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Methadone treatment in an intermediate care setting?

The paper by Keen *et al* on methadone treatment was interesting and helpful, and is further evidence that methadone treatment can be helpful for opiate addiction.[1] I was puzzled by the title, however, describing the study as one involving a primary care setting. If I have understood correctly, the study was based in dedicated premises, with one-and-a-half whole time equivalent doctors with supporting staff. This is not the same as managing addiction in a GP surgery, but appears to be more of an intermediate care model.

The practice that I work in, in Bath, has cared for addicts for a number of years, with individuals being seen in the surgery. Recently, a community drug service has been set up, which provides an intermediate care facility in addition to GP surgery care. Looking after addicts in a surgery can be difficult and disruptive, and other patients can feel threatened by addicts. The system described by Keen *et al* does appear to be an intermediate care model rather than GP surgery primary care, and I feel the difference needs to be acknowledged. It may well be that an intermediate care model is the best way to help this challenging group of patients, in view of the complexity of their needs and often challenging behaviour, although caring for them in general practice can be successful as well.

It would also have been helpful to have been given information on negative outcomes. A case report on page 471 of the same issue describes the sudden death of someone on methadone,[2] and it would have been useful to know about adverse events in the Sheffield clinic.

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Author's response

Dr Wayte's point regarding the nature of the Sheffield primary care service is a good one, in that the service does not represent a traditional general practice setting. With the advent of GPs with a special interest, GP specialists and so on, however, there have been new models of delivery for primary care, of which the Sheffield primary care drugs service is one example.

While this has some features of an intermediate level service, it has retained many features that we think are fundamental to primary care, however it is delivered. First, the long-term harm minimisation approach to the care of patients with chronic relapsing conditions, including physical and psychosocial aspects, in which the relationship with one doctor over the years gives continuity, comes naturally to GPs as it forms such a large part of their work, not just with drug users. Second, the gradual evolution of treatment goals between doctor and patient removes the necessity for a time-consuming system of paperwork and reviews. Third, the continuity inherent in primary care avoids the necessity for all patients to have a 'keyworker' at all times, but allows the GP to mobilise resources at times of crisis or increased need. Finally, and, not least important with this very at-risk group, trained GPs are up to speed on the physical aspects of medicine. All of these aspects have been retained in the Sheffield service.

There is probably room for a number of different models of primary care and shared care to be developed depending on local factors, while retaining the essential features of primary care.

With regard to the negative outcomes mentioned by Dr Wayte, we did report as fully as possible on our cohort, which did not include any deaths. In fact, the death rate from methadone-related causes has stayed extremely low in Sheffield, in spite of the large numbers of patients on methadone, and we have written this up in this journal.[1]

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Financing defibrillators in general practice

Over 65 000 out-of-hospital cardiac arrests occur in the United Kingdom every year. The survival rate remains very low, with only 6.4% of out-of-hospital cardiac arrest patients surviving to reach hospital discharge. The Department of Health recently pub-

lished a White Paper[1] aiming to reduce mortality from out-of-hospital cardiac arrest, placing particular emphasis on early defibrillation. This constitutes a major component of the 'chain of survival', which comprises of early cardiopulmonary resuscitation (CPR), rapid defibrillation and rapid ambulance response times. GPs can be a vital link in this chain, especially when equipped with an automated external defibrillator.

Studies have shown that when a GP can initiate resuscitation and defibrillation within 4 minutes of a patient collapsing (which should be feasible if the arrest occurs in a GP surgery), approximately 60% of patients survive to be discharged from hospital.[2,3] Despite this, defibrillators have yet to become commonplace in GP surgeries — possibly because they are considered expensive and not cost-effective. If GPs are to play a role in the management of out-of-hospital cardiac arrest, the issue of financing automated external defibrillators needs to be addressed.

I undertook a study to establish how defibrillators in general practice were funded and to establish GPs' views on how, if their practice were to receive a defibrillator, it should be financed. I queried all general practices in the Lothian and Borders region of Scotland with an EH postcode (112 practices in total, with 312 doctors) and asked them whether they were equipped with a defibrillator and, if so, how it was funded. Practices that were not equipped with a defibrillator were asked to select the source(s) of funding they felt most appropriate for the purchasing of any future machine. The results are shown in Table 1.

The results show that most defibrillators in general practice (75%) are purchased by the practice themselves. For the practices that did not have a defibrillator, the majority of GPs (87%) believed that the primary healthcare trust should provide funding. There is increasing scope for GPs to use defibrillators, as modern machines become easier to use, more portable, and less expensive. Operating them now requires less training, they are less maintenance-intensive and they are designed to be stored for long periods between use.

GPs have a key role to play in the 'chain of survival', but unless primary healthcare trusts are willing to purchase defibrillators they will remain a weak link.

Table 1. The financing of defibrillators by individual general practice.

Source(s) of funding	Practices with defibrillator (total = 32)[a]	Practices without defibrillator (total = 23)[a]
Practice	24	1
Donations	3	3
Charity	4	4
Primary healthcare trust	1	20
Other	1	1

[a]Several practices had more than one source of funding or gave more than one preferred source, hence the column totals are greater than the number of practices.

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Screening for domestic violence

It was good to see an editorial dealing with domestic violence in your journal.[1] We agree with the overall message that it is premature to introduce formal screening for domestic violence in general practice, but important for GPs to ask women about abuse and to respond appropriately. Unfortunately, the editorial contains a number of points that are misleading.

First, it is simply not true that no screening questions have been validated in general practice. Short tools, that are easy to use in practice, such as the HITS,[2] have been validated in primary care populations. We agree with the authors that further research on screening instruments is needed.

Second, although there is a range of responses in the small number of quantitative studies on the acceptability of screening to women patients, the overall conclusion of our systematic review was that most women find it acceptable.[3] This is also the message from qualitative studies in the United Kingdom of women who have experienced partner abuse.[4]

Third, we do not understand the authors' notion that if a woman discloses to her GP that her partner undermines or humiliates her, that her partner will be labelled a 'criminal'. Physical and, more recently, sexual violence against a partner are criminal offences, but this is not the case for most forms of emotional abuse, with the exception of stalking.

Fourth, targeted screening of demographic sub-groups is unlikely to be effective. Although it is true that certain characteristics are associated with a greater risk of partner abuse, they are poor predictors of abuse and only explain a small proportion of the variation in rates of abuse between groups.[5]

Fifth, the fact that many women in abusive relationships are not ready to leave their partners does not diminish the importance of support for leaving a relationship. Interviews with survivors of partner abuse highlight how trapped women can feel in an abusive relationship,[6] how afraid they are of leaving, and how important the non-judgemental support of doctors and other health workers can be.[7]

Finally, we are less optimistic about the benefits of couple counselling in the context of physical and sexual abuse than Goodyear-Smith and Arroll. The coercive control and fear that characterise abusive relationships mean that many women cannot participate equally or safely in couple counselling.[8]

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Authors' response

We concede that the HITS screening tool has been validated within family practice,[1] although this study also included self-identified domestic violence victims for whom HITS was a diagnostic test.

In Ramsay's systematic review,[2] 43–75% women favoured routine inquiry. Even if only one in ten object (90% favour screening), GPs will understandably be reluctant to routinely screen; this is particularly pertinent in a fee-for-service environment, where offended patients vote with their feet.

In some jurisdictions 'domestic violence' is defined broadly as actual or threats of physical, sexual or psychological abuse. Under the New Zealand Domestic Violence Act (1995), the court grants Protection Orders to applicants alleging abuse of any form. The Order usually includes the couple's children, requiring the respondent to avoid all contact. He is mandated to attend a stopping violence programme unless he legally challenges the Order, which may take many months.

Cohort study data found that partner violence is strongly linked to indicators of low socioeconomic status.[4] Women whose male partners are poorly educated, lacking in social supports and unemployed are at significantly greater risk of partner abuse.[5] Riggs similarly writes: 'men of lower socioeconomic status are at increased risk for perpetrating domestic violence'.[6] A survey of 5000 randomly selected New Zealand adults reported life-time prevalence of at least one experience of physical or sexual partner abuse as 15.3% for women and 7.3% for men.[7] Maori rates (women 26.9%; men 11.9%) were much higher than for white New Zealanders (women 14.6%; men 6.8%). This may reflect the greater representation of Maori in the lower socioeconomic bracket. This report highlighted an extremely uneven distribution of violent victimisation. Most people have little exposure to violence or threats, but for a small percentage of the population violent events are almost commonplace: 'Only 0.5% of the sample (6% of those who had been victimised) had been victims of a violent offence five or more times, but they accounted for a massive 68% of such offending'. The report recommended focusing prevention efforts on those small pockets of the population particularly at risk of multiple victimisation.

We agree that women at the extreme end of the partner-abuse spectrum, with concomitant safety issues, require support to leave their relationship. However, given a broad definition of partner abuse, which includes verbal fighting and name-calling, support services for couples to resolve conflicts and improve their relationships should also be available.

We agree that counselling for violent couples is probably ineffective and potentially dangerous. We advocate communication and conflict resolution skills training for couples early in their relationship (prenuptially, antenatally) to prevent interpersonal violence from developing. Pilot assessment of such an intervention with non-violent couples gave promising results, with statistically significant improvement in measures of consensus, satisfaction, affection, cohesion and use of reasoning to resolve conflicts in their relationships post-course, with the improvement sustained at 6-month follow-up.[8] In contrast, once significant violence has occurred, intervention is considerably more problematic. A systematic review of interventions for women suffering partner violence concluded that no high-quality evidence exists to assess intervention effectiveness.[9] Research into interventions should continue. Once effective treatment is found, then screening could be recommended.

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