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General Practitioner perspectives on and attitudes toward the Methadone Treatment Programme in Ireland

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Summary

Background: Methadone maintenance treatment in Ireland is provided in addiction clinics, and in primary community care settings by Level 1 and 2 specialist trained general practitioners (GPs). The Irish College of General Practitioners (ICGP) provides training and regulates the Methadone Treatment Programme (MTP). **Aim:** The study aimed to assess and compare GP perceptions of the scale of local illicit drug use, attitudes toward and obstacles in the provision of methadone treatment and preferred adjunct modalities. **Methods:** In 2006 and 2015, an online survey was undertaken with all Level 1 and 2 registered GPs in the MTP. **Results:** The majority of participants were male, aged between 35 and 60 years, treated between 1 and 25 patients in urban areas. In 2015, 44.7% with registered methadone patients reported no obstacles to taking on more (32% in 2006). In relation to GPs with no current methadone patients, reasons for not taking patients in 2015 were similar to 2006, and centred on no referrals or demand, and concern for negative affect on private patients. Majority attitudes toward the MTP remained positive, with one exception relating to greater disagreement in 2015 with the statement that supervised daily dispensing prevents patients from working ($p < .05$). Preferred adjunct services remained constant; addiction counselling, in-patient detoxification, employment schemes and consultant psychiatric services. **Conclusions:** The study illustrates a generally positive attitude toward the Irish MTP. Efficient referral mechanisms for stabilised patients to primary care settings, and greater psycho-social, vocational and detoxification supports are warranted.

Key Words: Methadone Maintenance Treatment; General Practitioner; Attitude

1. Introduction

Addiction to opiates is defined as a chronic, relapsing disorder with permanent metabolic deficiency [8]. Heroin dependence is the most common form of opiate dependence and is a complex condition commonly requiring long term treatment modalities typically incorporating pharmacological, psycho-social rehabilitation and relapse prevention interventions [3]. Treatment and detoxification using therapeutic agents are vital in the care and management of opiate dependent patients, and include oral administration of full or partial opioid agonists (i.e. methadone, buprenorphine, LAAM, codeine or oral morphine) [2, 27,]. Methadone maintenance treatment (MMT) is the most prescribed treatment worldwide, with the exception of France where buprenorphine is preferred [4]. Cochrane reviews indicate strong evidence to support oral agonist opioid treatment with methadone [14, 22,23] with low threshold methadone treatment increasing patient reach, uptake and retention, and reducing barriers to access, heroin use, injecting risk behaviours, mortality and criminal activity [20, 29]. Studies indicate strong retention rates in MMT when compared to detoxification [28].

Ireland has developed a model of care for delivering methadone treatment which acknowledges the central role the general practitioner (GP) plays in delivering care. MMT has been available since 1992, initially confined to the capital, Dublin, and with the 'Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone' under-

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taken in 1993. In 1998, the 'Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations' was introduced which implemented specific administrative structures designed to monitor treatment delivery and patient trends. The Irish College of General Practitioners (ICGP) has played a central role in developing the Methadone Treatment Protocol (MTP) which provided for the delivery of methadone treatment in primary care in the Irish context. The MTP has presented systematic protocols for the prescribing of methadone, management of patients, a scheme for general practitioner involvement in treating patients on methadone, the provision of GP training, expansion of methadone patients in the community based primary care context, and clinical audits [6]. Three types of MMT settings exist in Ireland:, in specialised addiction clinics, with Level 1 trained GPs are restricted to 15 patients, with patient stabilisation occurring in specialised addiction clinics or with Level 2 trained GPs who are qualified to initiate treatment, stabilise doses and provide on-going maintenance treatment. Inter-referral between Level 1 and Level 2 GPs is encouraged where this option is available. All patients on MMT in Ireland are listed on the confidential Central Treatment List (CTL) and each patient is listed with one specific prescriber and one specific dispensing site only.

Since the introduction of the 1998 MTP, the numbers of GPs participating in the MTP scheme have increased steadily each year. In 2005, an internal review was conducted by the Methadone Prescribing Implementation Committee. This was followed by an external review in 2010 [9], which referred to improved prescribing and quality of independent practitioner practice in the community. The review recommended further consideration of a range of approaches to maximize treatment provision and inter agency referral pathways. In 2015, there were 275 Level 1 and 70 Level 2 GPs on the CTL listing.

In the light of the strong evidence base for MMT as a treatment option for opiate dependence, the ICGP surveyed all Level 1 and 2 registered GPs in the Methadone Treatment Programme (MTP) in 2006 and 2015 in order to assess and compare variations in GP perceptions of the scale of local illicit drug use, attitudes toward and obstacles in the provision of methadone treatment and preferred additional support modalities.

2. Methods

In 2006 and 2015, an online survey was undertaken with all GPs in the MTP database. All GPs on the database were surveyed regardless of whether they had patients currently registered on the CTL. At both time points, the survey link was emailed to the email address supplied by the MTP with a reminder email sent two weeks later. A notice encouraging response was also placed on the drug misuse section of the ICGP website. Such attitudinal surveys of health professionals are exempt from ethical approval in Ireland.

The survey contained a series of descriptive and open ended questions. These related to:

- participant and practice profile, specifically age, gender, percentage of practice that were GMS patients, geographic information, and number of GPs in the practice;
- perception of scale of problem, specifically whether it was major or minor problem;
- provision of methadone treatment in practice, specifically whether respondents currently have any patients on MMT, and perceptions around obstacles to providing MMT and taking on additional methadone patients;
- attitudes to the methadone treatment programme, specifically a series of pre-defined statements measuring attitude toward MTP; and finally
- additional services, specifically areas of support GPs deem necessary to further enhance the services provided to their patients.

Anonymised data yielded descriptive statistics (number, percentages) and qualitative open ended comment data were manually thematically coded. Statistical tests using SPSS included Chi square tests, t-tests and p-values were used to assess differences in categorical data, with a significance level of 0.05.

3. Results

In 2006, there were 207 responses from 600 questionnaires sent, giving a response rate of 34.5%. In 2015, there were 217 responses from 949 questionnaires sent, giving a response rate of 22.87%. Reminder questionnaires were sent and a reminder notice was placed on the drug misuse section of the ICGP website for both surveys. Where possible the analysis outlined below is based on comparisons between GPs who had patients on the methadone treat-

ment protocol from the 2015 survey (n=170) and the initial 2006 survey (n=147).

3.1. Participant and Practice Profile

In terms of the profile of GPs, few differences were found between the 2006 and 2015 survey groups. The majority of GPs remained between 35 and 60 years of age, and were male. The profile is consistent with available statistics on the overall population of GPs in Ireland and in the trends evident between 2006 and 2015, particularly an increase in the proportion of females. The majority of practices were described as being in urban areas. In 2015, 69.5% of practices were located in urban areas, 3% in mixed urban/rural and 4.7% in rural (Table 1).

Table 1: Respondent demographics

Demographics	2006	2015
Age	(n=147)	(n=168)
<35	14 (9.5%)	19 (11.3%)
35-45	35 (23.8%)	50 (29.8%)
46-60	79 (53.7%)	70 (41.7%)
>60	19 (12.9%)	29 (17.3%)
Sex	(n=143)	(n=164)
Female	35 (24.5%)	55 (33.5%)
Male	108 (73.5%)	109 (66.5%)
Practice Area	(n=147)	(n=167)
Urban	111 (75.5%)	116 (69.5%)
Mixed	32 (21.8%)	43 (25.3%)
Rural	4 (2.7%)	8 (4.7%)

In Ireland, the General Medical Scheme (GMS) operates outside of private health care to provide free general practitioner services and free drugs and medicines to persons covered by medical cards. There are approximately 1.262 million people eligible to use the services under the scheme. In 2006 and 2015 the majority of GPs indicated that over 50% of their patient population were GMS patients. All patients are eligible to avail of the MTP free of charge. Single handed practices comprised 17.8% of GPs in 2015, a decrease from 31.3% in 2006. Both in 2006 and 2015, approximately 60% of practices had between two and four GPs in practice.

3.2. Perception of Scale of Problem

In 2015, when asked how big a problem illicit drugs were in their practice area, 66.5% of GPs felt there was a major problem (n=113), while 33.5% felt it was a minor problem (n=57). In 2006 (n=141), 53.2% felt there was a major problem in their practice area (n=75) and 46.8% felt it was a minor problem.

The perception of the scale of the problem in reference to location was analysed. It was found that the majority of GPS in 2015 who reported that illicit drugs were a major problem in their practice area were in an urban location (n=86); similar findings were reported in 2006 (n=64). The majority of GPs from rural areas reported little or minimal problems with illicit drug use in their practices. There was no observed statistically significant relationship between perception of scale of the problem and location; or perception of scale of the problem and number of patients on MTP in the practice.

3.3. Provision of Methadone Treatment in GP Practice

Of those GPs who had patients on the methadone treatment protocol, in 2015 (n=170) and 2006 (n=147), the majority were treating between 1 and 25 patients (Table 2)

Table 2: Number of patients on methadone treatment

2006			2015		
	n	%		n	%
<25	101	68.7	<25	97	77.6
25-50	38	25.9	25-50	22	17.6
50-75	4	2.7	50-75	3	2.4
>75	4	2.7	>75	3	2.4

GPs who did not currently have methadone patients were asked to select from a provided list all obstacles to taking on patients. They had the opportunity to add detail via open ended comment if they selected 'other'. In 2015, of the 46 GPs who indicated that they did not currently have patients, just over 51% reported that they had 'never been asked to' take on any patients, while 34% stated that there was 'no demand' in their area for methadone treatment. Nearly 27% of GPs reported that they were concerned that treating methadone patients in their practice would 'put off private patients'. In 2006, 57 GPs indicated that they did not currently have methadone patients. Just over 46% of those indicated that they had 'never been asked to' take on any patients. Approximately 27% reported that there was 'no demand' in their area for this form of treatment. (Table 3)

Table 3: GPs without Methadone Patients - Obstacles to taking on MTP patients

	2006		2015	
Obstacles, if any, to taking on patients	n	%	n	%
Never been asked to	21	51.2	33	46.5
No demand in the area	14	34.1	19	26.8
Practice too small	2	4.9	2	2.8
Fear of violence	9	22.0	10	14.1
Fear it would put off private patients	11	26.8	10	14.1
Other	19	46.4	35	49.3

GPs who had patients on the MTP were asked to indicate all reasons why they did not take on new patients from a provided list. In 2015, 44.7% of GPs who had patients on the MTP indicated that there were no obstacles to taking on more MTP patients; while 32% of GPs in 2006 indicated the same. (Table 4)

Where 'other' was given as a response, GPs were asked to specify via open ended comment section what other barriers they had encountered to taking on patients. In 2006 and 2015 common themes were 'work load involved', 'partners/practice principals not keen', 'size/location of premises', 'insufficient community supports', 'lack of knowledge/ training' and 'personal reasons'. One GP highlighted that they felt 'de-skilled' in terms of methadone treatment. Specifically in relation to 'personal reasons', some GPs offered insight on their lack of empathy with addicts and highlighted that it was not an enjoyable topic area to work in as it 'can be difficult, chaotic and demanding'.

3.4. Attitudes to the Methadone Treatment Programme

GPs were asked to rate a number of pre-defined statements with regard to the Methadone Treatment Programme on a scale from 'Strongly Agree' to 'Strongly Disagree'. Applying a scoring to responses, the mean scores in 2015 were similar to those from the 2006 study. The majority of respondents agreed that the MTP eliminates chances of double scripting, allows for a good relationship with patients, improves the health of patients and reduces criminality.

Opinions regarding the statement that "supervised daily dispensing prevents patients from working" were divided. In 2006 over half of respondents (57.8%) agreed that supervised daily dispensing prevents patients from working, while nearly 40% considered that it did not prevent them from working. However in 2015, the proportions were closer and reversed with 41.2% agreeing that supervised daily dispensing prevents patients from working, while nearly 46.5% considered that it did not prevent them from working. This shows a shift in GPs' opinion and may be indicative of positive experience with the supervision element of the programme. (Table 5)

GPs were given the option to comment via open-ended comment stating "any other comments regarding the MTP" at the end of the statement section. Other comments/suggestions given were:

- Need a shorter waiting list.
- Need a system for crisis intervention.
- MTP a little too vigilant for long term patients/protocol should be more relaxed for clean and stable patients.

Table 4: GPs with Methadone Patients - Obstacles (if any) to taking on *additional* MTP patients

	2006		2015	
Obstacles, if any, to taking additional patients	n	%	n	%
Have enough already	20	11.8	24	16.3
Have reached protocol maximum	28	16.5	40	27.2
No referrals	46	27.1	22	15.0
Practice staff don't want anymore	2	1.2	9	6.1
Other patients don't want anymore	4	2.4	2	1.4
No obstacles	76	44.7	47	32.0

Table 5: Attitudes to the Methadone Treatment Programme 2015 and 2006

Attitudes to the Methadone Treatment Programme	2006			2015		
	n	Mean	SD	n	Mean	SD
Allows good relationship with patients	144	1.65	.583	146	1.65	.537
Provides regular opportunity to monitor progress with patients	144	1.58	.549	148	1.48	.501
Essential service for drug users	1.47	1.47	.540	142	1.44	.513
It is an overly rigid protocol	145	2.73	.648	147	2.95	.710
Eliminates chance of double scripting	144	1.78	.650	150	1.77	.689
Improves health of patient	143	1.64	.538	150	1.63	.511
Reduces criminality	143	1.62	.541	150	1.65	.579
Supervised daily dispensing prevents patients from working	141	2.30	.684	148	2.47	.760
It is difficult to get off methadone	142	1.93	.637	150	1.86	.695
Keeps patients addicted to substance	141	2.27	.745	148	2.32	.767

- Little help to get patients off methadone.
- Impression is of long duration maintenance.
- Allows time to grow and be decoupled from heroin if so desired.
- Additional educational support to facilitate patients to become drug free.

Some GPs spoke positively of their experience of treating methadone patients "I find methadone prescribing one of the more enjoyable aspects of my practice. Only at it for less than a year and I still feel there's a lot to learn" GP01_2015. While another identified their perceived view of their patients experience to date: "Any patients I have had since I first started have done well. I feel I give them good support and reassurance and a sense of self-worth. They are treated with dignity and respect. It is also very confidential" GP02_2015.

GPs also identified a lack of access to assessment and support services, including community liaison officers, literacy support, alcohol support services and return to employment services, for patients on methadone treatment:

"The biggest drawback at present is the lack of access to a community based addiction counsellor without having to go to a treatment centre" GP03_2015.

"(Lack of) rehabilitation assessment and advice for all patients and easily accessible psychosocial support" GP01_2006.

"The options of a drop in centre and employment centres are, in my opinion, crucial in managing these patients" GP05_2015.

Some GPs also spoke of their lack of familiarity with appropriate services and how best to engage with them: "I have difficulties knowing the NGO services out there, the various criteria they all use for ac-

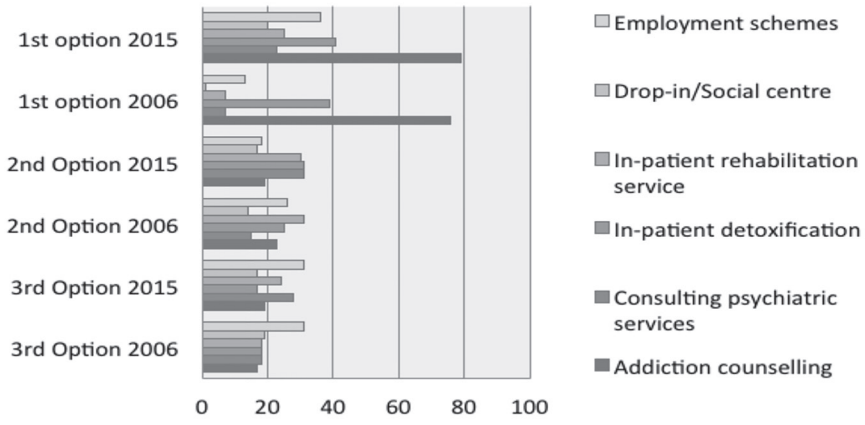

Figure 1. Areas of support from ICGP re providing care to patients in deprived areas - 2006 v 2015

cess to services, and generally how to link with them" GP 06_2015.

3.5. Additional Services

GPs were asked to rank from a provided list their top three areas of support they deem necessary to further enhance the services provided to their patients. The results of the 2015 survey and the 2006 survey reported similar findings. In both years, GPs selected addiction counselling as their primary choice (46.5% 2015; 51.7% 2006), followed by in-patient rehabilitation detoxification beds (24.1% 2015; 26.5% 2006), Of interest, the percentage of GPs who selected employment schemes and drop-in/social centres as their first choice in 2006 notably increased from 8.9% and 0.7% respectively to 21.2% and 11.76% in 2015.

4. Discussion

Given the unique nature of methadone treatment provision in specialist clinics and in community primary care settings, this Irish study yielded encouraging findings with regard to GP views on participation in the MTP, perceptions of the scale of local illicit drug use, obstacles and attitudes toward the provision of methadone treatment and preferred additional support modalities. Care of drug users in the community by primary care is extensively discussed in the literature, and is particularly cognisant of challenges presented by injecting drug users [1, 16, 17, 25, 33]. High methadone patient turnover, consultation time pressures and emergency appointments remain characteristic of the treatment cohort [18, 26]. Drug users themselves also report a preference for the treatment of their dependency within general practice [5]. Positive outcomes relate to methadone patient satisfaction, reduced criminal activity and drug use, and uptake in adjunct medical and social services [11, 15, 34]. Of note, was that the majority of GPs' attitudes toward the MTP remained positive over time, in that it is an essential service to drug users, improves patient health, allows a good relationship with patients, provides regular opportunity to monitor progress with patients, and reduces criminality, with one exception relating to increased disagreement that supervised daily dispensing prevents methadone patients from working. An earlier qualitative Irish study observed positive GP observations on MMT around harm reduction outcomes, and how MMT represents an important turning point for patients [31].

We recognise that the provision of MMT is not without problems. A minority of GPs reported concerns relating to potential negative effect on private patients. Studies have reported on GP reluctance to offer MMT in primary care as grounded in perceived lack of skills and expertise, workload, concerns around displacement of stigma from clinics into private/general practice and personal and staff safety [1, 6, 10, 12, 15, 17, 19, 21, 24, 31]. Of note, were the encouraging results around lack of obstacles to taking on more MTP patients, and that some GPs reported no current methadone patients due to lack of demand or referral. This indicates that there is significant scope for increasing the numbers of MTP patients in primary care in Ireland if GPs are approached by the relevant agencies. There is a need for continued support of existing Level 1 and 2 GPs, training of additional Level 1 GPs, and encouragement of further training to Level 2. Studies have indicated that newly qualified doctors report greater acceptance of problematic drug users, and self-awareness of their competency to treat dependencies [7,13].

The World Health Organisation guidelines advise that long term and multi component treatment modalities for opiate dependence incorporate elements of pharmacological, psycho-social rehabilitation and relapse prevention interventions within specialized stabilization and primary care settings [35]. Earlier qualitative research with Irish GPs involved in the MTP in 2013 underscored the need for a bio psycho social approach to treating opiate dependence within expanded interagency community based medical and psychosocial treatment detoxification provision. This study also illustrated how MTP GPs in Ireland currently navigate a multiplicity of roles, relating to patient advocacy, medical expertise and detoxification gatekeeping [31]. GP views in this national survey were similar and remained constant over time, thus highlighting the need for policy discourse and MTP expansion to incorporate such additional support modalities, and to additionally include employment support. Irish research in 2012 and 2014 has also emphasised the need to incorporate vocational and employment skills training into current levels and format of MMT provision [30, 32].

Limitations

Clearly the response rate is a limiting factor in this study, however, it is typical of response rates from GPs. Furthermore, the profile of those who did reply is consistent with the national GP population and the overall MTP GP population and are therefore

generalisable. Although this MTP model is unique to the Irish setting, and the findings presented are based on it, the model could be closely replicated across primary care settings in other countries and hence the findings could inform the establishment of such programmes.

5. Conclusions

Given the specialist and community primary care approach to providing MMT in Ireland, to a large degree GPs present a key and essential resource in the treatment of opiate and other drug misuse, and have responded well to the challenge of managing drug users. The study illustrates a generally positive attitude toward the Irish MTP, with a need for greater efficiency of referral mechanisms for stabilised patients to primary care settings, and greater incorporation of psycho-social, vocational and detoxification supports warranted.

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Contributors

All authors were involved in the study design, had full access to the survey data and analyses, and interpreted the data, critically reviewed the manuscript and had full control, including final responsibility for the decision to submit the paper for publication.

Conflict of interest

All authors declare no conflict of interest.

Ethics

Authors confirm that the submitted study was conducted according to the WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. The study does not have IRB review/approval; this study does not require ethics committee approval because attitudinal surveys of health professionals are exempt from ethical approval in Ireland.

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