) and changes in treatment would not therefore be obstacles to medical decisions but quite simply acts of autonomy which reveal a participation in the management of well-being, a profile of individual who sets the well-being bar high or who develops a low capacity for adaptation.
These practices are more in keeping with the concern to "take better control of one's health and therefore one's well-being" than with that of defiance towards medicine. Moreover the context here seems favourable since the attitude of prevention and health education emphasises the fact that the doctor is not the only person responsible and that the contribution of the users/laymen must be increasingly sought. This paradox would probably be the instigator of new social behaviours.

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For further information
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