



Evaluation of patients in opioid substitution therapy in the Kyrgyz Republic

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ABSTRACT

An evaluation of the Opioid Substitution Therapy programme in the Kyrgyz Republic took place during October 2008. As a consequence of the evaluation a survey on patients in Methadone Substitution therapy was prepared and conducted in December 2008. The result of this survey is described in this report and the result were presented at a parliamentary Round Table on 15 May 2009 in Bishkek, Kyrgyz Republic.

The result clearly shows that the treatment in methadone substitution therapy changes the risk behavior of the patients, decreases crime and increases the quality of life and self assessed level of health.

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Executive summary

The Kyrgyz Republic was the first country of Central Asia having initiated treatment with methadone for drug dependent patients in 2002. Between 2002 and 2008 three evaluations of the methadone programme have been performed. The last evaluation could not include actual data from patients in treatment as there was a lack of health related baseline data when patients entered the treatment with methadone.

In order to evaluate the efficiency of the treatment a study was performed in December 2008 where 701 of the 729 patients in methadone treatment (96%) were interviewed using a structured questionnaire. In addition, 100 patients who were in other kind of treatment or in an evaluation for methadone treatment were included.

The survey shows that all health indicators, social performance, drug use, risk behaviour and crime all improved during treatment.

Background and objectives

Substitution is defined as the administration under medical supervision of a prescribed psychoactive substance, pharmacologically related to the one producing dependence, to people with substance dependence, for achieving defined treatment aims.

Opioid substitution treatment is a form of health care for heroin and other opiate-dependent people using prescribed opioid agonists, which have similar or identical properties to heroin and morphine on the brain and which alleviate withdrawal symptoms and block the craving for illicit opiates.

Substitution treatment can be valuable because it provides an opportunity for drug dependent patients to reduce their exposure to high-risk behaviour and to stabilize in health and social terms before addressing the physical adaptation dimension of dependence (Lawrinson P., Ali R., Buavirat A., et al., 2008).

Substitution treatment is generally considered for people who have difficulty in stopping their drug use and complete withdrawal. It is desirable for substitution drugs to have a longer duration of action, or half-life, than the drug they are replacing to delay the emergence of withdrawal and reduce the frequency of administration. This allows the person to focus on normal daily activities without the need to obtain and administer drugs. Further, substituting prescribed medication for an illicit drug helps break the connections with criminal activity while supporting the process of changing lifestyle.

Although the ultimate goal of treatment may be to get people to stop using drugs, the main aims of substitution treatment are based on the concepts of public health and harm reduction. The aims of substitution treatment are:

- to assist people in remaining healthy until, with the appropriate care and support, they can achieve a drug-free life or, if they cannot or want to quit the programme, be in treatment for years or even for their lifetime;
- to reduce the use of illicit or non-prescribed drugs;
- to deal with problems related to drug misuse;
- to reduce the dangers associated with drug misuse, particularly the risk of transmitting HIV, hepatitis B and C virus and other blood-borne infections from injecting and sharing injecting paraphernalia;

- to reduce the duration of episodes of drug misuse;
- to reduce the chances of future relapse to drug misuse;
- to reduce the need for criminal activity to finance drug misuse;
- to stabilize the person where appropriate on a substitute medication to alleviate withdrawal symptoms; and
- to improve overall personal, social and family functioning.

The most common form of substitution treatment is methadone maintenance treatment. Methadone has been used to treat heroin and other opiate dependence for decades. Methadone has been proven to greatly reduce the risk of HIV infection by reducing drug injection and improving the health and quality of life of opiate-dependent people (Gowing et al. 2004, Mattic et al 2003).

Community substitution treatment programmes have rapidly expanded since the mid-1990s. Today, more than half a million drug users receive substitution treatment worldwide. Sixty five countries world wide provides substitution therapy (January 2009). Substitution treatment has expanded substantially in the European Union in the past 5–10 years (EMCDDA 2008). Today, all European Union countries have substitution treatment programmes in some shape or form, although countries vary considerably in the extent and nature of the treatment accessibility and quality. Substitution treatment in its different forms has established itself as a widely accepted harm reduction and treatment measure for opiate-dependent individuals in the community.

The latest scientific research data suggests that opioid dependence is a chronic brain illness with frequent relapses. Nowadays, opioid dependence is often compared with other chronic diseases, such as hypertension, diabetes and asthma (McLellan A.T. and al. 2000, WHO 2004a-d, WHO 2005 ac). There are no particular “cures” for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, and behavioral change in patients, it is possible to eliminate or reduce symptoms of chronic diseases and achieve a high quality of life. In this context, opioid substitution treatment (OST) is recognized as a cost-effective strategy, which allows achieving high retention rates of IDU in therapeutic programmes, significant reduction of illegal opioid use and reduction of injecting risk behavior. Both methadone and buprenorphine have been included into WHO XIV Edition of the Model List of Essential Medicines (WHO 2005b).

The new WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence recommend that OST with methadone or buprenorphine be used in preference to detoxification for most patients, that methadone be used in preference to buprenorphine, and that both methadone substitution therapy and detoxification services be made widely available (WHO, 2009).

The Kyrgyz Republic was the first country of Central Asia having initiated a pilot OST programme in 2002. The first evaluation of the OST program (Asanov T 2005) indicated that OST was effective in the reduction of illegal drug use and increased social adaptation of OST patients. By 2006 the number of the OST delivery centers was low (2 centers in Bishkek and Osh) and the number of patients in OST actually decreased (145). Thus, OST could not play any significant role in the prevention of HIV before 2006. Nevertheless the evaluation report (Subata E., Pkhakadze G. 2006) concluded that during the pilot phase of the OST programme in 2002-2006, substitution therapy with methadone in the Bishkek and Osh drug treatment centers was implemented in a comprehensive way, in cooperation with other medical institutions and NGOs. In October 2008 a third evaluation (Subata E., Moller L, Karymbaeva S, WHO 2008) of the programme was conducted and the following recommendations made:

1. Efforts should be continued to increase the access of IDU to OST in the Kyrgyz Republic in order to increase the impact on the prevention of HIV, hepatitis B and C, TB, and STI. It is recommended to further expand OST in Family Medicine Centers supported by capacity building of existing staff.
2. Comprehensive health care should be continuously available in health care institutions, including infectious disease prevention and care, and psychosocial support. Naloxone should be available in drug treatment service centers to prevent deaths from opioid overdose in patients, who are not in OST. Testing for hepatitis C among all patients at a volunteer basis should be promoted.
3. Cooperation of drug treatment service with family physicians should be strengthened by encouraging patients to use the services of Family Health Centers. Inclusion of NGOs in providing social and legal support for OST patients should be continued at all levels.
4. Capacity building of the OST staff, family physicians, and infectious disease specialists should include the system of provision of basic and continuous training on OST. For this purpose it is recommended to develop a training module for the multidisciplinary staff. Training should be provided by local experts.
5. The monitoring and evaluation plan to monitor the treatment outcomes should be established in the country. Monitoring and evaluation activities should be an integral and continuous part of each OST programme as is indicated in the clinical protocol. For monitoring purposes a short data collection tool should be developed to follow dynamics in drug use, health, social integration and risk behavior. This should be based on already available methodologies.
6. It is recommended to finish an outcome evaluation study of the pilot OST programme in penitentiary institution No 47 in comparing the number of indicators at the baseline, after 3 and after 6 months. Based on the results of the evaluation of the pilot OST, the expansion of OST in the penitentiary system should be considered.
7. An information dissemination strategy targeting government employees, law enforcement officers, and medical professionals should be developed to avoid misconception about OST at all levels.

During a WHO expert mission in October 2008 where an evaluation of the methadone program was performed, some government agencies in the Kyrgyz Republic, expressed doubts on the effectiveness of OST in Kyrgyzstan. The necessity for rapid assessment of the effectiveness of OST in Kyrgyzstan became therefore apparent in order to further build consensus among main stakeholders regarding the expansion of OST in the country.

In December 2008 WHO initiated an evaluation of patients in methadone therapy as well as 100 drug dependent patients there were waiting for methadone treatment or who had started other form of treatment.

Methodology

A special questionnaire for the study was developed in order to evaluate the actual use of drugs, risk behaviour and social performance. Questions were related to actual situation as well as to the situation before the methadone treatment started. In order to compare retrospective data of

patients in treatment, it was decided also to include 100 drug users, who currently were waiting for treatment in other kind of drug treatment. The questionnaire is attached in Annex 1.

Each patient was interviewed by a trained interviewer and the survey results were anonymous. In total 701 (96.2%) currently in treatment were interviewed out of a total of 729 patients and 100 patients, who are not in methadone substitution therapy. Twenty-eight patients did not want to attend or were difficult to find.

In total 801 patients were interviewed between 20 November and 20 December, 2008. The survey was conducted in Tokmok, Bishkek, Kant, Lebedinovka, Sokuluk, Belovodsk village, Osh, Kara-Suu cities and in prison #47 in Bishkek city.

In all the points, the methadone is distributed from 8am to 1pm, except for the point in Belovodsk, where the methadone is distributed from 8am to 4pm. This extended distribution time is to allow time for the clients of the programme living in villages outside Belovodsk to arrive on foot, because of experiencing financial hardships to afford paying for transportation.

Most of the participants of the programme expressed their willingness to take part in the survey. There were also some trying to avoid participation the survey, on the grounds of lack of time, and fear of being late to work, but in most of the cases the provided information changed their mind and they agreed to participate in the survey.

The interviews by medical staff were conducted in a friendly atmosphere, and there were not any incidents during the survey period. The interviewers were given a separate room, where they freely conducted the survey with clients of the methadone programme.

Table 1. Name of the institution and number of MST programme patients

Name of the institution	Number of MST programme patients
National Narcological Centre	94
Family Group Practitioners Centre № 1	47
Family Group Practitioners Centre № 6	33
Family Group Practitioners Centre № 8	59
Osh town and Kara-Suu town	143
Kant town	45
Tokmok town	60
Alamedin region FGC	38
Kara-Balta town	50
Sokuluk region FGC	44
Moscow region FGC	38
Prison no.47	50
Total:	701

Results

Table 2 shows the baseline data for men and women in substitution therapy. In total 701 were interviewed and of these 76 were women (10.8%). The mean age is a little lower among men (35.7 years) than among women (38.0 years). The male patients have had longer schooling (9.7 years) compared to 9.1 years for females and for both sexes about half of them (47.1%) have been in prison.

Table 2. Baseline data for men and women in methadone substitution therapy, n=701.

	Men (n=694)	Women (n=76)	Total (n=701)	p-value
Age (years)	33.7	34.1	33.8	0.86
Years in school (years)	9.8	9.1	9.7	0.009
Been in prison (%)	32.9	28.6	32.0	0.80
Contact relatives (%)	88.6	81.0	87.0	0.46
Years using drugs (years)	13.8	11.8	13.4	0.44
Years injecting (years)	10.8	10.4	10.7	0.84
First time injected was in prison (%)	6.3	0	5.0	0.58
Injected last 3 months (%)	98.7	100	99.0	0.99
Needle/syringe sharing last 3 months (%)	36.7	38.1	37.0	0.99
Crime last 3 months (%)	11.1	5.0	9.8	0.68

Table 3 shows the results among 100 random selected patients who were under treatment at the narcological centres but without using methadone. These patients are included in the survey in order to compare exact baseline data with the retrospective data collected among patients in methadone treatment.

The baseline data for patients in methadone treatment (table 2) and the data for patients not in methadone treatment (table 3) show almost similar results on average age, years in school, contact relatives, years using drugs, years injecting drugs and first time injected in prison. Fewer of the patients in the non methadone group have been involved in criminal activity during the last three months. A higher proportion compared to the methadone treatment group has been sharing needles and syringes (37%) compared to 22% of patients not in methadone treatment.

Table 3. Baseline data for drug dependent patients who did not use methadone (n=100)

	Men (n=79)	Women (n=21)	Total (n=100)	p-value
Age (years)	35.7	38.0	36.0	0.041
Years in school (years)	9.7	9.1	9.6	<0.0001
Been in prison (%)	46.7	50.0	47.1	0.63
Contact relatives (%)	75.9	78.4	76.2	0.70
Good or very good quality of life (%)	18.5	21.6	18.9	0.49
Satisfied or very satisfied with own health (%)	18.3	21.6	18.7	0.41
Years using drugs (years)	12.3	11.9	12.3	0.67
Years injecting (years)	10.7	10.9	10.8	0.81
First time injected in prison (%)	4.3	13.4	5.4	<0.0001
Injected last 3 months (%)	100	100	100	NA
Needle/syringe sharing last 3 months (%)	22.6	17.1	22.0	0.31
Casual sex partners last 3 months (%)	18.6	0	16.5	<0.0001
Crime last 3 months (%)	34.6	34.2	34.5	0.99
Able to work (%)	40.1	51.5	41.4	0.037

Table 4 shows the data for patients in methadone treatment before starting the treatment and currently in treatment. Significantly more patients in treatment are working and 53.6% of the patients have a job when in treatment. None of the patients in treatment report any criminal activity during the last three months where almost 30% committed crime the last three months before starting methadone treatment. The quality of life and self-reported health have been significantly improved after starting treatment. Before treatment all patients were injecting drugs, in methadone treatment this proportion decreased to 14.5% during the last months and most of these patients only tried heroin a few times.

Needle and syringe sharing decreased from 18.2% to 3.6% during a three month period. None of the patients in the methadone treatment who have been using methadone for more than a year have been sharing needles and syringes during the last three months (data not shown).

Table 4. Baseline and follow-up data on patient in methadone substitution therapy (n=701)

	Before treatment	On methadone treatment	p-value
Have a job	39.4	53.6	<0.0001
Good or very good quality of life (%)	7.3	74.6	0.005
Satisfied or very satisfied with own health (%)	0	78.2	<0.0001
Casual sexual partners (%)	17.8	7.3	0.007
Crime last three months (%)	28.5	0	<0.0001
Injected drugs last three months (%)	100	14.5	<0.0001
Sharing injecting equipment last three months (%)	18.2	3.6	0.137

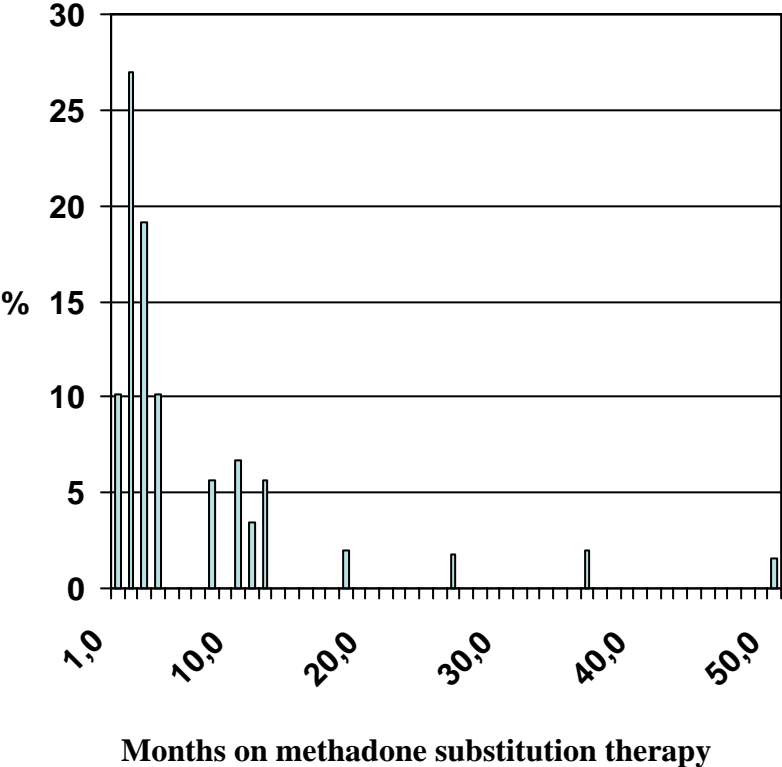
Table 5 shows the use of drugs and alcohol in a period of 30 days before and after the start of methadone treatment. The use of all substances decreased when the patients started methadone substitution therapy and heroin use decreased from 100% to 12.7% (p<0.0001).

Table 5. Use of alcohol and drugs during last 30 days for patients before and after start of methadone substitution therapy (n=701).

	On methadone treatment	Before treatment	p-value
Alcohol – used last month (%)	10.1	16.5	0.74
Alcohol – intoxicated last month (%)	9.7	16.4	0.23
Heroin – used last month (%)	12.7	100	<0.0001
Other opiates used last month (%)	9.3	16.0	0.21
Barbiturates used last month (%)	10.4	16.0	0.19
Hypnotics used last month (%)	11.3	16.9	0.19
Cannabis used last month (%)	10.3	16.3	0.31
Inhalants used last month (%)	9.6	15.8	0.99

Figure 1 shows the percentage of patients using methadone and heroin at the same time compared to the period they have been using methadone. The figure shows that the side use of heroin during treatment with methadone decreases especially during the first months of treatment but about 1-2 % of the methadone patients continue to use heroin at least once a month.

Figure 1. Percentage of patients that sometimes use heroin according to the period they have been using methadone.



Discussion

Opioid substitution therapy has been shown in a large number of studies to be very effective in reducing crime, improving overall health and social performance and in reducing risk behaviour.

This study uses retrospective data that are collected when the patients were in methadone treatment. This methodology by all means has limitations, as data was gathered from patients not only about the current situation, but also about their situation before they started methadone treatment. Nevertheless, by comparing data gathered retrospectively and obtained from those in treatment, one can see the general identity of main indicators, which verify that data obtained retrospectively corresponds to the actual situation of untreated subjects. The average of treatment in the methadone group is 8.5 months and for most of the patients the time before treatment is not too far away.

The changes in self-reported health is very clear and “good quality of life” increased from 7% to 75%, “satisfied own health” increased from 0 to 78%, “crime” decreased from 29% to 0, “injecting drugs during a three month period” decreased from 100% to 15% and “sharing of injecting equipment” decreased from 18% to 4%. There are also significant more patients now employed.

Data also show the dramatic decrease in heroin use when starting treatment. In the initial phase when methadone slowly is introduced there is still some use of heroin (see fig. 1) but after a period of 6-12 months only 1-2% of the patients use heroin at least once during the last 30 days.

Such a methodological approach allows us to obtain in a very short time some a rough estimation of the effectiveness of OST in the Republic of Kyrgyzstan, which could be used for future health

policies. Previous experience in similar situations has shown, that more sophisticated and much more costly studies inevitably confirmed the effectiveness of OST in the significant reduction of illicit drug use, risk injection behavior, criminality and the significant increase in individual's health and quality of life indicators in spite of economic status and cultural specificity of the country (Lawrinson P., Ali R., Buavirat A., et al., 2008).

During the survey, the HIV positive clients did not try to hide their status. Overall 50 participants of the 701 drug users included in the study were infected by HIV. However, it is noteworthy that out of 50 PLHIV among MST patients, only 3 get treatment.

Almost all of the clients of the methadone programme were covered by the survey, except for those who do not go to get the methadone by themselves, but rather receive it through their relatives. Also, there are some clients, who continue using injecting drugs and abandon the methadone programme.

In the given context, the cost effectiveness of the methadone therapy relates to the cost for a patient on MST roughly amounting to 1 USD, totally per year - 365 USD. In comparison, if an IDU is infected by HIV, the cost for ARV alone amounts to 600 USD without other direct and indirect expenditures which will be spent till the end of the HIV-infected person's life. In addition, it should be considered that there is a risk of OI or co-infection. Thus, in total, if someone is infected, the costs may increase at least by 2.5 - 3 times if MST is not applied.

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Appendix 1

Questionnaire on drug dependence for patients in methadone treatment and for patients that is waiting for methadone treatment

Anonymous – completed by interview.

A. What is your age? _____ years.

B. What is your gender? Male Female

C. How many years have you been in school? _____ years

D. Have you ever been to prison? yes no

E. The first time you injected drugs was that:

Outside the prison

Inside a prison

F. How many years have you been using illicit drugs? _____ years

G. How many years have you been injecting drugs? _____ years

H. Have you contact with your relatives? yes no

If yes – how often?

Every day

Most often 2-5 times a week

Most often once a week

Less than once a week

I have no contact with my relatives

I. Do you have a job at the moment? yes no

J. If yes – how many days a week have you been working during the last three months?

_____ days a week

K. How would you rate your quality of life at the moment?

Very poor

Poor

Neither poor nor good

Good

Very good

L. How satisfied are you with your health at the moment?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied

M. Do you use methadone at the moment? yes no

If yes how many months have you used methadone? _____ months

If yes, what is the dose of methadone at the moment? _____ mg

N. During the last 30 days how many days have you been using:

- Alcohol – any use at all _____ days
- Alcohol – to intoxication _____ days
- Heroin _____ days
- Other opiates as opium _____ days
- Barbiturates _____ days
- Other sedatives, hypnotics,
tranquillisers _____ days
- Cannabis _____ days
- Inhalants _____ days
- More than one substance
- Per day (including alcohol) _____ days

O. Have you injected drugs during the three months?

yes no

if yes how often during the last three months?:

- More than 2 times a day
- Most often ones a day
- Most often 2-5 times a week
- Most often once a week
- Less than once a week
- Most often once per months
- I have not used drugs during the last three months

P. During the last three months have you been sharing syringes or needles when you injected drugs? yes no

If yes, how often have you been sharing needles and syringes during the last three months?

- Most often ones a day
- Most often 2-5 times a week
- Most often once a week
- Less than once a week
- Most often once per months
- I have not shared needles or syringes during the last three months

Q. Are you infected with:

Tuberculosis

- HIV
- Hepatitis B
- Hepatitis C

R. Do you receive treatment for HIV with ART
yes no

S. Have you had any casual sexual partners during the last three months?
yes no

If yes, have you used condoms with these partners?

- Always
- Most often
- Sometimes
- Very seldom
- I have not used condoms
- I have not had casual sex

T. Have you during the last three months been involved in any crime such as break and enter, robbery, shoplifting and other kind of stealing?
yes no

If yes, how often?

- No crime
- Less than once a week
- Once a week
- More than once a week (but less than daily)
- Daily

From here only for patients that are in methadone treatment.

I will now ask you some questions for the period just before you started the methadone treatment:

U. Before starting the methadone programme did you then have contact with your relatives?
yes no

If yes – how often?

- Every day
- Most often 2-5 times a week
- Most often once a week
- Less than once a week
- I have no contact with my relatives

V. Did you have a job just before you started the methadone treatment?
yes no

W. If yes – how many days a week did you work during the last three months before treatment?

_____ days a week

X. How would you rate your quality of life at that time?

- Very poor
- Poor
- Neither poor nor good
- Good
- Very good

Y. How satisfied were you with your health at that time?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied

Z. During the last 30 days before starting the methadone treatment how many days have you been using:

Alcohol – any use at all _____ days
Alcohol – to intoxication _____ days
Heroin _____ days
Other opiates as opium _____ days
Barbiturates _____ days
Other sedatives, hypnotics,
tranquillisers _____ days
Cannabis _____ days
Inhalants _____ days
More than one substance
Per day (including alcohol) _____ days

AA. Did you inject drugs during the last three months before you started the methadone treatment?

yes no

if yes how often during the last three months before starting methadone treatment?:

- More than 2 times a day
- Most often ones a day
- Most often 2-5 times a week
- Most often once a week
- Less than once a week
- Most often once per months
- I have not used drugs during the last three months

BB. During the last three months before starting methadone treatment have you been sharing syringes or needles when you injected drugs? yes no

If yes, how often did you share needles and syringes during the last three months before starting the methadone treatment?

- Most often ones a day
- Most often 2-5 times a week
- Most often once a week
- Less than once a week

- Most often once per months
- I have not shared needles or syringes during the last three months

CC. Have you had any casual sexual partners during the last three months before you started the methadone treatment?

yes no

If yes, did you used condoms with these partners?

- Always
- Most often
- Sometimes
- Very seldom
- I have not used condoms
- I have not had casual sex

DD. Starting the methadone treatment did that change:

- Now, I am able to work
- Now, my health is much better
- Now, I have increased contact with family
- Now, I have increased contact with friends
- I do not feel any change in my health
- I have not increased contact with my family
- I have not increased contact with friends

EE. Have you during the last three months before starting the methadone treatment been involved in any crime such as break and enter, robbery, shoplifting and other kind of stealing?

yes no

If yes, how often?

- No crime
- Less than once a week
- Once a week
- More than once a week (but less than daily)
- Daily