Buprenorphine substitution treatment in France: Drug users' views of the doctor-user relationship.

Anne Guichard, France Lert, Jean-Marc Brodeur, Lucie Richard

To cite this version:

Anne Guichard, France Lert, Jean-Marc Brodeur, Lucie Richard. Buprenorphine substitution treatment in France: Drug users' views of the doctor-user relationship.. Social Science and Medicine, 2007, 64 (12), pp.2578-93. 10.1016/j.socscimed.2007.02.049 . inserm-00142914

HAL Id: inserm-00142914
https://inserm.hal.science/inserm-00142914

Submitted on 23 Apr 2007

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

HAL author manuscript

Soc Sci Med 06/2007; 64(12): 2578-93

HAL author manuscript inserm-00142914, version 1

BUPRENORPHINE DRUG MAINTENANCE TREATMENT IN FRANCE:

DRUG USERS' VIEWS OF THE DOCTOR-USER RELATIONSHIP

Key words: drug use, drug maintenance treatment, buprenorphine, doctor-user relationship, drug users' views, France.

HAL author manuscript inserm-00142914, version 1

Abstract:

The French system for drug substitution, or maintenance treatment, established in 1996, differs from the often strict conditions attached to methadone clinics in other countries. Because of the predominant role of general practitioners and the flexible prescription rules for Subutex® in France, the relationship between the physician and the drug user becomes a central element in the treatment. This article deals with the expectations that these users have of the physician, and their perception of his or her attitude towards them. In order to identify possible reasons for the absence of treatment compliance and of Subutex® misuse, it focuses on the users' assessment of the physician's response to the problems they report.

This study, based on a diversified sample of 28 persons in treatment, showed 4 patterns of relationships between physicians and users, which differed in their focus: a) dosage, b) compliance, c) the person and d) obtaining a prescription. In all four case types, users had difficulty reporting other drug use or intravenous Subutex® injection within this relationship in which the stigma attached to drug dependence seems to reappear. Moreover, the lack of clarity about the treatment objectives and time frame limits the users' ability to integrate the treatment into their lives and to commit themselves to it. The heterogeneity and fragility of the users' situations are elements related to dependence that, during contact with the physician, require regular assessment of the individual's situation and of the treatment objectives. This constant reappraisal of the situation with the physician should help to optimize the treatment and avoid the hiatus that can generate or continue "misuse."

HAL author manuscript inserm-00142914, version 1

1- Backgrounds

In France, the development of drug substitution treatments for opiate users was late in coming (1995), and was part of the implementation of the risk reduction strategy adopted in 1993. As in other countries, this transformation of the health policy for drug users came about in connection with the HIV epidemic among drug users in France, in which heroin was the main product used, mainly by injection. The adoption of these treatments was a radical change in the care of drug users, which had previously been based on a drug-free, psycho-educational analytical approach. However, The French system for drug maintenance treatment (DMT) differs from the often strict system for methadone clinics in other countries where such treatment has long existed.

From 1971 to 1993, there was only capacity for 50 individuals available for methadone maintenance in two hospitals in Paris. In 1994, the first 1000 places open in drug clinics took a long time to be assigned because of resistance from the specialized services, even though general practitioners (GPs) in big cities received numerous requests and prescribed drugs illegally. In 1995, Subutex® (trade name for high doses of buprenorphine) was put on the market.

Buprenorphine and methadone have common regulations regarding special prescription forms but differ on key aspects: methadone treatment is initiated only in drug maintenance clinics (DMCs) or hospital-based clinics with the possibility of transferring to family practice after stabilization, while any GP in family practice is allowed to prescribe Subutex®. Maximum prescription length is 14 days for methadone and 28 days for Subutex® with divided dose dispensing at a community pharmacy for 7 days unless the prescribing physician allows longer periods. Methadone treatment in a DMC is free. Subutex®, prescribed in the community or in a DMC, is purchased in a pharmacy and refunded

HAL author manuscript inserm-00142914, version 1

according to classic methods for prescription cost coverage (third party paying all or part, very often possible).

Compared to methadone, the buprenorphine regimen can be seen as being relatively flexible, considering the following: it can be prescribed by any GP without approval; no notification to health officials for users undergoing substitution treatment; the duration of the prescription; the non-supervision of administration of the substance; the absence of biological testing for uses of other substances (heroin, cocaine, benzodiazepines, etc.). Thus Subutex® is accessible from general practitioners' offices and in DMCs. DMCs also have GPs who prescribe Subutex®. In general practitioners' offices, a small number of doctors (10% of GPs) prescribe to the majority of users (75% of users undergoing treatment), which leads to a defacto specialisation (Feroni et al., 2004). However, in all cases, treatment is delivered in the pharmacy with no direct supervision, and with the prescriptions renewed on average every three weeks, so that the users followed in the DMCs maintain quasi exclusive contact with the prescribing doctor (Guichard, Calderon, Maguet, & Lert, 2004). Although they are referred, a very small proportion of users seek a psycho-social follow-up from the DMC staff and even when obtained, sessions are infrequent. Thus, there appears to be little difference in the actual conditions for DMT Subutex® treatment, whether they are office-based or in DMCs (Aides-Inserm., 2001).

Thus, the dominant role of general practitioners and the adaptable rules for prescribing and dispensing Subutex®[1] (prescription for up to 28 days, no urine tests, users take prescription at home, no recording) in France allow the user substantial autonomy. The reasons for adopting such a system are a combination of the urgency of the AIDS epidemic, the safety of buprenorphine compared to overdose risks, resistance from specialized professionals, demand

[1] Subutex® is manufactured as a tablet to be taken sublingually once a day. Three doses are available in France: 0.2 mg, 4 mg and 8 mg.

HAL author manuscript inserm-00142914, version 1

from GPs, a response to strong advocacy from AIDS NGOs, and pressure from People Living with Aids. Use of these treatments, principally Subutex®, by physicians in private practice grew quickly and continued over time, as shown by the number of physicians treating these users and the volume sold in pharmacies[2]. Subutex® has thus become the DMT of reference in France, with over 80,000[3] users under Subutex® treatment (vs. 15,000 for methadone).

After several years, this policy showed positive outcomes at both the community (indicators of deaths by overdose, arrests for use, heroin seizures) and individual (observational follow-up) levels (O.F.D.T., 2003, 2004). Stricter regulation followed the observation of abuses, including street sales of buprenorphine tablets and diverted use (including injection). Many questions about improving treatment organisation and outcomes remain unanswered. Clinical trials have shown the advantages and disadvantages of several of the drugs available for substitution treatment. Today's questions focus mainly on management, which varies according to how health care is organized in different countries. Ethnographic work in the United States, Australia, and Great Britain is studying the most vulnerable (socially, economically and otherwise) drug users receiving methadone treatment from DMCs that impose strict rules for dispensing, monitoring, and follow-up, with urine tests and a reward/punishment system. Drug users there appear to have little autonomy in such a sanction/reward system (Agar & Stephens, 1975; Bell, 1998; Beschner & Walters, 1985; Bourgois, 2000; Brown, Benn, & Jansen, 1975; Caplehorn & Bell, 1991; Fischer, Chin, Kuo, Kirst, & Vlahov, 2002; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985; Koester, Anderson, & Hoffer, 1999; Rosenbaum & Murphy, 1981).

[2] Data come from the French SIAMOIS database, which monitors monthly sales of sterile syringes and substitution treatments (high-dosage buprenorphine, methadone) to intravenous drug users. SIAMOIS also tracks the number of syringes distributed to groups and associations working with drug users and the quantity of methadone prescribed in drug dependence clinics.

[3] Source : SIAMOIS, Institut National de Veille sanitaire (InVS)

HAL author manuscript inserm-00142914, version 1

Until 1995, relations between doctors and users were extremely conflicted, even violent, in France (Lert, 2000). GPs were very reluctant to use opiates for drug users (Beck, 1998; Moatti, Souville, Escaffre, & Obadia, 1998). When substitution treatment was marketed, replacing a street drug with a "legal" one was a completely new experience for the user. As a result, the doctor-user interaction of an "ordinary" medical relationship had to be shaped for each of the protagonists. In France, successive surveys of the attitudes of physicians in private practice show that their attitudes towards maintenance treatments and drug users have improved over time (Moatti et al., 1998; O.F.D.T., 2003). Similarly, studies have focused on changes in the behaviour and social situation of drug users on maintenance treatment, but their perceptions of the attitudes of professionals and treatment delivery have not been considered. As in any long-term treatment, the efficacy of maintenance treatment depends on how it meets the expectations and needs of its users and on better knowledge of their experience and their understanding of the treatment (Adrian, 2002; Montagne, 2002). Studies show that the quality of the interactions between the user and the professional plays a major role in adherence to, and success of, drug maintenance treatments (Fischer et al., 2002; Lalande & Grelet, 1999; Lovejoy et al., 1995; Strang et al., 2005; Sullivan, Chawarski, O'Connor, Schottenfeld, & Fiellin, 2005).

The purpose of this exploratory study is to examine the doctor-user interactions from the user's point of view, and to elicit dominant patterns.

2- Methods

The material for this analysis comes from 28 drug users receiving Subutex® treatment, who were met with about three times over a 4-month period (i.e., 84 interviews), in 2000. The

HAL author manuscript inserm-00142914, version 1

study was conducted in the Île-de-France region, where 40% of the total Subutex® delivered volumes are concentrated. A convenience sample was recruited by diversifying the locations for investigation, a central area of inner Paris and a nearby suburban area, and in each area, the settings: DMCs and GPs' offices. These GPs were known to be committed to drug treatment and harm reduction, and had large caseloads. As Subutex® injection behaviour was known to be a frequent phenomenon among drug users taking Subutex®, a sub-sample of users was recruited from 2 needle exchange programmes (NEPs) located in the two search areas. The purpose was not to compare the treatment facilities or settings but to take into account the diversity of the population taking Subutex® treatment. In total, four doctors participated in the recruitment within the care structures. So as to take into account the length of the treatment period, the doctors were asked to put us in contact with users who had been obtaining prescriptions for more than six months and for less than three months. For those who had been in treatment for more than six months, physicians were asked to recruit both adherent and non-adherent users, that is, those viewed as complying with the treatment regimen (keeping appointments, continuity of treatment, exceptional extra requests for the supply of Subutex® and those who regularly missed appointments, asked for extra psychotropic prescriptions, and did not take their medication as prescribed. These criteria were given for information purposes in order to diversify the characteristics in the final sample. In the two NEPs (n=7), the only criterion was to obtain Subutex® on a medical prescription. These users were followed by 4 other doctors, different than those who participated in the recruitment, but known as well to be highly experienced with these treatments. We do not have any other information about them. Finally, the aim of the convenience sampling procedure was to obtain subjects with a diverse mix of social and demographic characteristics (sex, age, living alone or with a partner, employed or not). Users

HAL author manuscript inserm-00142914, version 1

clearly high at the initial contact and those with psychiatric disorders were not asked to participate.

The investigator informed the potential subjects at all sites: a) of their strict anonymity and the complete confidentiality of the interviews, especially in relation to their health care providers; b) of the study conditions and procedures, in particular, its voluntary nature and the plan for repeated interviews; c) that they could refuse subsequent interviews without consequences for their treatment and without giving a reason; and d) that participation would not be remunerated.

The interview outline was developed from ten exploratory interviews and from observations in two drug-treatment facilities. The interviews were planned as part of a more extensive study intended to illuminate various issues relating to the user's experience of the treatment and use of maintenance drugs. The interview thus investigated a variety of related topics, including: a) the conditions under which the user began Subutex® treatment (substance use history, previous treatment, other elements of history and lifestyle; b) aspects of management, medical follow-up, relationship with the physician (psychosocial management, dose prescribed, co-prescriptions, information received, timing and content of the consultations, satisfactory or unsatisfactory elements, needs and expectations, and difficulties in the doctor-user relationship); c) Subutex® use (dose prescribed, dose used, rhythm and mode of administration, other substances used, etc.); and d) lifestyle (housing, work situation, legal/administrative situation, family life or relationships, etc.). For most of the topics explored, users were asked to focus on the situation during the 3-4 months of the study. The interaction with the prescriber is referred to as a "usual" clinical interaction at the moment of the study as well. We chose not to interview the prescribing physician so as to lessen desirability bias in user discourse.

HAL author manuscript inserm-00142914, version 1

The methodology used was based on the phenomenological approach to in-depth interviews described by Seidman (1998), which uses a semi-directed interview technique repeated over time to gauge the experience and put it into context. This method was also used to establish a bond of trust over time and to facilitate discussion and lessen the formality often encountered during initial contacts with a user. In addition, repeating the interviews allowed sufficient information to be obtained for people who could not manage lengthy interviews. Thus, three interviews (lasting from 40 minutes to two hours) were conducted, the two first ones about 15 days apart and the third one three months later. Nearly all those interviewed had cellular telephones, which were extremely useful for organising the subsequent interviews over the next 4 months. The interviews took place outside the recruitment site, in premises chosen by the subject: parks, cafes, squats and, more rarely, their homes. All interviews were recorded and transcribed in full.

The 19 men and 9 women were aged 23 to 42 years (mean: 33 years). Half were working and living in stable housing. Most saw GPs (n=17, including users recruited in the needle exchange programmes). The duration of the treatment was 3 years and more for 19 users, 2 years for 8, and less than 1 year for a single user. Only two persons reported receiving mental health services at the same time the interviews were taking place. Almost all had a long history of heroin use, from 5 to 10 years for 12, and more than 15 years for 5. All but one (who had snorted) had injected it. The recent history (several months to 3 years) of three users included combinations of illegal and diverted drugs. At the time of the investigation, the main distinctive trait of the users recruited in the NEPs was injection with Subutex®. They were no different from the others in regard to illegal substances.

HAL author manuscript inserm-00142914, version 1

This article considers only the sections of the interviews related to treatment modalities, medical monitoring, and the users' relationships with their physicians during the 4-month study. They were analyzed following the *grounded theory* approach using a multi-step inductive procedure based on ATLAS TI software (Win 4.2). The development of concepts and their scope was based on textual analysis through coding of the material. The first step in the analysis consisted of classifying the information contained in the interviews into different categories of analysis (open coding). Certain codes also resulted from the review of the literature, that is to say they were created prior to the data collection and thus were immediately defined as concepts (secondary codes). On the whole however, this is partly field experience and partly work on the re-transcriptions to which they gave rise (primary codes). The successive coding steps were carried out through repetition to formulate and progressively refine the hypotheses on the relationships among the categories and between the categories and their properties (axial coding) and to apply discursive logic. The last step in the analysis consisted of eliciting the patterns illustrating the various relationships of the interviewees with their doctors.

3- Results

3-1- Four doctor-user patterns

Analysis of the discussions with the users interviewed provides 8 dimensions characterising the relationship with the physician, including the doctor's function relative to DMT, the relative positions of the two protagonists within the relationship, the prescription (product, dose, duration), the users' disclosure of "misuse" and the doctor's response, the perception by each user of the treatment plan, his or her self-image in relation to treatment and to the

HAL author manuscript inserm-00142914, version 1

physician, and the incongruities that can develop over time between doctor and user (see Table 1).

The role of the physician is described according to 4 functions: the function of prescriber, the classic function of paternalistic authoritarian, a true expert in drug dependence, and a white-coat dealer. When with the physician, the user feels he is in a position that we can describe, depending on the case, as purely utilitarian, dissymmetrical, participatory or being seen as manipulative and instrumental. The prescription for medication (the product itself, the dose, the duration) is, depending on the case, central to the relationship, even the sole subject of the medical consultation or perhaps considered as a therapeutic tool in the overall caretaking. In the absence of urine testing, the reporting of deviations from the prescription, the use of illegal drugs or injection practices is a very important issue in relations between the physician and the user. This reporting may in fact be avoided, whether for instrumental purposes, to preserve the quality of the relationship or due to concerns over sanctions. The user and the physician may co-construct the therapeutic plan by negotiating an agreement on the adjustments needed in the face of the difficulties encountered by the user; on the other hand, the user may feel passive in a plan defined by the physician alone and according to the latter's concept of substitution as maintenance for life or as a closely monitored treatment. The relationship established with the physician contributes greatly to the image that the user has of himself: the physician's behaviour may convey to the user that he is, depending on the case, a life-long junkie or a repentant junkie, or on the other hand may allow him to see himself as a whole person. The user who uses his physician as a dealer is placing himself in the position of a client. The relationship is put to the test throughout the long-term maintenance treatment, its indefinite term and the difficulties in communication. The user tends to keep his distance vis-à-vis the physician, thereby increasing the risk of isolation, interruption of treatment or feeling he is at an impasse with no way out.

HAL author manuscript inserm-00142914, version 1

From these four dimensions, 4 dominant doctor-user patterns of interaction were identified, corresponding to specific combinations of attitudes and characteristics of interaction for each dimension: Pattern 1) a relationship closely focused on the posology of the prescription; Pattern 2) a relationship in which compliance with the prescribed regimen is the main issue in a relationship dominated by the physician; Pattern 3) a relationship created as an alliance between the physician and the user who is acknowledged as a person; and Pattern 4) a relationship that is instrumental solely on the part of the user, who comes to procure a free, legal drug from a doctor's office. For a better understanding, these patterns are summarised in Table 1.

Insert Table 1

3-2- Relationship focused on dosage

After the initial phase, during which the appropriate dose is determined, the doctor focuses on medicine prescription only. Doctors were seen as passive and indifferent when users described their personal situations (social, administrative, legal, relationship problems), ill-health, and existential questions. The consultation is reduced to a courteous exchange of platitudes, concluding with the prescription.

Gregory (30, on Subutex® for 3 years)*: At the start, when we were looking for the best dose for me it went well even though I always had the impression that it was only the products that counted for him. But now, I really have the impression I bore him stiff with my stories, he doesn't give a damn about whether I am feeling well or not, the only thing that interests him is if I am happy with what he's giving me. The consultations are rushed, he gives me my prescription and then it's "Bye for now, Doc!"*

HAL author manuscript inserm-00142914, version 1

Any problem mentioned (continued drug use, life events, relationship problems, social difficulties) is interpreted and treated in terms of dosage adjustment, leading to increased doses. This attitude thwarts the controls users are trying in vain to impose on themselves. Dosage can thus become the focus of tension, with the user insistent on decreasing the dose prescribed while the physician leaves the option (and thus the daily decision) of reducing the daily dose up to the user himself. Disclosure of misuse (other drug use, extra Subutex® doses, injection, etc.) is encouraged and played down by the physician. Nonetheless, most users said they had stopped mentioning their lapses with Subutex® either because the response was to offer them a higher dose or because these difficulties did not receive the attention or response expected.

Elodie (29, on Subutex® for 2 years): *Before with Dr M—, I never went there just to get the paper. We talked, he was interested, asked me if I was doing better. He told me, 'The day you tell me you've touched the stuff, you'll hear from me.' So the other day, to see what he'd say, I told him, 'Yesterday, I did some heroin.' He's like, 'If it's only once, it'll be ok. Do you want to increase the dose?' No but what's that, you clown? He's good for what? He's a jerk!*

Users' questions about the ultimate goal of the treatment, starting to lower the dose or the time required before stopping, receive only vague answers, with the physician insisting on the need to continue with no timetable in view and with a stable dose. Users see in this an obstacle to creating plans for the future. In the end, they feel they are held captive by the medication and dependent on the prescriber.

HAL author manuscript inserm-00142914, version 1

***Sébastien (35, on Subutex® for 3 years)**: I go see him to get the treatment, not to be told nothing. When I tell him that in the long run I can't stand it, that it flips me out not to be able to see the end of the road, he doesn't help, he even says: 'if it bothers you, stop it.' He treats me like an idiot. Once I asked him about stopping, seeing if there wasn't something else, I'm at 2 mg. He says: 'No, it's better to continue with it.' Ok, and after? Hey, I'm not going to spend my whole life popping pills. I can't manage. I stopped something, I'm going to take something else, I still have to stop ...where am I going like that? Before, detox was in, now it's the fad to let you drag on through the system. This treatment, it's a chemical strait jacket, it's worse than the slammer. Me, I have a wife and a family, I don't want any more things like that, I want to move on to something else.*

This attitude of the physician, narrowly focused on the medication and indifferent to personal problems, exacerbates feelings of failure, absence of perspectives and impossibility of escape until the user views himself as an incurable junkie. Some of them go as far as comparing the condition of being a substitution user to that of a dying person in palliative care.

***Sébastien (35, on Subutex® for 3 years)**: In any case, he doesn't give a damn, I could croak, I'm just a piece of shit for him. But who can tell me how to stop this bloody treatment? No but do you realise what they're feeding to us? It's super strong, this thing, it's like for people with cancer or guys who are going to die of AIDS... And if one day I have cancer, what am I going to do then, huh?*

HAL author manuscript inserm-00142914, version 1

Over time, the relationship deteriorates and distrust in the skills of the physician occurs. Then the user accuses the physician of only looking for economic benefit and abandoning his responsibilities for providing care.

Philippe (43, Subutex® for 4 years)*: In fact, there is no follow-up besides the treatment, you're left to yourself. I realised that he's groping forward, it makes me sick... He just leaves me to drift completely. He gives me his Subutex® and his pills ...but it's not the substitution that helps you to get past it, it's everything that comes with it, around it.*

Depending on the user's resources and expectations, this situation can lead either towards the user progressively taking ownership of the drug as part of his self-regulated treatment process, or towards his becoming less involved in the treatment, adopting a drug abuser's logic towards the substance and manipulating the physician to obtain it.

Paulo (35, Subutex® for 4 years MG)*: My doc, I consider him a charlatan, who found a little gold mine with us. I don't trust him.*

3-3- Relationship focused on compliance

Relations between the physician and the treated user are centred on strict adherence to the therapeutic regimen. The user-physician relationship is marked by the physician's paternalistic authoritarian role, and the recognition of his skills and knowledge by the user. This pattern reflects the classic dissymmetry of information and decision-making between physician and user. Despite cordial relations with their physicians, drug users did not always feel at ease. They perceived cordiality as overdone, even manipulative, and they interpreted it as the physician's strategy to promote adherence to treatment and limit abuse of the system.

HAL author manuscript inserm-00142914, version 1

***Yves (31, Subutex® for 2 years)**: He tries to find out if I'm taking the treatment seriously, correctly, if its effects are the ones expected, but without wanting to know too much about my life…I don't feel comfortable with him, I always have the impression that there's nothing free in the way he does it, especially when he wants to be my pal, I have the impression he's trying to catch me out.*

Reports or disclosure of deviations from the prescribed regimen (use of non-prescription benzodiazepine, alcohol, illicit substances, or injection) are punished by a reduction in the dose prescribed, or by threats to stop the prescription or transfer the user to methadone, which is more tightly controlled. Often, the physician will have stated these conditions clearly at the beginning and expects some stabilisation before starting to decrease the dosage to achieve abstinence. A standard progression of treatment in three phases is usually envisaged: induction-stabilisation-reduction. Most users in the stabilisation phase, depending on their psychological condition or their day-to-day situation (health or housing problems, stress, etc.), feel unstable under the effects of Subutex®. The doctor may however try to begin reducing the posology without taking the circumstances into account.

***Philippe (43, Subutex® for 4 years)**: There's a complete gap between me and my doctor, he just can't get it, his ability to understand is very limited. He does his therapy the way he wants to, and goes through the different stages. I try to explain to him that I'm sick [HIV+], that I have worries about the kids [twins] coming, that I still don't know where we will find day care for them when they get here, I try to explain it to him but he has his own personal logic and it's really different from mine.*

HAL author manuscript inserm-00142914, version 1

Lapses are tolerated and relatively well accepted at the beginning of treatment, but are understood/accepted less and less by the physician if they persist. They are interpreted as an attempt to abuse the system. Under these circumstances, even when the physician encourages them, most users are afraid to report their problems/keep their problems secret.

Catherine (23, Subutex® for 3 years): *No, I don't tell him I still shoot, he doesn't know. I don't want to talk to him about it because I'm afraid he'll stop my treatment. It's true that it's paradoxical because after all, that's what I'm there for, to talk about my substance problems. But I don't know, I don't feel right, and I don't want to take the risk.*

The consultation leaves little room for negotiation, and the physician interprets any points raised by the user (anxiety, depressive symptoms) as ploys to obtain a higher dose or an unjustified benzodiazepine prescription. Physicians sometimes try to begin to reduce the dosage without taking the circumstances into account.

Danièle (23, Subutex® for 2 years): *I've tried to talk to him, to say I need more. Whatever I say, he turns it around. He imagines that I was cheating, and it wasn't that at all, I wasn't cheating, I was really sick. I let it go, I got it taken care of somewhere else.*

This climate of suspicion keeps the user from asking for information, since the questions might be perceived as curiosity about using Subutex® for abusive purposes. In interviews, users expressed their need for clarifications about the treatment and its long-term toxic effects and risks (interactions with treatment for HCV or HIV, the risks and effects of interaction with other psychoactive substances, pregnancy, etc.).

HAL author manuscript inserm-00142914, version 1

Jean-Pierre (42, on Subutex® for 4 years)*: In fact, I ask myself lots of questions about Subutex®, it's crazy, I still don't know what's in it, what it's made of: is it morphine? I've never dared ask my doctor, sometimes he thinks I'm a little too interested and that I would try to find out, to know if I could...*

The physician is described as authoritarian, moralistic, and often patronising. Users perceive that they are expected to be disciplined and grateful, as if they have a "social debt" to pay.

Saïd (36, Subutex® for 3 years)*: I feel like a kid who has to confess he was naughty.*

They have to behave as a "good patient", penitent and irreproachable. The impossibility of gaining the physician's trust or even of acquiring more than a little leeway for negotiation in the decisions is expressed by some as a feeling of humiliation or revolt that can even lead to abandonment of the treatment.

Luc (33, Subutex® for 2 years)*: It's a long time now that I've been at that centre, exactly 10 years that they know me. With my doctor, it's not complicated, I have an appointment every Tuesday at 3 pm. And so Tuesday, three weeks ago, I arrived at 3:10 pm and I had to play the guitar in the tube. I had reserved a place for 4 pm. If I'm late, someone else takes my spot and at this hour to find another one.... I said to Dr -- that I was late, I asked him if he could give me my treatment and we could talk next time. He says: No, I have to see you for 5 or 10 minutes, where do you think you are? I was irritated, I said to him: I don't have anything to say to you, and I slammed the door. I said: all the information you have on me, you can tear it up, stop spying on me....That's 10 years they've known me.*

HAL author manuscript inserm-00142914, version 1

A rift can occur over time in the relationship between the physician and the user: the user learns to regulate his/her treatment independently, reduce or relinquish his/her expectations of the physician, be silent about his/her (mis)use of the drug. The user may then, out of necessity, have to buy the Subutex® on the street or obtain a parallel prescription from another physician.

3-4- Relationship focused on the person

This relationship with the physician allows the user to participate in decisions in which he feels he is recognised as a whole person, and in turn acknowledges the physician as a true expert in drug dependence. The treatment regimen appears to be put together jointly, like a partnership based on mutual respect, the sharing of information, discussion of each person's point of view, and the search for a compromise in case of disagreement. The physician's trust promotes the adoption of responsible behaviour with the Subutex®. The drug user recognises the relationship with the physician as a "therapeutic" component. Adaptation of treatment modalities to fit the user's needs, personal situation or preferences is an important priority. Dose-setting and prescription are therapeutic tools, but not the only ones. Dose adjustment is a negotiation between the user and doctor, modifiable during the course of treatment, as the user's situation and needs are continuously reassessed. Most often, this negotiation occurs at the end of each visit, after most of the time is spent in discussion. The user expresses his worries about the treatment or another topic related to his personal life (work, health, mood, daily or existential problems, children-rearing, sexuality, substances, the news, jokes, hobbies, etc.).

Yves (31, Subutex® for 2 years): *What's also good, I don't know if all doctors are alike, but the doctor who treats me takes the time to listen to me, she doesn't interrupt or cut me off each*

HAL author manuscript inserm-00142914, version 1

time I open my mouth. She's given me confidence and especially we don't only talk about that (drugs). She pays real attention to the person, I go and talk about myself, my life, work, what I've done. She thinks that's more important than the medication. In the end, treatment's one thing and the person is another.

The security provided by this type of relationship results in less worry about the treatment and its ultimate purpose, compared to the two preceding patterns. These users accept the idea of long-term maintenance better, without excessive preoccupation about the treatment outcome. This listening attitude allows the physician to be inquisitive, firm, discreet, or direct, depending on what the user has to say, and thus promotes the maintenance of a long-term objective.

Sophie (35, Subutex® for 3 years)*: He understood everything, he's a specialist general practitioner. When you hear him talk, it's as if you were talking to another addict. He knows everything and he tells you about it. He's certainly never taken drugs, but you can't fool him…. And that's what we need. And then he talks hard to us too. Me, he's talked hard to me because when I was a druggie, I don't think I was a saint. He's: you want to get out of it, you blow it, you come back, and we try again.*

These users did not perceive going to the doctor as a constraint; the doctor's office was instead a special space where they could renew their strength, rest, be themselves, and find some kind of comfort. The physician appears to be the user's preferred contact, viewed as a bridge between the world of drugs and mainstream society. At this point in their progress, these drug users felt they occupied a difficult position between these worlds. They no longer fully shared the values, references, interests and lifestyles that previously linked them to the

HAL author manuscript inserm-00142914, version 1

drug culture, but could not yet lay claim to those prevailing in mainstream society. In this context, the physician may be the only touchstone that gives meaning and continuity to their history (depository for the past, witness to the present, participant in a future). The doctor is one of the rare persons in their environment with whom they can "fully exist" and remain coherent with themselves.

Sophie (35, Subutex® for 3 years)*: He just knows about my whole life, my alcoholic mother, the life I led, the "Patriarch"*[4]*, the operations, my projects with L—, etc. Now, we laugh or I cry when I arrive at his office. I go once a month, and if I need to talk to him, I talk to him. I write down my questions when I go see him. Essentially, he's the only person I can really confide in now, with whom I can really be myself. I don't have anything to say anymore to the people I used to see, and among my family and friends, there are lots of things I can't say, they wouldn't understand.*

This attitude responds to the user's need for individualisation and promotes her (re)construction of a positive worthwhile image free of the stigma of the junkie. All who fit this profile report a personalised, singular, special relationship with their physician. Their answers were punctuated with expressions of attachment and gratitude, allowing for the recognition of his authority.

Alain (29, Subutex® for 4 years)*: We're not friends but almost, I tell him everything that's bothering me, I dump it all out. He doesn't watch me out of the corner of his eye when I come for Subutex®. When I come, I'm always glad to see him, it lets me clear my mind. It's as if I*

[4] Name of a therapeutic community

HAL author manuscript inserm-00142914, version 1

were seeing a shrink at the same time. He's part of the process; if he weren't there, I don't think I could do it.

Actually this relationship, in which the user has a strong affective investment, is tested at moments of relapse. Reporting misuse is welcomed in the first period of treatment, but becomes more and more difficult as the relationship of trust is established. More than the inability to meet the conditions that were jointly agreed upon, it is guilt over breaking the contract that prevents sincerity and incites fear of disappointing the doctor. Escape from the pejorative representations of drug dependence is part of a change in self-identification, towards perceiving oneself as a normal person. In this context, preservation of trust, which is difficult to recreate among family and friends, may have stakes more important than the substance-use problems. The relationship is sometimes trapped by the image reflected by the physician, and may be depleted by the accumulation of lies or even of things left unsaid. It can lead to situations of great vulnerability that become dead ends.

Isabelle (29, Subutex® for 2 years)*: I can't tell him about the crack, what will he think of me?... I don't know what to do anymore, I thought it was just a little casual thing, but I'm in the process of falling apart[...]. No, it's impossible, he'll be too disappointed after all he's done for me... If I tell him, he won't want to work with me, it won't be like before.*

3-5- Relationship focused on the user's manipulation to obtain a prescription from the physician

Some respondents claim a relationship with the physician based solely on obtaining a prescription without committing to treatment. The physician is the supplier of a legal drug, a white-coat dealer.

HAL author manuscript inserm-00142914, version 1

Stéphane (26, Subutex® for 3 years)*: He's my new dealer, except him, he's legal. It's a little like someone who goes up to Stalingrad [an open drug scene in Paris] to buy crack, but going to the doctor, everything's in order, you're ok, there's no risk. [...] At the beginning, it was just for when I was short, but it's so easy to get. Besides, he doesn't ask me too many questions, he prefers to give rather than make you run around for it.*

The prescription is the exclusive focus of the relationship, and the user exploits every aspect of the relationship towards this end, even "adjusting" some aspects of his substance-use history (substances and doses, duration of use, mode of administration), lifestyle or health status. His arguments and negotiations are intended to lead to a prescription for the maximum dose. In practice, the amount requested is always reduced by the physician in the course of the negotiation.

Stéphane (26, Subutex® for 3 years)*: He asks the usual questions, how's it going, if I'm succeeding, if I'm trying to cut back. He must suspect I'm shooting it up, but he acts sort of like he doesn't want to know. He'd rather give it to me than that I go see someone else.*

The user has no expectations in terms of therapeutic management, at least not initially. It is more like a real negotiation between two parties who say only what is useful for their own ends. The user does not look for much information and provides nothing of himself but the minimum necessary to justify the prescription of the medicine. Arguing that he wants to protect his private life and some autonomy in relation to the health-care system, the user considers it important to "give the fewest explanations possible." Users thus have available to them a series of arguments or motivations: for example, that they are seeking or organising a less risky substance use, temporarily out or need a little more than the prescription, getting out

HAL author manuscript inserm-00142914, version 1

of the illegal drug environment. Since the end justifies the means, respondents report their manipulative behaviour without embarrassment. They thus play the role of the "good patient", who is irreproachable. Some mention a role-playing game that exploits the clichés of the penitent drug addict to attain their goals and think they flatter the physician's vanity in pushing their expression of recognition to extremes. Others say they are putting their cards on the table and trying to convince the physician of their vital, sincere or exceptional character and of their good usage of the prescription. A tacit agreement is thus established to avoid pushing the other out of his position and to maintain the relationship where one party is interested in the prescription and the other awaits a change in attitude.

Annette (35, Subutex® for 4 years): *In fact, it's not complicated, I know what he wants to hear and I say it to him! Doctors like to be flattered, to be shown that we need them, blahblahblah... and regrets and apologies, they adore that, that we double up in pain and apologise, they love that.*

Users present the experience of using a medical prescription as a continuation of the heroin experience: their self-representation is still as a drug addict, dependent on a legal substance dispensed by physicians who are prescribers but not caregivers. They present themselves as customers, controlling the relationship with the physician without having to account for or justify their lifestyle beyond expedience alone.

Abdel (36, Subutex® for 4 years): *When I talk with him, I don't talk like I would to a doctor. I use him for my prescriptions, and the rest...if I had a physical problem, I wouldn't go see him. I don't want to tell him my life, it's none of his business, I just ask him to do his job. I'm involved as a customer.*

HAL author manuscript inserm-00142914, version 1

Over time, consultation after consultation, the relationship with the physician can lead to a real request for care, or just come to an end.

Karim (30, Subutex® for 3 years)*: It's true that I was on a different wavelength than my doctor; I saw what his aim was, what goal he was trying to help me to. I also see what my goal was in using his help. Now I want to make up for all that. Subutex®, it must be almost three years I've been taking it, but the first two years, it was less serious. Finally, it was serious anyway because overall, finally, it allowed me to work, to have fewer money problems, I've regained contact with my family also.*

Sometimes, the user can become caught in his own game, moving away from the logic of using the physician as a means to an end towards thinking about treatment by the same physician; then it seems difficult to go back and start over.

Claire (33, Subutex® for 2 years)*: I'd really like to say to him, it's not possible, all these lies, I confuse myself with all my stories, I never know what I said to him the last time. Now I would really like to take things seriously, but there, I think it's not possible to move backwards, I went too far.*

HAL author manuscript inserm-00142914, version 1

4- Discussion

4-1 Review of results

In this survey in the *Île-de-France* region, we found 4 patterns in the drug-users' points of view about their relationships with their physicians for their drug maintenance treatments with Subutex®. In Patterns 1, 2 and 4, prescription and dose were the primary issues; these served as a lever and as a response to strict substitution (Pattern 1), as a means of controlling the behaviour of users who deviate from the standard treatment (Pattern 2), or inversely, they were perceived by the user as the culmination of successful manipulation of the physician (Pattern 4). In the participatory pattern described by some users (Pattern 3), prescription and dose were only two of several aspects of "person-centred management".

Mentioning use of other drugs or medications or injecting the substitution drug remains difficult in all cases: in the first two patterns, the existence of this behaviour, or misuse alone, serves as a guideline for the physician to adjust the treatment; accordingly, the drug user, who has little room to negotiate, tends not to mention it. In the participatory pattern (Pattern 3), the users perceive that confessing resumption of uncontrolled drug use threatens the trust established between user and physician. In the manipulation pattern (Pattern 4), mentioning or not mentioning misuse is purely instrumental. Drug users thus face the paradox of a therapeutic model intended to treat heroin dependence that in fact prohibits mention of its principal problems: the need for drugs and medication, and how they are used.

The redefinition of self in an identity released from the stigma of drug dependence remains unlikely: response to this dependence by medication assigns the user a lifetime identity as a junkie in the first pattern; in the second, the ex-addict presents himself as the reflection of the compliant patient. In pattern 4, the subject plays the game of obedience without any qualms.

HAL author manuscript inserm-00142914, version 1

On the other hand, the therapeutic alliance (pattern 3) makes it possible for the user to express himself/herself in the relationship as a person in his/her own right.

4-2 Methodological limitations

These issues were identified from interviews with people recruited in different sites and settings, and according to a variety of criteria. This study thus differs from the types that tend to dominate the literature on this subject: work conducted in settings with highly marginalised participants (Bouhnik & Touzé, 2001; Bourgois, 2000) or in a single treatment facility (Gayre & Richard, 2000; Lalande & Grelet, 1999). Nonetheless we cannot rule out the possibility of bias, either in the selection of interviewees or in their narratives. In both the doctors' offices and DMCs, the physicians, who provided the initial contact with interviewees, could have chosen the users they considered most representative of their practices and thereby introduced or accentuated a social desirability bias. This bias might be still stronger because the interview deals with highly stigmatised practices and behaviour. This bias should have been attenuated by our direct recruitment of a sub-sample in low-threshold services. Conducting the interviews outside the health care facilities, most often in a place chosen by the user, should have attenuated any bias still further (Rosenblum, Magura, & Joseph, 1991). The repetition of interviews also contributed to creating trust in the investigator and allowed us to take time into account, especially the instability that characterises the life of drug users and their relationships with those involved in their care.

Most interviewees were on maintenance treatment for several years and no newly treated users were interviewed. This situation reflects the French situation. Currently in France, 70% of drug users are on substitution treatment with high retention rates (Duburcq, Charpak, Blin, & Madec, 2000), which is related to the overall flexibility of the buprenorphine regimen. After several years of substitution treatment availability, few users are entering the treatment

HAL author manuscript inserm-00142914, version 1

programmes. Doctors participating in the study did not feel at ease seeking consent from those newly admitted with whom bonds were still fragile. The few very rare refusals or lost contacts (n=4) were users who, according to their physicians, presented themselves for treatment on an irregular basis and/or had only a recent history of treatment (< 6 months).

4-3 The pivotal function of the doctor-user interaction in the process of change

The design of maintenance treatment in France — a drug prescribed by a physician and purchased in a pharmacy — concentrates the outcomes for this treatment on the relationship that develops between physician and user. The type of treatment facility (private practitioner or specialised centre) does not appear to determine the user's perception of treatment; users in drug treatment centres reported conditions similar to those seen in physicians' offices, and only two respondents reported more extensive psychosocial management. Other possible caregivers or participants in this care were mentioned only rarely, even by users at DMCs that in principle offer multidisciplinary care and sometimes a mentor with whom the user can confer regularly about his or her problems. This observation matches the results obtained in a study of components and results in a comparison between DMC and office-based substitution treatments (Guichard et al., 2004). Consultations with social workers or psychotherapists appear to be separate and distinct dimensions of the treatment. As a private practitioner, the physician fulfils all of these roles using the appropriate amount of force for each case. Prescription and dispensing rules are interpreted and applied piecemeal for each individual by each physician. The relationship with the physician is therefore the mainstay that integrates the various elements of treatment and the focal point of all the expectations and difficulties of the substitution process. Strongly invested, it appears as the space containing negotiations, adjustments and tensions around the drug, dose determination and amount of attention paid to the individual in his or her daily difficulties.

HAL author manuscript inserm-00142914, version 1

There is no doubt that the physicians' attitudes towards and ideas about maintenance treatments, drug dependence and drugs generally determine their practices with regard to this treatment; this has already been shown for the treatment of HIV users infected through drug use (Moatti et al., 2000). Medical practices regarding maintenance are related to training, experience, personal attitudes towards drugs use, and type of setting. Doctors unfamiliar with opiates treatment, or those poorly trained, are more likely to offer sub-optimal treatment and inconsistent prescription (Feroni et al., 2005). In this study, only doctors highly experienced in drug use treatment were asked to facilitate contacts with interviewees. Drug users recruited at NEP sites were receiving Subutex® from equally highly experienced GPs. Thus, apart from these characteristics determining the medical practices, the interaction with the user in treatment seems to be built on a case-by-case basis. In fact, there was no configuration associated with a particular physician in this small sample. Since we did not directly observe the interactions during a consultation, we cannot grasp precisely what in the perception of the user is actually linked to the physician.

Drug maintenance treatment can be practiced on the basis of diverse models: harm reduction, long-term maintenance, treatment of addiction (Gayre & Richard, 2000; Lalande & Grelet, 1999). Specific objectives (stabilisation of health and social situation, stopping drug use, social and work insertion, etc) may be associated with each model (Hunt & Barker, 1999; Mavis, DeVoss, & Stoffelmayr, 1991). The same physician may apply different concepts to different users, or successively over time to the same user. Physicians tend to reason that some link to treatment is always better than contacts with the drug scene and the street, and adopt a "low threshold" attitude as a waiting or holding position: prescribe immediately without an in-depth assessment and see the user later to renew the prescription and begin real treatment. The doctor can then engage the user in less dangerous management of his risk and

HAL author manuscript inserm-00142914, version 1

help orient him towards less abusive and more socially acceptable practices (Lalande & Grelet, 1999).

The strong commitment to treatment (Pattern 3), observed to be based on attachment to the physician, feeling respected and worthwhile, self-confidence and a perception of constant support, serves to corroborate the factors favourable to treatment adherence shown elsewhere: information and advice about products (Hser, Polinsky, Maglione, & Anglin, 1999; Lamb, Greenlick, & MacCarty, 1998; Najavits & Weiss, 1994), empathy (Hatcher & Barends, 1996), the physician's perceived expertise (LaCrosse, 1980), and the perception of closeness to personalities or "cultures" (Agar, 1985; Vera, Speight, Mildner, & Carlson, 1999) are all factors that promote adherence to the treatment process (Kasarabada, Hser, Boles, & Huang, 2002).

4-4 Multiple and changing issues in a long-term process:

The diversity of the relationship configurations can be related to the diversity and instability of the user's expectations of and needs for (Lalande and Grelet 1999; Guichard et al. 2004) the maintenance drug and the doctor (Guichard et al., 2004).

4-4-1 Taking the disruptive events and instability in their daily lives into account

Numerous factors and events can interfere with a long-term treatment and modify the users' needs and expectations: health impact of serious diseases (especially HIV and HCV), weight of "past debts" (for example, revoking of suspended sentences, financial debts), social insecurity, fragile social and personal support (Guichard, Lert, Brodeur, & Richard, to be publ.). These fluctuating situations, combined with the capacity of individuals to manage their treatment more or less independently (Lovejoy et al., 1995; Neale, 1999a), are expressed in

HAL author manuscript inserm-00142914, version 1

different ways of relating to treatment: some recognise the usefulness of a directive method (frequent contacts with the health care centre, compliance with hours, etc.), to help them to develop some control over their consumption and resume a more "normal" lifestyle (Neale, 1999a); others, more likely to manage their prescription independently, perceive these same conditions as an obstacle to their adhesion to the therapeutic plan (Hunt & Rosenbaum, 1998), a barrier to common activities (moving, working, travelling) and likely to push them towards passivity and accentuate their poor self-esteem (Bourgois, 2000; Rosenblum et al., 1991). The users' personal or social situations are not related here to the observed patterns. In such a study, it is impossible to disentangle pre-existing situations from changes that occurred after treatment started. Different studies have nonetheless shown that the users' social situations influence the results of the treatments (Bouhnik & Touzé, 2001; Bourgois, 2000; Guichard, Lert, Brodeur, & Richard, à venir; Johnson & Friedman, 1993; Rosenbaum & Murphy, 1984). Positive changes are attributed to treatment, and conversely, when personal situations deteriorate, the treatment is blamed and labelled ineffective or even harmful (Beschner & Walters, 1985; Lovejoy et al., 1995).

4-4-2 Need to clarify the chronic dimension of dependence and the different treatment steps

According to both the professional ideal and the published objectives, a life free from addiction remains the final objective of treatment. Nonetheless, observations of long-term cohorts (Hser, Anglin, & Powers, 1993; Hser, Hoffman, Grella, & Anglin, 2001; Maddux & Desmond, 1992) show the durability of dependence, or at least the frequency of relapses even after long periods of controlled use or abstinence. The idea of very long-term maintenance treatment is not yet accepted, and no standard treatment duration has been set. This population, unable to make commitments beyond the short term, responds with anxiety to this lack of certainty about the expected outcome and the time needed to reach it (Rosenblum et

HAL author manuscript inserm-00142914, version 1

al., 1991). Users' difficulties in staying the course appear differently in each of the configurations described here. In Pattern 1 (focus on dosage), some would like to start this route but face opposition from their physician, while in Pattern 2, users mention pressure by their physician to decrease the dosage before they are ready to begin this phase. Other factors help to create incongruities between the protagonists: the user progressively develops autonomy in handling the drug, feels unable to report misuse, fears (justifiably or not) retaliation or disappointing the physician. These manifestations of resistance and the worries associated with the prolongation of the treatment also appear to result from a lack of information about the treatment objectives. It makes it impossible to project into the future. In this context, the relationship becomes a power struggle (Hunt & Barker, 1999), and the maintenance drug, as the vehicle for strong dependence and multiple secondary effects, comes to be perceived as a form of persecution (Rosenblum et al., 1991).

4-5 Supporting the process of identity change

The problem of identity also plays a role in the configuration of the relationship. It involves the ability of users to rebuild a self-image free of the stigma of the junkie, and is a fundamental element of commitment to treatment; acquiring self-respect is one of the principal motivations reported by users at the beginning of treatment (Neale, 1999b). If conditions at methadone centres make users feel they are treated as children and stigmatised (Fischer et al., 2002), the dual aspects of the relationship with the general practitioner proposed in France is, on the face of it, suited to individualised management and to the user's role as a patient.

Most Subutex® users, however, apparently do not succeed in freeing themselves from the labels assigned to drug abusers. They are ill at ease talking about their substance use and their

HAL author manuscript inserm-00142914, version 1

difficulties in managing their prescription (Hunt & Rosenbaum, 1998); they perceive suspicion when the physician asks them about their use of the maintenance drug, or interpret the physician's impersonal attitudes as rejection. The lack of consideration given, and the passivity and impotence to which users feel they are reduced during this treatment accentuates their lack of self-esteem to the point of inducing different forms of "identity regression" (Bourgois, 2000; Rosenblum et al., 1991). This debased self-image contrasts with the street lifestyle in which the user had to participate actively to survive and use specific skills, all of which brought with it a valuable identity and a feeling of greater autonomy (Hunt & Barker, 1999).

Some analyses show that the identity of the drug user in treatment remains subject to the social, legal, moral and ideological representations linked to drug addiction, and that these continuously interfere with the reconstruction of his self-image (Lalande & Grelet, 1999). Hunt and Barker (1999) consider the dimension of the identity of users in treatment and show how the treatment process tends to model the person's "deviant and wayward" identity to make him an almost religious figure of redemption through discipline and conformity with the institutional rules. If we follow these analyses, we can see in the user's role-playing (e.g., simulation of the role of the "good patient" or penitent attitude) appropriate recourse to skills developed on the street to cope with the influence exerted by the medical institution. Similarly, in the "client-centred" attitude displayed by some respondents, we can find forms of resistance to a system whose standards push the user into becoming a "patient despite himself." (Hunt & Barker, 1999).

5- Conclusion

HAL author manuscript inserm-00142914, version 1

Drug maintenance was introduced late in France, where it was seen as a social control policy and where only drug-free treatment based mainly on psychoanalytic theory was offered to drug users. Introduced as an emergency response to AIDS epidemics among intraveinous drug users, its objectives and its conditions are interpreted very diversely by physicians and users. Objectives for the treatment range from abstinence to very long-term maintenance that tolerates the continuation of use of illegal substances and injections in a very open approach to reducing the risks. With this variability on the part of the physicians comes a corresponding lack of information for the users. The treatment goals are rarely explained by the physicians or negotiated with the users on an individual level. Communication between the physician and the user in substitution treatment is often poor, making it difficult to talk about problems, make the adaptations needed for the treatment and for the user, and for self-redefinition as a person leaving the drug culture behind. It could be suggested that from the perspective of very long-term maintenance with a large risk for relapse, the treatment should be seen as a series of episodes for which the methods and objectives are negotiated to take into account fluctuations in real-life situations and the vulnerability of the users. This would perhaps limit the difficulties encountered when the treatment is long term, and which often translate into misuse or deviation from the prescriptions, or relapses.

References

Adrian, M. (2002). Whose needs are to be met? Customer satisfaction with delivery of treatment services for heroin users. *Subst Use Misuse, 37*(4), 543-547.

Agar, M., & Stephens, R. C. (1975). The methadone street scene. *Psychiatry, 38*, 381-387.

Agar, M. H. (1985). Folks and professionals: different models for the interpretation of drug use. *Int J Addict, 20*(1), 173-182.

Aides-Inserm. (2001). *Attentes des usagers de drogue concernant les traitements de substitution: expérience, satisfaction, effets recherchés, effets redoutés* (Rapport). Paris: Aides/Inserm.

Beck, F. (1998). *Perception, attitudes and knowledge of the french population as regard drug use since 80's.* Saint-Denis: OFDT.

Bell, J. (1998). Delivering effective methadone treatment. In J. Ward & R. Mattick & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 161-175). Australia: Harwood Academic Publishers.

Beschner, G. M., & Walters, J. M. (1985). Just another habit? The heroin users' perspective. In B. Hanson & G. M. Beschner & J. M. Walters & E. Bovelle (Eds.), *Life with heroin: voices from the inner city* (pp. 155-173). Lexington MA: Lexington Books.

Bouhnik, P., & Touzé, S. (2001). Précarisation et consommations de drogues illicites: amplification des prises de risques à l'ère de la substitution. In M. Joubert & P. Chauvin & F. Facy & V. Ringa (Eds.), *Précarisation, risque et santé* (pp. 395-412). Paris: Inserm.

Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry, 24*(2), 165-195.

Brown, B. S., Benn, G. J., & Jansen, D. R. (1975). Methadone maintenance: some client opinions. *Am J Psychiatry, 132*(6), 623-626.

Caplehorn, J. R., & Bell, J. (1991). Methadone dosage and retention of patients in maintenance treatment. *Med J Aust, 154*(3), 195-199.

Duburcq, A., Charpak, Y., Blin, P., & Madec, L. (2000). [Two years follow-up of a heroin users cohort treated with high dosage buprenorphine. Results of the SPESUB study (pharmacoepidemiologic follow-up of general practice Subutex)]. *Rev Epidemiol Sante Publique, 48*(4), 363-373.

Feroni, I., Paraponaris, A., Aubisson, S., Bouhnik, A., Masut, A., Ronfle, E., Coudert, C., & Mabriez, J. C. (2004). [Prescription of high dose buprenorphine by general practitioners]. *Rev Epidemiol Sante Publique, 52*(6), 511-522.

Feroni, I., Peretti-Watel, P., Masut, A., Coudert, C., Paraponaris, A., & Obadia, Y. (2005). French general practitioners' prescribing high-dosage buprenorphine maintenance treatment: is the existing training (good) enough? *Addict Behav, 30*(1), 187-191.

Fischer, B., Chin, A. T., Kuo, I., Kirst, M., & Vlahov, D. (2002). Canadian illicit opiate users' views on methadone and other opiate prescription treatment: an exploratory qualitative study. *Subst Use Misuse, 37*(4), 495-522.

Service users' and providers' perceptions of a methadone maintenance program: a Queensland qualitative pilot study 1-150 2000).

Guichard, A., Calderon, C., Maguet, O., & Lert, F. (2004). Du point de vue des usagers, quels sont les effets, les bénéfices et les difficultés suscités par les traitements de substitution aux opiacés? [From the user's point of view, what are the effects, benefits, and difficulties associated with opioid replacement therapy?]. *Alcoologie et Addictologie, 26*(4 Suppl.), 61S-74S.

HAL author manuscript inserm-00142914, version 1

HAL author manuscript inserm-00142914, version 1

Guichard, A., Lert, F., Brodeur, J. M., & Richard, L. (à venir). Pluralité des modes d'appropriation du Subutex: de la reconquête de l'autonomie à la spirale de l'échec.
Guichard, A., Lert, F., Brodeur, J. M., & Richard, L. (to be publ.). Pluralité des modes d'appropriation du Subutex: de la reconquête de l'autonomie à la spirale de l'échec. *Sciences Sociales et santé*.
Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance of psychotherapy: exploratory factor analysis of three alliance measures. *J Consult Clin Psychol, 64*(6), 1326-1336.
Hser, Y. I., Anglin, D., & Powers, K. (1993). A 24-year follow-up of California narcotics addicts. *Arch Gen Psychiatry, 50*(7), 577-584.
Hser, Y. I., Hoffman, V., Grella, C. E., & Anglin, M. D. (2001). A 33-year follow-up of narcotics addicts. *Arch Gen Psychiatry, 58*(5), 503-508.
Hser, Y. I., Polinsky, M. L., Maglione, M., & Anglin, M. D. (1999). Matching clients' needs with drug treatment services. *J Subst Abuse Treat, 16*(4), 299-305.
Hunt, D. E., Lipton, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and its effect on recruitment into treatment. *Int J Addict, 20*(11-12), 1751-1771.
Hunt, G., & Barker, J. C. (1999). Drug treatment in contemporary anthropology and sociology. *Eur Addict Res, 5*(3), 126-132.
Hunt, G., & Rosenbaum, M. (1998). "Hustling" within the clinic: consumer perspectives on methadone maintenance treatment. In J. A. Inciardi & L. D. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 188-214). London: Sage Publ.
Johnson, P., & Friedman, J. (1993). Social versus physiological motives in the drug careers of methadone clinics clients. *Deviant Behavior, 14*, 23-42.
Kasarabada, N. D., Hser, Y. I., Boles, S. M., & Huang, Y. C. (2002). Do patients' perceptions of their counselors influence outcomes of drug treatment? *J Subst Abuse Treat, 23*(4), 327-334.
Koester, S., Anderson, K., & Hoffer, L. (1999). Active heroin injectors' perceptions and use of methadone maintenance treatment: cynical performance or self-prescribed risk reduction? *Subst Use Misuse, 34*(14), 2135-2153.
LaCrosse, M. B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the Counselor Rating Form. *Journal of Counseling Psychology, 27*(4), 320-327.
Lalande, A., & Grelet, S. (1999). *Pratiques de la substitution en ville. Suivi de patients usagers de drogues en médecine générale, approche qualitative*. Paris: OFDT.
Lamb, S., Greenlick, M. R., & MacCarty, D. (1998). *Bridging the gap between practice and reearch: Forging partnerships with community-based drug and alcohol treatment*. Washington DC: National Academy Press.
Lert, F. (2000). Drug use, Aids and social exclusion in France. In J. P. Moatti & Y. Souteyrand & A. Prieur & T. Sandfort & P. Aggleton (Eds.), *Aids in Europe: new challenges for the social sciences* (pp. 189-2003). Paris: Routledge.
Lovejoy, M., Rosenblum, A., Magura, S., Foote, J., Handelsman, L., & Stimmel, B. (1995). Patients' perspective on the process of change in substance abuse treatment. *J Subst Abuse Treat, 12*(4), 269-282.
Maddux, J. F., & Desmond, D. P. (1992). Ten-year follow-up after admission to methadone maintenance. *Am J Drug Alcohol Abuse, 18*(3), 289-303.
Mavis, B. E., DeVoss, G. H., & Stoffelmayr, B. E. (1991). The perceptions of program directors and clients regarding the efficacy of methadone treatment. *Int J Addict, 26*(7), 769-776.

HAL author manuscript inserm-00142914, version 1

Moatti, J. P., Carrieri, M. P., Spire, B., Gastaut, J. A., Cassuto, J. P., Moreau, J., & The MANIF 2000 study group. (2000). Adherence to HAART in French HIV-infected injecting drug users: the contribution of buprenorphine drug maintenance treatment. *Aids, 14*, 151-155.

Moatti, J. P., Souville, M., Escaffre, N., & Obadia, Y. (1998). French general practitioners' attitudes toward maintenance drug abuse treatment with buprenorphine. *Addiction, 93*(10), 1567-1575.

Montagne, M. (2002). Appreciating the user's perspective: listening to the "methadonians". *Subst Use Misuse, 37*(4), 565-570.

Najavits, L. M., & Weiss, R. D. (1994). The role of psychotherapy in the treatment of substance-use disorders. *Harv Rev Psychiatry, 2*(2), 84-96.

Neale, J. (1999a). Drug users' views of substitute prescribing conditions. *International Journal of Drug and Policy, 10*, 247-258.

Neale, J. (1999b). Understanding drug-users clients' views of substitute prescribing. *Br J Soc Work, 29*(1), 127-145.

O.F.D.T. (2003). *Substitution aux opiacés: Synthèse des informations disponibles de 1996 à 2001 en France*. Paris: OFDT.

O.F.D.T. (2004). *Les traitements de substitution en France: résultats récents 2004. N°37*. Paris: OFDT.

Rosenbaum, M., & Murphy, S. (1981). Getting the treatment: recycling women addicts. *J Psychoactive Drugs, 13*(1), 1-13.

Rosenbaum, M., & Murphy, S. (1984). Always a junkie?: the arduous task of getting off methadone. *Journal of Drug Issue, 16*(4), 527-552.

Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *J Psychoactive Drugs, 23*(1), 21-27.

Seidman, I. (1998). *Interviewing as qualitative research*. New York: Teachers College Press.

Strang, J., Sheridan, J., Hunt, C., Kerr, B., Gerada, C., & Pringle, M. (2005). The prescribing of methadone and other opioids to addicts: national survey of GPs in England and Wales. *Br J Gen Pract, 55*(515), 444-451.

Sullivan, L. E., Chawarski, M., O'Connor, P. G., Schottenfeld, R. S., & Fiellin, D. A. (2005). The practice of office-based buprenorphine treatment of opioid dependence: is it associated with new patients entering into treatment? *Drug Alcohol Depend, 79*(1), 113-116.

Vera, E. M., Speight, S. L., Mildner, C., & Carlson, H. (1999). Patient's perceptions and evaluations of similarities to and differences from their couselors. *Journal of Counseling Psychology, 46*(2), 277-283.

Table 1: Doctor-user patterns of interaction				
Dimensions	**1 Focused on drug dosage (n=6)**	**2 Focused on compliance (n=8)**	**3 Focused on the person (n=10)**	**4 Focused on drug prescription (n=4)**
Doctor's function	***Prescriber only***	***Authoritarian and paternalistic***	***Professional experienced in drug dependence***	***White-coat dealer***
Relative positions	***Utilitarian***	***Dissymmetry*** (Physician: judge and decision-maker)	***Participation-contractualisation*** (supervised autonomy)	***Manipulation***
Place of the prescription	***Central: physician tends to increase the dose***	***Central: physician tends to reduce the dose***	***Therapeutic tool treatment - dosage negotiated***	***Nearly exclusive topic of physician-user interaction***
Misuse and response	***When they are mentioned, the physician interprets them as a problem of dosage***	***Kept secret because of fear of dosage reduction.***	***Often kept secret by fear they would threaten the physician's trust***	***Not mentioned***
Therapeutic plan	***Strict drug maintenance, for the physician (divergent plans)***	***Adoption of a linear treatment outline vs. unstable situations (divergent plans)***	***Joint proposal*** (Therapeutic alliance***)***	***No expectations of treatment***
Self-image	***Still a junkie***	***Ex-junkie (Role of good patient)***	***Person in own right***	***Client-customer (Acts the role of the good patient)***
Incongruities over time	***Distancing and rupture:*** - User becomes progressively more independent in treatment management - Increasing gap between what is said and what is done, which can lead to rupture or manipulation		***Transference and the risk of isolation*** - Difficulties in coping with situations of vulnerability - Discrepancy and disappointment	***Dissembling reaches deadlock***

HAL author manuscript inserm-00142914, version 1