

Prescribing Doctor attitudes, experiences and perspectives on the provision of methadone maintenance treatment in Dublin.

Dr Marie Claire Van Hout

Tim Bingham

2012

Acknowledgement

With great thanks and sincerest appreciation to the doctors who participated in the research.

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Executive Summary

Background to Research

Methadone maintenance treatment (MMT) has been available in Ireland since 1992, with initial provision of treatment in Dublin. The Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone was undertaken in 1993. In 1998, the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations* was introduced, with specific administrative structures implemented in order to monitor treatment delivery and patient trends (Central Treatment List or CTL). The Methadone Treatment Protocol was devised by the Irish College of General Practitioners (ICGP) in 1998, in order to present systematic protocols for methadone prescription and patient management, support MMT delivery across Ireland, general practitioner (GP) training, increase the number of clients on MMT within a community based primary care context, and assist in audits (Butler, 2002). An internal review was conducted in 2005 by the Methadone Prescribing Implementation Committee (2005). Currently, there are three types MMT service provision in Ireland namely; in specialised clinics, and with Level 1 and 2 trained prescribing doctors. Level 2 trained doctors are qualified to initiate treatment, stabilise doses and provide ongoing maintenance treatment (Delargy, 2008). Level 1 trained doctors are restricted to 15 patients, with patient stabilisation occurring in specialised clinics or with a Level 2 trained doctor. The number of Level 1 doctors has increased grown from 151 in 2002 to 218 in 2009. However, less than 5% of patients in Level 2 practice were transferred to level 1 doctors per year over the period 2002 to 2009. Most recent data indicates that in 2008, 259 Irish doctors provided MMT, with 2/3 of MMT clients treated in specialised clinics and 1/3 treated in the community (Health Service Executive, 2011).

The first external review of the Methadone Treatment Protocol was undertaken in 2010, so as to maximize treatment provision, assess clinical governance and audit, referral pathways, doctor enrollment, training (Level 1 and 2) and coordination, appropriateness and efficacy of urine testing, data collection and analysis and engagement with the Department of Justice on methadone prescribing in Garda stations was published in December 2010 (Farrell and Barry, 2010). The review commented on improved prescribing and quality of independent practitioner practice, and advised the need to maximize treatment provision and referral pathways with requests for detoxification reviewed as part of a service audit process and with a timely response (see '*National Drugs Rehabilitation Framework*' Working group on drugs rehabilitation, 2007), rural service development, improved integration between and among services, improved clinical governance and audit (see '*Achieving Excellence in Clinical Governance: towards a culture of accountability*, 2010), a need to review benzodiazepine prescribing (see '*Report of the Benzodiazepine Committee*' Department of Health and Children 2002), changing urine analysis

regimes, Garda prescribing of methadone in stations, expansion of the number of Level 2 doctors with greater emphasis on moving patients from Level 1 to Level 2 doctors. Farrell and Barry also commented on the inclusion of buprenorphine and naloxone treatment modalities, and to revise the title to "*The Opioid Treatment Protocol*".

The research consisted of two distinct phases with Phase One representing CE scheme participant views on client concerns relating to informed decision-making around MMT, patient-doctor relations, long term MMT and efforts directed at tapering methadone dosages, detoxification and rehabilitation. This Phase One report (Van Hout and Bingham, 2011) concluded by underscoring the need to explore the attitudes and experiences of MMT treatment provision from the prescribing doctors' perspectives in Phase Two.

Methodology

Qualitative methodology using semi structured in depth interviews was selected in order to fully explore the topic of MMT with prescribing doctors in a variety of settings. Ethical approval for the study was granted by Waterford Institute of Technology, Ireland in 2011. Semi structured interviews were conducted with a snow sample of methadone prescribing doctors (n=16) willing to partake in the study in Dublin. The ICGP and the Methadone Implementation Protocol Committee were unable to assist in recruitment of participants. 38 doctors were invited to partake. 2 doctors declined to partake and 20 did not respond to email and telephone messages. The researchers did not offer the doctors an incentive (i.e financial or CME) for participation. Each participant was informed as to the research aims, objectives and procedures prior to participation in the interviews. Fieldwork for the study commenced in November 2011, following an email containing information and consent protocols for each participant. All participants gave written consent, were assured of anonymity and allowed to withdraw if and when they wished. Audio recordings of the interviews were destroyed following transcription of narratives. All transcripts were stored in a locked cabinet and password protected computer at WIT. When data saturation was reached, recruitment of participants ceased.

The participants were interviewed using an interview guide developed from issues identified in the literature, and contained the following key themes; perception and knowledge of problematic alcohol and drug use in their practice, attitudes toward drug misuse as societal versus medical issue, attitudes to MMT, issues regarding MMT provision in their practice, confidence in ability to provide quality MMT, gaps in MMT service supports, attitudes to shared treatment care approaches, relationships with MMT patients, opinions on methadone dosages and tapering, patients continuing heroin and other drug use, licit drug prescribing, minors dependent on opiates, and identified MMT training needs. The interview guide was piloted with 4 prescribing

doctors in another area prior to the main study. Interviews were conducted at a pre arranged time with the participants, with all interviews audio recorded with permission. Each interview was undertaken using a conversational tone and began by asking the participants to provide their initial opinions on MMT prior to use of the semi structured interview guide. Interviews lasted between 45 and 70 minutes, with a mean length of 50 minutes.

The data was analysed with assistance from NVivo 8, a qualitative content analysis software package. Interviews were transcribed shortly after each interview and were supported by reflective researcher field notes and memos. A simple thematic analysis was conducted (Krippendorff, 2004). Each transcript was read and reread several times by both members of the researcher, which assisted in the identification of coded categories, interpretation of data and in the explanation of any data outliers. Six major themes were identified from the data.

Results

Ten Level 2 prescribing doctors and six Level 1 prescribing doctors were interviewed, of which five operated in both specialised clinics and private practice, three worked only in specialised clinics, and seven were in private practice. Three participants described situations where they were certified as Level 1 in their private practices, but were operating as Level 2 in specialised clinics. All participants described working closely with local pharmacists.

Theme One: Viewpoints relating to opiate dependency and MMT

Several participants described the interplay between genetic predisposition to addiction, drug availability and socio economic environmental factors in the form of poverty, unemployment, marginalisation, family history of problematic substance use, childhood trauma, early school leaving, peer drug use, and personality factors, which were observed to contribute to the escalation of opiate and other drug addiction, negative health consequences and criminal activity. All participants described opiate dependency as a bio psycho social issue, but observed that the current approach to treating opiate dependence was confined to the medical approach, despite the recognition of a multiplicity of personality, social and psychological influences on addiction and recovery. They highlighted the need to recognise both the pharmacological and psychosocial complexities of opiate addiction and the need to treat using combined approaches. Many participants described MMT as essentially a successful medical and harm reducing treatment approach to addressing opiate dependence and harmful injecting drug use, and that it is supported with a strong evidence base. However, medical implications relating to blood borne virus (BBV) transmission (Hepatitis C, HIV), infection from injecting drug use, and co occurring psychiatric illness were described.

All participants observed that MMT offers patients the opportunity to lead a (semi) normal lifestyle, but described negative abstinence focused opinions around MMT amongst some community based services and also the general public. Whilst offering the patient some normality in daily life, and the relinquishing of prior addictive behaviours, all participants described MMT as restricting patient freedom. Examples included remembering to take the methadone dose every day, going to the pharmacy at least every week, having to attend the doctor for prescriptions and urine screening, and planning ahead for holidays. Several participants described issues relating to the long term maintenance of patients with MMT, the tapering of methadone dosage and the chronic nature of relapse.

Theme Two: Alcohol, illicit and licit drug use in MMT patients

When questioned with regard to the area characteristics and social consequences of drug and alcohol use, a majority of participants described working in deprived and marginalised urban areas characterised by high rates of problematic drug and alcohol use. Some participants observed that drug education in schools appeared lacking in their areas, and contributed youth drug experimentation, pathways toward serious forms of drug use, opiate dependencies and destructive social consequences.

Alcohol was observed to be of most concern given its effect on methadone metabolism, increased risk for overdose, and potential addiction displacement. The majority of participants stated that excessive alcohol consumption, and alcohol dependency was common amongst their patients, with some participants estimating that 25-40% of their patients were misusing alcohol. Some made comments around the Irish drinking culture, and the potential normalisation of irresponsible drinking of alcohol among youth and adults.

Participants in some cases appeared restricted to the substitution treatment of opiate dependence via MMT, and described difficulties in treating alcohol misuse. Many participants observed that problematic alcohol use was a draw on their resources in managing substitution treatment, and in some cases were unable to test for alcohol use due to lack of provision of breathalyzers. One participant described concerns for over dose risk in patients misusing alcohol whilst in MMT, and increased rates of MMT patient mortality in older individuals, due to problematic alcohol use. Several reported concerns for the lack of specific alcohol treatment pathways and adjunct counseling services for MMT patients misusing alcohol.

Patient poly drug taking whilst engaging in MMT was mentioned by several participants, and included drugs such as cocaine, cannabis, amphetamine, ecstasy, street and prescribed benzodiazepines, new psychoactive substances and heroin. In particular, the emergence of

new psychoactive substances such as keto amphetamines (mephedrone) and synthetic cannabinoids available from headshops¹ prior to legislative controls, and subsequent availability on the street thereafter was observed to create difficulties, due to the lack of available screening mechanisms and clinical information available.

Participant views on continued opiate, other drug and alcohol use whilst in MMT were mixed, with some participants accepting of continued licit and illicit drug use whilst on methadone, and others strongly opposed to supplying methadone (particularly takeaways) in these circumstances. Several participants described opiate screening difficulties in distinguishing the frequent heroin user from the occasional heroin user, and additionally distinguishing potential harms associated with the injecting versus smoking of heroin.

Continued dialogue between doctor and patients was viewed as paramount in reducing harm associated with continued heroin injecting, smoking and the use of other substances. Participants described dealing with positive opiate urine screens by increasing methadone dosage to try and keep patients from using heroin, probing their patients about discontinuing the programme, and working towards a harm reduction dose. MMT patients were observed in some cases to *'simply give up heroin'* over time.

When questioned around the use and misuse of licit drugs, some participants described the prescribing of benzodiazepines (*'benzos'*) as problematic, and in most cases not initiated by the doctor in question. Examples included the use of street benzodiazepines, prescribing by prison doctors and in the case of Level 1 private practice, by specialized clinics during stabilization periods. Participant concerns centred on difficulties in controlling their patients' use of benzodiazepines, and the potential for development of benzodiazepine dependency. Most participants assisted their own patients in undertaking lengthy and gradual benzodiazepine detoxes. Several participants also described prescribing SSRIs.

Theme Three: The Methadone Protocols

The majority of participants observed difficulties in the prescribing of methadone as per the National Methadone Protocols as advised by the methadone implementation protocol committee. Many described these protocols and related audits as *'big brother looking over you'*, and reported conflict between the protocols, and real life practice. Issues in the auditing of

¹ A head shop is a retail outlet which specialises in drug paraphernalia related to consumption of cannabis, other recreational drugs, and New Age herbs, as well as counterculture art, magazines, music, clothing and home decor.

prescribing doctors, doctor adherence and non adherence to the protocols, variation in doctor approaches to MMT, and levels of patient centredness in the MMT treatment pathway were mentioned.

Despite the protocols in guiding MMT, some participants described the autonomy of doctor management of MMT as impacting negatively on parity of treatment and prescribing approaches, with some patients observed to be inappropriately managed. Several participants described ignoring the Methadone Protocols or not reading them, and adapting the protocols to suit their practices. Several participants described the methadone protocols as a policing system rather than therapeutic intervention for opiate dependents, with little evidence consulted in the design of specified guidelines or the evaluation of individual outcomes. The requirement for regular patient urine screening was observed by most participants to be degrading and unnecessary. The management of methadone prescribing was observed to be restrictive and related to the 7 day methadone prescription pads provided by the Methadone Protocol.

Several participants commented that the Methadone Protocols placed unnecessary and unwanted restrictions on MMT patient numbers and their freedom to prescribe as normal doctors, particularly in the case of prescribing doctors placed in addiction clinic settings, as opposed to doctors operating in general practice. These caps on patient numbers and regulations around methadone prescribing at Level 1 and 2 also appeared to restrict numbers of treatment places.

The Methadone Protocols were observed by some participants to contribute to patient institutionalisation, and in some instance an unequal, punitive doctor-patient relationship. Some participants stated that a political cap had been put on estimations of safe methadone dosage amid fears around methadone takeaway measures. In general, participants described aiming to keep the methadone level safely between 60 and 80mls, in order to avoid potential for overdose and cardiac arrhythmias. Some practices had developed specific and improved screening and monitoring procedures involving ECGs. Participants described adjusting dosage in order to avoid potential methadone diversion (onto the streets) and the continued use of heroin. Several participants described how their patients were fearful of heroin withdrawals, and how this manifested in a phobic fear of reducing methadone down to too low a dose.

All participants observed that levels of methadone dosage were dictated by the patient's wishes with support from established doctor-patient collaborative work within the therapeutic alliance. One participant described less concern for overdose risk in heroin smokers, than injecting drug users. Only in the case of psychiatric disorder, underlying health condition (i.e. HIV) or other

drug dependencies (i.e. alcohol, benzodiazepines) would the doctor take control and dictate methadone dosage.

Levels of patient methadone dosage were also observed to contradict with community employment (CE) scheme entry guidelines, with some participants stating that patients were reducing in order to get accepted onto local CE schemes. Others commented on the operation of CE Schemes as '*cherrypicking*' patients who had stabilised, were reducing methadone dosages, and who were detoxing. This was observed to impact negatively on the patient progress for excluded individuals.

Theme Four: The Doctor -Patient relationship

The majority of participants described that the doctor patient relationship differed from normal general practice due to the weekly contact with their patients, variance in levels of patient cooperation, and varying degrees of positive therapeutic alliance. No participants distinguished MMT patients from other patients attending their practices, but some participants described MMT patients as '*difficult to deal with*' at times. Issues relating to mistrust, control and sanctioning (in some instances) were observed to form the basis for the MMT based doctor patient relationship, and appeared related to the patient stage of stabilisation and recovery. Many participants described positive relationships encompassing supportive roles with their patients and within a regular routine of consultations. Some participants observed that their role was restricted to methadone prescribing and the social consequences of opiate dependence, with some patients seeing their own GPs for other general health concerns.

Theme Five: MMT Treatment Care Planning

Collaboration in treatment care planning between the doctor and patients was underscored by all participants, despite observations around the restrictions of methadone prescribing and necessity for patients to attend the doctor weekly. Patient empowerment in recovery was deemed an ultimate goal. A continuum of patient self actualisation was described. Participants were described as controlling the starting dose, and the rate of increase, with patients controlling a slow tapering and final detoxification under doctor supervision and advice. In all instances, client requests to reduce or increase methadone were heard and facilitated within a supportive patient led approach, and when stable social circumstances such as housing were in place. This was done in order to avoid potential destabilisation and overdose risk. Mixed feelings were recorded, with some participants describing reluctance to encourage full detoxification, due to the high rates of relapse, and others encouraging full patient detoxification, and rehabilitation.

All participants described instances of successful patient detoxification from methadone, but also observed patients reducing to 40mls or less, and then destabilizing. The revolving door of relapse and MMT uptake was common, particularly among young dependents attempting fast reduction of methadone, in some instances resulting in high rates of mortality. Some participants described a need for community detoxification *'in the real world'* and observed the small success rates recorded in inpatient settings. Several participants described experiences of patient self detoxification at home, and observed how improved community detoxification protocols were effective in providing supports for both methadone and benzodiazepine. Despite this, many instances of home detoxification led to opiate cravings and withdrawals, with many patients recommencing heroin, alcohol and other drug use. Underlying mental health issues were also observed to further complicate safe home detoxification. Participants underscored the need for improved aftercare *'safety nets'* supports for both residential detoxification and community detoxification.

All participants were of the view that shared care treatment approaches in Ireland were much needed and essential. Others described the difficulties of classification as Level 1 or Level 2 as difficult to implement in practice, and particularly given the nature of relapse where unstable patients necessitate greater levels of support within an interagency support network. Some participants described the need for universal and all encompassing treatment services and the need for a shift away from strict MMT and toward community based treatment for alcohol, opiate and mental health. This could potentially increase treatment uptake and remove the stigma attached to clinics. Several participants described the need for alternative forms of opiate substitution treatment such as buprenorphine, the need for specialized in patient stabilisation, in patient benzodiazepine detoxification, and support structures for those with underlying psychiatric conditions. However, several voiced concerns around community service competencies, level of staff training in the area, and service philosophies around harm reduction versus abstinence, and issues around patient confidentiality. Several comments were made with regard to service rigidity with regard to patients needs (i.e. location, opening times), and the need for development of community nurse prescribers with minor input from doctors.

All participants observed issues relating to minors presenting with opiate dependency, and highlighted the need for specialised inpatient detoxification services without the need for parental consent and substitution pathways involving a multi disciplinary youth centred approach. Many concerns were raised with regard to adolescent treatment readiness and environmental factors needing psycho social intervention.

Theme Six: MMT Training needs

Several participants were happy with MMT training levels at the time of the research, and indicated no further training needs. Some comments were made about the lack of formal training in the addiction field for doctors in clinics and community practice, and the failure of the ICGP to provide adequate training, practitioner networking, evidence based protocols, and CMEs. A minority of participants working in private practice described feeling isolated and a need to meet and network with practitioners in clinics in order to update and consult around MMT issues. Supports for clinical practitioners were described as very good.

Conclusion

The research, however small scale and exploratory, represents an important description of prescribing doctors experiences of MMT in Dublin. Observations around MMT were positive in both reducing harm and presenting an important turning point for opiate dependents. It is important to underscore that doctor efforts to assist their MMT clients were grounded in positive, empathic relationships with their patients, and in many cases surpassed their roles as methadone prescribers. The researchers wish to sincerely thank the participants for their involvement in the research, and recognise that the findings cannot be representational of all prescribing doctors in Ireland. Concerns are evident with regard to the impact of the National Methadone Protocols, on two levels, namely the preoccupation with the methadone prescribing process as opposed to outcomes, and the restrictions imposed on both Level 1 doctors, and the number of resulting treatment places available. Policy makers would be advised to consider the expansion of MMT provision to include alternative substitution drugs, improved interagency psychosocial supports and the development of a network of community nurse prescribers. Additional concerns remain in the form of alcohol and poly drug taking, and pervasiveness of benzodiazepine misuse. Community detoxification protocols must continue to be implemented in all areas.

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Chapter 1. Background to Research

Methadone maintenance treatment (MMT) has been available in Ireland since 1992, with initial provision of treatment in Dublin. The Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone was undertaken in 1993. In 1998, the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations* was introduced, with specific administrative structures implemented in order to monitor treatment delivery and patient trends (Central Treatment List or CTL). The Methadone Treatment Protocol was devised by the Irish College of General Practitioners (ICGP) in 1998, in order to present systematic protocols for methadone prescription and patient management, support MMT delivery across Ireland, general practitioner (GP) training, increase the number of clients on MMT within a community based primary care context, and assist in audits (Butler, 2002). An internal review was conducted in 2005 by the Methadone Prescribing Implementation Committee (2005). Currently, there are three types MMT service provision in Ireland namely; in specialised clinics, and with Level 1 and 2 trained prescribing doctors. Level 2 trained doctors are qualified to initiate treatment, stabilize doses and provide ongoing maintenance treatment (Delargy, 2008). Level 1 trained doctors are restricted to 15 patients, with patient stabilization occurring in specialised clinics or with a Level 2 trained doctor. The number of Level 1 doctors has increased grown from 151 in 2002 to 218 in 2009. However, less than 5% of patients in Level 2 practice were transferred to level 1 doctors per year over the period 2002 to 2009. Most recent data indicates that in 2008, 259 Irish doctors provided MMT, with 2/3 of MMT clients treated in specialised clinics and 1/3 treated in the community (Health Service Executive, 2011).

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inclusion of buprenorphine and naloxone treatment modalities, and to revise the title to “*The Opioid Treatment Protocol*”.

MMT has long been recognised as an effective treatment for heroin dependence (Amato *et al.*, 2005; Clausen *et al.*, 2008). In short, MMT has been evaluated with regard to its efficacy in reducing heroin and other forms of substance use, reducing risk behaviours associated with injecting drug use and the transmission of blood borne viruses such as HIV and Hepatitis, reducing criminal activity and overdoses (Mattick *et al.*, 2009; Corsi *et al.*, 2009; Coviello *et al.*, 2011). Other improvements in MMT client individual and social functioning relate to family relationships, employment, education and community integration (Corsi *et al.*, 2009; De Maeyer *et al.*, 2011; Coviello *et al.*, 2011; Van Hout and Bingham, 2011). MMT is not without problems, and most particularly in terms of organization of the treatment and stigma relating to its use which has restricted its uptake, its efficacy, relationships with treatment providers, treatment retention and optimum MMT service provision (Joseph *et al.*, 2000; Bell *et al.*, 2002; Van Hout and Bingham, 2011; Harris and McElrath, 2012). A great variation of health professional attitudes toward MMT and treatment outcomes exists (Gjersing *et al.*; 2010; Lloyd, 2010). Commentaries have discussed MMT's problems as grounded in its status as ‘*non treatment*’ where one drug is essentially replaced by another, and its challenge of abstinence focused ideologies (Lloyd, 2010). Research has underscored the presence of public, institutional and private stigma associated with MMT on the part of patients themselves, health professionals, pharmacy settings and the general public (Luoma *et al.*, 2007; Ormston *et al.*, 2010; Harris and McElrath, 2012). This serves to contribute to MMT patients' continued identity as ‘*drug addict*’ which exposes them as so called ‘*undeserving*’ customers in the public domain, and encourages patients to act as passive recipients of treatment (Harris and McElrath, 2012; Van Hout and McElrath, 2012). At best, Harris and McElrath (2012) in their studies on MMT in north and south Ireland, observe that MMT in Ireland is best viewed as an intervention rather than a treatment modality, with pharmacological aspects to treatment undermined by client service experiences typified by social control. Research has commented on conflicting evidence in terms of patient satisfaction with methadone prescribing doctors (McLaughlin *et al.*, 2000; Winstock *et al.*, 2011), and experiences of prejudice and discrimination (Holt, 2007; Järvinen, 2008). Indeed, patients with a history of drug use, particularly that of heroin may believe doctor attitudes towards them to be negative and prejudicial, which highlights the need for recruitment of doctors with positive attitudes towards helping those with drug dependence (Gabbay *et al.*, 1996; Abouyanni *et al.* 2000; Kelly and Westerhoff, 2010). According to Dole and Nyswander (1980) mutual respect between the MMT client and treatment staff is fundamental to reduce perceived structural and interpersonal factors which impact negatively on treatment progression.

The shared care of drug users has been extensively discussed in the literature (Watson, 2000; Abouyanni *et al.*, 2000; Langton *et al.*, 2000; Keen, 2001; McKeown *et al.*, 2003). Opiate drug users represent a challenge to general practice (Leaver *et al.*, 1992). Indeed, general practice represents the first port of call

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and main point of contact between drug dependents and medical services and presents a unique opportunity to assist early with minimal stigmatisation in comparison to that attached to more formalised addiction treatment (Greenwood, 1992; Bucknal *et al.*, 1986). Research indicates that drug users also record a preference for the treatment of their dependency within general practice (Bennett and Wright, 1986). Research shows that shared care incurs many positive effects in terms of increased client satisfaction, reductions in crime and other drug use, and uptake in preventative health measures (Wilson *et al.*, 1994, Gossop 1997, Gruer *et al.* 1997; Gabbay *et al.*, 1996). However, reports of high patient turnover and consultation time pressures are evident in the MMT literature (Neville *et al.*, 1988). Research by Leaver *et al.*, (1992) reported that the methadone prescribing element of MMT is responsible for greater numbers of doctor visits and emergency appointments to obtain methadone prescriptions to relieve withdrawals. Problematic drug users reportedly consult their general practitioner significantly more often than non-drug using patients, and particularly those with HIV infection (Neville, 1988; Robertson, 1989; Leaver *et al.*, 1992). Research in the UK has reported on successful general practice based MMT interventions (Parker and Kirby 1996; Wilson *et al.*, 1994, Gruer *et al.* 1997; Farre11 and Gerada 1997, Scott 1997, Teijlingen and Porter 1997).

Traditionally, general practitioners have reported negative attitudes to methadone prescribing (Glanz and Taylor 1986 a; b, Leaver *et al.* 1992). Prescribing doctor attitudes to MMT are frequently grounded in drug use as social manifestation, with medicalised and abstinence based focus (McKeown *et al.*, 2003; Van den Brink and Haasen, 2006; Ford and Ryrie, 2010). Some doctors lack interest in the treatment of problematic drug use within the context of primary care service provision (Kapadia *et al.*, 2007). This is seen to contribute to displacement of stigma from MMT clinic settings and into general practice (Matheson *et al.*, 2003). Reluctance is grounded in perceived lack of skills and expertise, workload, concerns around safety and aggressive patients, and attitudes to drug users (Langton *et al.*, 2000; Abouyanni *et al.*, 2000; McGillion, 2000; Ford and Ryrie 2000; Matheson *et al.*, 2003). Doctor attitudes can be particularly negative toward opiate and intravenous drug users as opiate dependent patients often present with manipulative, aggressive and chaotic behaviours, with fluctuating levels of motivation impacting on the doctor patient therapeutic alliance (Gruer *et al.*, 1997, Gabbay *et al.*, 2001; Butler, 2002). However, research has reported that newly qualified doctors indicate greater acceptance of problematic drug users, and self awareness of their competency to treat dependencies (Glanz and Taylor, 1986; Roche *et al.*, 1991; Carnwath *et al.*, 1999). Research on MMT consistently highlights training needs in this area (Bell and Zador, 2000; Ford and Ryrie, 2000; Gabbay *et al.*, 2001; Strang *et al.*, 2004; Delargy 2008) alongside efforts to reduce health professional negative stereotypical opinions and attitudes toward problematic drug users (Miller *et al.*, 2001; Merrill *et al.* 2002; Landy *et al.* 2005; Henderson *et al.*, 2008; Lloyd, 2010; Gjersing *et al.*, 2010).

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Research has also underscored the need to reframe MMT as treatment modality to view clients in a more positive accepting manner as customers or consumers (Luty and Grewal, 2002; Luoma *et al.*, 2007; Fraser and Valentine, 2008; Reisinger *et al.*, 2009), and where clients can be organized in a collective manner in the form of service user forums so as to create autonomous and inclusive dialogue and stakeholder relations between those on MMT and their treatment providers (Patterson *et al.*, 2007; Harris and McElrath, 2012, Van Hout and McElrath, 2012 forthcoming). MMT clients are rarely consulted as consumer group in Ireland (UISCE, 2003) with emergent attitudinal shifts evident in promoting methadone maintenance service user involvement in treatment pathways (King 2011; Van Hout and McElrath, 2012 forthcoming). Indeed, the Phase One Research Report on perspectives of Special Community Employment (SCE) scheme participants on MMT in the Dublin North East Task Force area (Van Hout and Bingham, 2011) was based on a partnership between the Task Force and Client Forum representing participants of several SCE schemes and used a peer research led approach to discuss (amongst themes regarding education and employment) client concerns relating to informed decision-making around MMT, patient-doctor relations, long term MMT and efforts directed at tapering methadone dosages, detoxification and rehabilitation. The research concluded by underscoring the need to explore the attitudes and experiences of MMT treatment provision from the prescribing doctors' perspectives in Phase Two.

Chapter 2. Methodology

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Participants

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Chapter 3. Results of Narrative Analysis

Ten Level 2 prescribing doctors and six Level 1 prescribing doctors were interviewed, of which five operated in both specialised clinics and private practice, three worked only in specialised clinics, and seven were in private practice. Three participants described situations where they were certified as Level 1 in their private practices, but were operating as Level 2 in specialised clinics. All participants described working closely with local pharmacists. Due to confidentiality it is not possible to engage in a gender analysis.

'In my practice I am Level 1, but I work as Level 2 in the addiction services, it's ridiculous. I am working in the area for over 5 years full time in Level 2, but in my private practice, I am Level 1. Participant 7

Theme One: Viewpoints relating to opiate dependency and MMT

Several participants described the interplay between genetic predisposition to addiction, drug availability and socio economic environmental factors in the form of poverty, unemployment, marginalisation, family history of problematic substance use, childhood trauma, early school leaving, peer drug use, and personality factors, which were observed to contribute to the escalation of opiate and other drug addiction, negative health consequences and criminal activity.

'It is multi-factorial. There is a medical component to addiction, and reward and the withdrawals, and that's dependence...and then social is the availability, social deprivation and life events that would lead people to ignore things in their life and turn to drugs and alcohol, it's a combination.' Participant 10

All participants described opiate dependency as a bio psycho social issue, but observed that the current approach to treating opiate dependence was confined to the medical approach, despite the recognition of a multiplicity of personality, social and psychological influences on addiction and recovery. They highlighted the need to recognise both the pharmacological and psychosocial complexities of opiate addiction and the need to treat using combined approaches.

'The drug addiction always had two responses from the community and the professionals. The professionals tended to treat it as an isolated medical problem, and the community treated as it was meant to be treated, which was a social psychological and a biological model. The problem was that these two sectors didn't work as well as they could, and continues to remain a problem.' Participant 1

Many participants described MMT as essentially a successful medical and harm reducing treatment approach to addressing opiate dependence and harmful injecting drug use, and that it is supported with a strong evidence base. However, medical implications relating to blood borne virus (BBV) transmission (Hepatitis C, HIV), infection from injecting drug use, and co occurring psychiatric illness were described.

'It is fantastic, it is wonderful , it's a wonderful drug, it has immediate benefits in pretty much

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every aspect of a person's life, that have been dysfunctional or impaired in any way, it effects every part of their life, it's just wonderful.' Participant 6

'I am a big supporter, it's been proven to be a very effective way of dealing with the problem... it's not a cure for the ills of the individual or society that has to deal with it. I am a great believer in harm reduction right up to abstinence to clean living. Methadone maintenance is a completely proven modality of treatment.' Participant 13

All participants observed that MMT offers patients the opportunity to lead a (semi) normal lifestyle, but described negative abstinence focused opinions around MMT amongst some community based services and also the general public.

'I do support it, for me, my aim is to help the individuals to get to a point, where they are able to function reasonably normally in their own lives, to do whatever they feel is normal. Methadone Maintenance for a lot of my clients is their goal, if they can get to a point where they can function normally in their lives through methadone maintenance, then that's good enough.' Participant 3

'People who are on it long term, have a life. Drug users who aren't on methadone, they haven't a hope, they cannot possibly manage their children or do anything at least it allows them to lead a semi normal life.' Participant 2

Whilst offering the patient some normality in daily life, and the relinquishing of prior addictive behaviours, all participants described MMT as restricting patient freedom. Examples included remembering to take the methadone dose every day, going to the pharmacy at least every week, having to attend the doctor for prescriptions and urine screening, and planning ahead for holidays.

'I think it's great, but a bit limited. I take quite a pragmatic approach. I think if people need to stay on methadone for the rest of their lives, in order to be able to live a useful satisfactory life, then I have no problem with that. Methadone is not a cure and they are not free of the addiction, so it still limits their lives a lot, the best thing of all, is if we had something that would free them of their addiction, and then they could lead a completely normal life, but by its very nature its addictive, so you're dependant on it, you don't have quite the same freedom, as someone who is not dependant on something.' Participant 2

Several participants described issues relating to the long term maintenance of patients with MMT, the tapering of methadone dosage and the chronic nature of relapse.

'The biggest problem with methadone is getting them off methadone, it's a bit like using the nicotine patches for nicotine, we are aware we need to get them off the patches, but we don't seem to have a handle on this thing, where they should be off the methadone within a certain amount of time. I think it's this fear we have of heroin, that it's a more addictive drug than any other, and it cannot be dealt with like any other addiction.' Participant 6

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Theme Two: Alcohol, illicit and licit drug use in MMT patients

When questioned with regard to the area characteristics and social consequences of drug and alcohol use, a majority of participants described working in deprived and marginalised urban areas characterised by high rates of problematic drug and alcohol use. Some participants observed that drug education in schools appeared lacking in their areas, and contributed youth drug experimentation, pathways toward serious forms of drug use, opiate dependencies and destructive social consequences.

'I see it as primarily a physical addiction, the consequences are physical. But its social in a sense that you would sell your mother to fund it, so you end up losing everything, your family, your self respect, your house, your kids and your freedom, ending up in prison if you go all the way, which a lot of them do.' Participant 11

Alcohol was observed to be of most concern given its effect on methadone metabolism, increased risk for overdose, and potential addiction displacement. The majority of participants stated that excessive alcohol consumption, and alcohol dependency was common amongst their patients, with some participants estimating that 25-40% of their patients were misusing alcohol. Some made comments around the Irish drinking culture, and the potential normalisation of irresponsible drinking of alcohol among youth and adults.

It's an enormous problem, the substance that is killing most of my patients, taking up most of my time....significant physical and medical complications, psychological and massive social consequences.' Participant 7

Participants in some cases appeared restricted to the substitution treatment of opiate dependence via MMT, and described difficulties in treating alcohol misuse. Many participants observed that problematic alcohol use was a draw on their resources in managing substitution treatment, and in some cases were unable to test for alcohol use due to lack of provision of breathalyzers. One participant described concerns for over dose risk in patients misusing alcohol whilst in MMT, and increased rates of MMT patient mortality in older individuals, due to problematic alcohol use.

Their alcohol problem would be way above and beyond their drug use problem...it's the biggest cause of death in our slightly older patients, is alcohol and Hepatitis C together. They know we are bothered by the use of alcohol and methadone in relation to overdose risk because we reduce their methadone.' Participant 4

Several reported concerns for the lack of specific alcohol treatment pathways and adjunct counseling services for MMT patients misusing alcohol.

'A lot of doctors don't really engage with those who use alcohol, we have precious little to offer them... all we have is methadone for heroin users.' Participant 8

Patient poly drug taking whilst engaging in MMT was mentioned by several participants, and included drugs such as cocaine, cannabis, amphetamine, ecstasy, street and prescribed benzodiazepines, new psychoactive substances and heroin. In particular, the emergence of new psychoactive substances such

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as keto amphetamines (mephedrone) and synthetic cannabinoids available from headshops¹ prior to legislative controls, and subsequent availability on the street thereafter was observed to create difficulties, due to the lack of available screening mechanisms and clinical information available.

Participant views on continued opiate, other drug and alcohol use whilst in MMT were mixed, with some participants accepting of continued licit and illicit drug use whilst on methadone, and others strongly opposed to supplying methadone (particularly takeaways) in these circumstances. Several participants described opiate screening difficulties in distinguishing the chaotic heroin user from the occasional heroin user, and additionally distinguishing potential harms associated with the injecting versus smoking of heroin.

'I am always disappointed, but I would always continue to give them their usual methadone dose.' Participant 2

Continued dialogue between doctor and patients was viewed as paramount in reducing harm associated with continued heroin injecting, smoking and the use of other substances. Participants described dealing with positive opiate urine screens by increasing methadone dosage to try and keep patients from using heroin, probing their patients about discontinuing the programme, and working towards a harm reduction dose. MMT patients were observed in some cases to *'simply give up heroin'* over time.

'There cannot be a one attitude in addiction treatment, you must be prepared to take the patients where the patient is at, there are many patients who dabble, who become sick and tired and then stop, and then come off methadone. I have many patients who were heavy users and are now drug free.' Participant 3

When questioned around the use and misuse of licit drugs, some participants described the prescribing of benzodiazepines (*'benzos'*) as problematic, and in most cases not initiated by the doctor in question. Examples included the use of street benzodiazepines, prescribing by prison doctors and in the case of Level 1 private practice, by specialized clinics during stabilization periods. Participant concerns centred on difficulties in controlling their patients' use of benzodiazepines, and potential development of benzodiazepine dependency. Most participants assisted their own patients in undertaking lengthy and gradual benzodiazepine detoxes. Several participants also described prescribing SSRIs.

'I don't tend to initiate benzos. I do benzo detox's. Benzos are not indicated for anything more than short term, and I don't even believe they are for that. I don't see any role for benzodiazepines in the treatment for an underlying condition, particularly in this cohort of patients.' Participant 9

¹ A head shop is a retail outlet which specialises in drug paraphernalia related to consumption of cannabis, other recreational drugs, and New Age herbs, as well as counterculture art, magazines, music, clothing and home decor.

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Theme Three: The Methadone Protocols

The majority of participants observed difficulties in the prescribing of methadone as per the National Methadone Protocols as advised by the methadone implementation protocol committee. Many described these protocols and related audits as *'big brother looking over you'*, and reported conflict between the protocols, and real life practice.

'There is a disconnection between the people on the methadone protocol implementation committee and people making decision and those who are working on the ground.'

Participant 15

'The way I am forced to practice with the guidelines being enforced, having this big stick held over me, if I don't practice exactly the way, according to the guidelines which I don't agree with. I must practice in quite a restrictive way which is controlling and disempowering. I am subject to an audit and in the audit. I have to prove I am asking for four urines a week and change takeaways, if a patient gives a opiate positive urine.' Participant 2

Issues in the auditing of prescribing doctors, doctor adherence and non adherence to the protocols, variation in doctor approaches to MMT, and levels of patient centredness in the MMT treatment pathway were mentioned.

'Absolutely the problem with them, is not the actual content of the guidelines, it's the problem how they are enforced, they are enforced, as if they are a standard operating procedure, if you make any attempt to go outside of them, you are stamped on.' Participant 8

Despite the protocols in guiding MMT, some participants described the autonomy of doctor management of MMT as impacting negatively on parity of treatment and prescribing approaches, with some patients observed to be inappropriately managed.

'I am aware of colleagues practicing differently, being told that they are not getting any more patients.' Participant 2

Several participants described ignoring the Methadone Protocols or not reading them, and adapting the protocols to suit their practices.

'In Ireland, nobody obeys the rules to the letter, mostly the protocol is fine, if it was called a guideline, I would be happy with it, because guidelines are only expected to be a guideline, and as a doctor you are able to adapt that according to the circumstances. I think it would be impossible to write a protocol that would be right for everybody as a general guideline.'

Participant 2

'I tend to ignore them now, some of the protocols are good, some of them would be useful to people new to the area. I would interpret these as a guideline. It's very rare that you find a individual patient that fits all guidelines.' Participant 7

Several participants described the methadone protocols as a policing system rather than therapeutic intervention for opiate dependents, with little evidence consulted in the design of specified guidelines or

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the evaluation of individual outcomes. The requirement for regular patient urine screening was observed by most participants to be degrading and unnecessary.

'The audit is about process and not about outcomes. This is a glaring failure, it would be so much better to audit outcomes.' Participant 7

The management of methadone prescribing was observed to be restrictive and related to the 7 day methadone prescription pads provided by the Methadone Protocol.

'It does need to be managed fairly tightly, there is maybe scope of extending the length of prescriptions like in other countries, but the prescription pads that we have for methadone that have to be used, they are specifically for seven days treatment, it's the methadone protocol, as set up and approved.' Participant 5

Several participants commented that the Methadone Protocols placed unnecessary and unwanted restrictions on MMT patient numbers and their freedom to prescribe as normal doctors, particularly in the case of prescribing doctors placed in addiction clinic settings, as opposed to doctors operating in general practice.

'I am not entirely free to prescribe the way I would like to prescribe in any setting. The problem with the protocol, is that it does not help people who would like to open up a methadone clinic, whereby someone could set up a clinic in an existing general practice and treat patients there without a cap. Because I don't do anything else then to treat methadone patients, the random figures of 25 and 15 for level 2 and level 1, these concepts were meant to assist a busy general practitioner and it does assist them, but it works against those who are dedicated Methadone prescribers.' Participant 1

'They restrict my private practice, I am Level 1 and there is a restriction on numbers but there are people like me who are Level 2 in the clinic and Level 1 in private practice. When they say that you cannot initiate your own patients when you're Level 1, and when you have been initiating very chaotic clients in the clinics, then yes, its restrictive and there are a lot like me..' Participant 7

These caps on patient numbers and regulations around methadone prescribing at Level 1 and 2 also appeared to restrict numbers of treatment places.

'This prohibits more patients entering treatment than otherwise could be, we could reduce many waiting lists and work in community programmes. This is my career. I do nothing than other prescribe methadone. However there are too many constraints on me, a lot of the constraints have to do with the fact that you need to separate the issue around prescribing in a protocol practice with prescribing in a clinic, because there is a multidisciplinary team in the clinic. In your general practice, you are relatively free to do what you want, especially if you have a good relationship with your community pharmacist.' Participant 1

The Methadone Protocols were observed by some participants to contribute to patient institutionalisation,

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and in some instance an unequal, punitive doctor-patient relationship. Some participants stated that a political cap had been put on estimations of safe methadone dosage amid fears around methadone takeaway measures. In general, participants described aiming to keep the methadone level safely between 60 and 80mls, in order to avoid potential for overdose and cardiac arrhythmias. Some practices had developed specific and improved screening and monitoring procedures involving ECGs. Participants described adjusting dosage in order to avoid potential methadone diversion (onto the streets) and the continued use of heroin. Several participants described how their patients were fearful of heroin withdrawals, and how this manifested in a phobic fear of reducing methadone down to too low a dose.

'There is this huge obsession that the patient should not be on too much methadone because if they are on a high level of methadone, they are going to get worse, where in fact the exact opposite is the case, if a patient needs a lot of methadone, that is where they are at that particular point in time, provided you give them that dosage and continue to work with them they will invariably reduce their dosage.' Participant 1

All participants observed that levels of methadone dosage were dictated by the patient's wishes with support from established doctor-patient collaborative work within the therapeutic alliance. One participant described less concern for overdose risk in heroin smokers, than injecting drug users. Only in the case of psychiatric disorder, underlying health condition (i.e. HIV) or other drug dependencies (i.e. alcohol, benzodiazepines) would the doctor take control and dictate methadone dosage.

'In principle you would like to them to receive a dose that makes it easier for them to abstain from heroin.' Participant 14

Levels of patient methadone dosage were also observed to contradict with community employment (CE) scheme entry guidelines, with some participants stating that patients were reducing in order to get accepted onto local CE schemes. Others commented on the operation of CE Schemes as *'cherry picking'* patients who had stabilised, were reducing methadone dosages, and who were detoxing. This was observed to impact negatively on the patient progress for excluded individuals.

Theme Four: The Doctor -Patient relationship

The majority of participants described that the doctor patient relationship differed from normal general practice due to the weekly contact with their patients, variance in levels of patient cooperation, and varying degrees of positive therapeutic alliance.

'I have a counselor psychotherapist therapeutic model of alliance with my clients, rather than the general practice model of alliance, it's based on being client centered but with a element of control, while I am more than happy to listen to what my clients has to say, what I can actually do and give to the patient is dictated by the control element of prescribing a controlled drug.' Participant 1

'I am not sure if it would be typical of a GP client relationship in general practice, it's an ongoing relationship, so it's not quite like a ordinary GP relationship, it can be a bit traumatic

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and confrontational at times, because there is an element of control with the methadone that introduces a different dynamic, so within that you have very good relations with some of the patients, middling with others and not great relations with some.' Participant 4

No participants distinguished MMT patients from other patients attending their practices, but some participants described MMT patients as *'difficult to deal with'* at times.

'I don't see them as any different to any other patient. I am a doctor, they come into me, they tell me what's wrong with them, what they want. I try and get them to be as honest as possible. I need to know as to ensure I am giving them the right treatment, then they can make the choice about what they take in terms of treatment. My primary concern is patient safety and then the community safety.' Participant 13

Issues relating to mistrust, control and sanctioning (in some instances) were observed to form the basis for the MMT based doctor patient relationship, and appeared related to the patient stage of stabilisation and recovery.

'I try to make it respectful that they respect me and I respect them. I try and give them some kind of control about what they are doing. I have a good relationship with them but at the back of it, it's not quite a normal doctor patient relationship. When people are doing well or when they are chaotic and have no takeaways and they have nothing to lose, then you can have quite an open honest relationship with them, but the most difficult time is when someone has been doing well and de stabilises. So if they have got takeaways and you see it going wrong and they don't want to lose the takeaways, so all trust breaks down then, and you cannot believe a word they say and then it becomes more punitive. You are almost like a policeman to them, you are doing things they don't like, which doctors don't often have to do to their patients.' Participant 2

Many participants described positive relationships encompassing supportive roles with their patients and within a regular routine of consultations. Some participants observed that their role was restricted to methadone prescribing and the social consequences of opiate dependence, with some patients seeing their own GPs for other general health concerns.

'I get on well with them. I find I am a bit of a social worker, bit of a police person, school teacher and then a medic. I find that I fill a lot of roles because they trust me.' Participant 12
'Principally the doctor patient relationship is different in that I see them every week. It's different that I only prescribe methadone to them. I am not actually their GP, they have another doctor who interestingly would know them less well than I would, but I try and get them to keep that normal primary care relationship. As well, I find that I am in a position to be asked about a lot of other things which are not medical.' Participant 5

Theme Five: MMT Treatment Care Planning

Collaboration in treatment care planning between the doctor and patients was underscored by all

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participants, despite observations around the restrictions of methadone prescribing and necessity for patients to attend the doctor weekly. Patient empowerment in recovery was deemed an ultimate goal. A continuum of patient self actualisation was described. Participants were described as controlling the starting dose, and the rate of increase, with patients controlling a slow tapering and final detoxification under doctor supervision and advice.

'It's a collaborative relationship. The most important thing for me is that I don't make the patient worse. It's a straight relationship. I don't fight over urine results, because I have no interest in them. I never impede anyone who wants to detox. I know that we get a lot of bad press keeping people on methadone. I don't keep anyone on methadone. I give them my opinion, we discuss it and they make a decision. I facilitate their detox because they will do it on their own, and it's better to have me with them than to do it on their own.' GP Participant 5

'They have to reduce slowly. It is like a baby learning to walk.' Participant 9

In all instances, client requests to reduce or increase methadone were heard and facilitated within a supportive patient led approach, and when stable social circumstances such as housing were in place. This was done in order to avoid potential destabilisation and overdose risk. Mixed feelings were recorded, with some participants describing reluctance to encourage full detoxification, due to the high rates of relapse, and others encouraging full patient detoxification, and rehabilitation.

'I will encourage detox as much as I can because I don't want any of my patients enslaved to any institution, medical or pharmaceutical. The sooner they get free, the better, it's all about being ready and able to do that.' Participant 1

'I don't make anyone take a dose of methadone that they don't want to take. When I start them, I explain to them what our philosophy is on methadone. So they know where we stand. I explain that we will give them any amount of methadone, they require and that we will advise them when they are coming down. I do state that we don't formally detox people, but patients may detox themselves.' Participant 4

'It's a straight jacket for some in that they are caught and cannot get off the methadone.'
Participant 8

All participants described instances of successful patient detoxification from methadone, but also observed patients reducing to 40mls or less, and then destabilizing. The revolving door of relapse and MMT uptake was common, particularly among young dependents attempting fast reduction of methadone, in some instances resulting in high rates of mortality. Some participants described a need for community detoxification *'in the real world'* and observed the small success rates recorded in inpatient settings.

'Methadone is not compulsory. I don't detox them. I facilitate their detox. I say that we cannot detox you, but you can detox yourself. I cannot control your detox. I can control your increase, but not your decrease. The only person who can detox is the patient themselves.'

Participant 4

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'Giving someone a gradual and supportive detox as they demand it, with as much aftercare support as they can is ideal. I rarely use in patient detox units because I do not trust them.'

Participant 7

Several participants described experiences of patient self detoxification at home, and observed how improved community detoxification protocols were effective in providing supports for both methadone and benzodiazepine. Despite this, many instances of home detoxification led to opiate cravings and withdrawals, with many patients recommencing heroin, alcohol and other drug use. Underlying mental health issues were also observed to further complicate safe home detoxification.

'I would say that the majority of patients have done this at some stage, especially when someone become stable and just take methadone. A lot of patients do try and detox themselves, people forget there are physical and psychological components to addiction, they may get over the physical withdrawals within a day, it's the psychological issues such as triggers that can lead to problems.' Participant 3

Participants underscored the need for improved aftercare 'safety nets' supports for both residential detoxification and community detoxification.

'There is a community detox programme in this area. The community detox protocols are very positive and progressive, and working closely with our colleagues is the only way forward.' Participant 3

'I am increasingly conscious of the huge benefits and necessity to do residential aftercare following their detox to learn and prepare them with life without drugs and reduce the risk of relapse.' Participant 7

All participants were of the view that shared care treatment approaches in Ireland were much needed and essential. Others described the difficulties of classification as Level 1 or Level 2 as difficult to implement in practice, and particularly given the nature of relapse where unstable patients necessitate greater levels of support within an interagency support network.

'The theoretical concept of Level 1 and Level 2 is excellent, but the practical implementation is a totally different story. The clinics do need to concentrate on chaotic patients, these patients should be treated in controlled environment, until they have become stable and then passed onto the community GP's. Drug users by their nature are unpredictable, even the ones who are stable can suddenly become unstable and when the patient becomes unstable, then the community GP will not have the time to work with the patient.' Participant

1

Some participants described the need for universal and all encompassing treatment services and the need for a shift away from strict MMT and toward community based treatment for alcohol, opiate and mental health. This could potentially increase treatment uptake and remove the stigma attached to clinics. Several participants described the need for alternative forms of opiate substitution treatment such as

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buprenorphine, the need for specialized in patient stabilisation, in patient benzodiazepine detoxification, and support structures for those with underlying psychiatric conditions.

'There are reasonable services for treating the heroin dependency medically, but all the other support services are sadly lacking, and there is not enough co ordination and cohesion between the two. I think the medical model seems to run separately to the other models and that's a big problem.' Participant 2

However, several voided concerns around community service competencies, level of staff training in the area, and service philosophies around harm reduction versus abstinence, and issues around patient confidentiality.

'It's essential, we have these barriers that are thrown up all the time, one of which is insurance and the second one is medical confidentiality, we are constantly told, we cannot share information with community treatment programmes and other rehab programmes, that is rubbish, if the patient agrees and signs a form and saying yes I want these people included in my care, you have the freedom to share the information.' Participant 7

'In hindsight, we got a awful lot of things wrong, we should have been looking at a model of community pharmacies and small clinics, we need to normalize the treatment and make it as small as part of the patients life.' Participant 4

Several comments were made with regard to service rigidity with regard to patients needs (i.e. location, opening times), and the need for development of community nurse prescribers with minor input from doctors.

'Because only doctors can prescribe it, that tends to cause a barrier because a lot of doctors hide behind the fact, that they can only that can prescribe it, and it creates a wedge between them and other services that are in touch with service users. I do think it's too elitist, though I don't think it should just be doctors prescribing, there are some very good skills people with expertise who could easily prescribe this medication.' Participant 15

'I personally believe that methadone prescribing is a technical task, it's very, very simple and very easy. There is no great scientific or other knowledge required to prescribe methadone. My thoughts are that methadone prescribing would be better done by nurses and probably should be done by nurses, and that the doctors will have a role of overseeing the treatment and providing for primary care more so.' Participant 16

All participants observed issues relating to minors presenting with opiate dependency, and highlighted the need for specialised inpatient detoxification services without the need for parental consent and substitution pathways involving a multi disciplinary youth centred approach. Many concerns were raised with regard to adolescent treatment readiness and environmental factors needing psycho social intervention.

'They are a difficult group to treat because of the whole adolescent thing. They are not children and they are not adults, and they are quite irrational and unreasonable at times, the

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same issues apply if you have a 16 yr old who is injecting heroin four times a day, there is no question that he is better off on methadone.' Participant 4

Theme Six: MMT Training needs

Several participants were happy with MMT training levels at the time of the research, and indicated no further training needs. Some comments were made about the lack of formal training in the addiction field for doctors in clinics and community practice, and the failure of the ICGP to provide adequate training, practitioner networking, evidence based protocols, and CMEs.

'New people coming in, might not realise that the top dose of 80mls is nonsense, there is no programme of training other than online, nobody gets to hear others views' Participant 8

'It's bad, the training is awful, the guidelines, they have failed miserably in training GP's. A lot of the training need to be scrutinised, it's not evidenced based and it is damaging to have something that has poor evidence. We should have something similar to the NICE guidelines in the UK and these have been produced by experts.' Participant 15

A minority of participants working in private practice described feeling isolated and a need to meet and network with practitioners in clinics in order to update and consult around MMT issues. Supports for clinical practitioners were described as very good.

'The GPs like myself who don't work in clinics have no opportunity to meet, there seems to be a policy for isolating us and making sure we do not meet. We are not allowed to know each other's names. In the long run, it cannot be conducive to good practice or consistent practice across the country.' GP Participant 7

Chapter 4. Discussion

Qualitative research on doctor experiences of MMT remains scant, with most research efforts concentrating on patients overall life functioning and addiction treatment pathways. The research presents a *'snapshot'* of participant observations and perspectives on MMT obtained from a convenience sample of participating doctors, and cannot be generalised or viewed as representative of all methadone prescribing doctors in Ireland.

All participants were of the view that shared care treatment approaches in Ireland were much needed and essential. Some participants described the need for universal and all encompassing treatment services and the need for a shift away from strict MMT clinics and toward community based treatment for alcohol, opiate and mental health. Indeed, contemporary research underscores the need for long term and multi component treatment modalities for opiate dependence which include pharmacological, psycho-social rehabilitation and relapse prevention interventions (World Health Organisation, 2009). The findings highlight the need for continued development of community detoxification initiatives for both methadone and benzodiazepines (Progression Routes Initiative, 2011a;b). An effective treatment system for drug and alcohol dependence requires the availability of inpatient and community based detoxification to individuals, in the context of provision of managed withdrawal (Gowing *et al.*, 2000a;b). However, concerns around community service competencies, level of staff training in the area, and service philosophies around harm reduction, and abstinence, and patient confidentiality were observed. The need for governmental consideration of alternative forms of opiate substitution treatment such as buprenorphine, the need for specialised inpatient stabilisation in patient benzodiazepine detoxification, and support structures for those with underlying psychiatric conditions were reported. Comments were also made with regard to development of nurse prescribers and support staff roles in MMT provision. The lack of specific alcohol treatment pathways and adjunct counseling services for MMT patients was underscored. All participants observed issues relating to minors presenting with opiate dependency, and highlighted the need for specialised inpatient detoxification services without the need for parental consent and substitution pathways involving a multi disciplinary approach. Many concerns were raised with regard to adolescent treatment readiness and environmental factors needing psycho social intervention.

A minority of participants working in private practice described feeling isolated and a need to meet and network with practitioners in clinics in order to update and consult around MMT issues. Research on general practitioner roles also call for expansion of roles into other health services, and continued professional development (Wynne-Jones *et al.*, 2010). The same could be said for MMT training, certification and supports within a shared care system. Supports for clinical practitioners were described as very good. Several participants were happy with training levels at the time of the research, and indicated no further training needs. However, some comments were made about the lack of formal

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addiction training for doctors in clinics or community practice, and the failure of the ICGP to provide adequate training, practitioner networking, CMEs and evidence based guidelines for MMT provision. Research on MMT has highlighted continued general practitioners' training needs in this area (Ford and Rylie, 2000; Gabbay *et al.*, 2001; Strang *et al.*, 2004; Delargy 2008;). Observations were made with regard to new inexperienced prescribing doctors. However, it is encouraging to see that newly qualified doctors generally report greater acceptance of problematic drug users, and willingness to treat drug dependencies (Glantz and Taylor, 1986; Roche *et al.*, 1991; Carnwath *et al.*, 1999). It remains of paramount importance, as is evident in this research, that the recruitment of sympathetic doctors with positive attitudes towards helping those with drug dependence is vital (Bennet and Wright 1986b, Gabbay *et al.*, 1996; Hindler *et al.* 1996; Abouyanni *et al.* 2000; Kelly and Westerhoff, 2010).

Of interest is that participant observations around MMT observed its effectiveness in reducing a range of patient harms in the form of injecting drug use, continued opiate use, transmission of BBVs, and stimulating recovery processes. Indeed, research findings consistently indicate MMT's effectiveness in reducing drug use and risk activities such as needle sharing, improving health outcomes and reducing mortality, its cost effectiveness, its ability to reduce criminal activity, and stimulate social, educational and employment engagement (Corsi *et al.*, 2002; Sheerin *et al.*, 2004; Teesson *et al.*, 2006; Simoens *et al.*, 2006; Gowing *et al.*, 2006; Mattick *et al.*, 2009). Also of interest, were participant observations around inability to screen for frequent versus occasional heroin use, and injecting versus smoking opiate users for those on MMT. Negative service and community opinions around MMT were mentioned by some participants, and were centred on its substitution of one drug for another, and its conflict with abstinence focused treatment ideals (Joseph *et al.*, 2000; Bell *et al.*, 2002; Vigilant, 2004). Studies do show that MMT programmes differ in terms of clinical practices (Stewart *et al.*, 2003), and objectives which range from harm reduction (Roe, 2005), to long term maintenance (Ball and Ross, 1991) to abstinence from all drugs (Gossop *et al.*, 2001). The need for a combined approach by utilising harm reduction such as methadone maintenance in conjunction with abstinence based approaches to treatment has been extensively proposed (Broekaert and Vanderplasschen, 2003; McKeganey *et al.*, 2004; McKeganey, 2005).

Despite reporting very positive outcomes in providing the former addict with opportunity to recommence and lead a (semi) normal day to day life, participants observed how MMT restricted their patients' freedom. Leaver *et al.*, (1992) in their study of intravenous heroin users in MMT, reported on the greater numbers of routine consultations, emergency appointments to secure methadone, missed appointments and prescribed items in comparison with control subjects attending general practice, and indicated that intravenous heroin users utilised general practice to a greater extent than non drug users. This restriction of patient freedom and anxieties around chronic dependence is present in many studies on MMT (McKeganey *et al.*, 2004; Holt, 2007), despite the correlation between longer treatment duration,

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stabilisation and improved psycho-social outcomes, with reduced morbidity, poly drug use and crime involvement (Winstock *et al.*, 2011). Research by Leaver *et al.*, (1992) reported that the prescription and collection of methadone is responsible for greater numbers of patient visits. Structural factors relating to MMT create conditions for such premature treatment exit, and include daily collections of methadone, supervised consumption and urine analysis, clinic sanctioning of 'dirty screens', restricted 'takeaways', client discomfort in pharmacy settings and impact on day to day freedom (Reisinger *et al.*, 2009; Mancino *et al.*, 2010; Harris and McElrath, 2012). Despite these favourable outcomes in the reduction of opiate use and harmful routes of administration, participants also observed problematic issues relating to long term MMT, the tapering of methadone, and patient destabilisation. Similar findings are reiterated in the methadone research base (Bell *et al.*, 2006; Coviello *et al.*, 2011).

Of note, is that although participants observed being restricted to methadone prescribing, many described providing their patients with a range of psychosocial supports within a positive, supportive and patient centred approach. In some instances, participants described knowing their patients much better, than the patients' main permanent general practitioner consulted for general health conditions. Research shows that MMT patients often consult their permanent general practitioner for medical issues, whilst undergoing treatment for drug dependency in other practices and clinic settings (Leaver *et al.*, 1992). This was observed to occur in order to preserve confidentiality. It is evident from the research that participants cared deeply for their MMT patients, and acted beyond their remit as prescribing doctor by providing crucial social support. Wynne-Jones *et al.*, (2010) underscore the presence of both conflict between patient and GP, and between all stakeholders, and described the role responsibility of GPs as centred within a multiplicity of roles the GP is expected to play. Von Knorring *et al.*, (2008) have reported on difficulties for GPs in leading 'dual roles' as patient advocate, medical expert, and gatekeeper. All participants observed patient centred and supportive views of MMT patients, which contributed to patient empowerment and self actualisation toward recovery.

No participants described their MMT patients as any different to other patients attending their practice, with some participants describing MMT patients as problematic. At times and depending on client stabilisation, relations were compromised by instances of mistrust and loss of respect, with participants undertaking a policing role. Indeed, some research has observed that due to the nature of addiction, MMT clients are often not treated as patients, but rather as suspects (Vigilant, 2001; De Leon, 2000; Butler, 2002; Luty and Grewal, 2002; Saris, 2008). Research commentaries have been made around 'dysfunctional consultations' in MMT (Gabbay *et al.*, 1999). Research has shown that GP attitudes can be negative toward opiate dependent patients due to manipulative, aggressive and chaotic type behaviours, and incur fluctuating levels of motivation impacting on the GP patient therapeutic alliance (Gruer *et al.*, 1997, Gabbay *et al.*, 2001; Butler, 2002). In this way, despite the presence of potent doctor patient collaborative relations, these relationships between doctor and MMT patients were described as not quite

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fitting into the normal doctor patient consultation due to the control of a prescribed drug, the level of contact between individuals on a weekly basis, and utilisation of urine screening. The disparity between medical service provider and client experiences is evident in the current literature base with medical supervision of opiate dependence promoting treatment retention, in contrast to patients requesting treatment completion (Winstock *et al.*, 2011).

Continued dialogue between doctor and patients was viewed as paramount in reducing harm, despite instances of destabilization and chaotic drug taking patterns. Indeed, patient centred medicine by consideration of patients' knowledge, feelings, experiences, aspirations and desires is positively associated with patient satisfaction and improved patient outcomes (Nettleton, 1995; Steward, 1995; May and Mead, 1999; Kennedy, 2003). Despite the best efforts of prescribing doctors in the research to undertake shared decision making, on some level the doctor patient relationship remained doctor centred, by the very virtue of methadone prescribing. Participants were described as controlling the starting dose, and the rate of increase, with patients controlling a slow tapering and final detoxification under GP supervision and advice. Participants observed that levels of methadone dosage were dictated by the patient's wishes with support from prior doctor-patient collaborative work within the therapeutic alliance. Methadone dosage appeared to be dictated by level of stabilisation and patient progress, attempts to secure placing in local CE schemes and therapeutic alliance between the doctor and patient. Several participants described how their patients were fearful of heroin withdrawals, and how this manifested in a phobic fear of reducing methadone down to too low a dose. Lintzeris *et al.*, (2007) has described patient fear of remaining on methadone as contributing to attempts of clients to avoid higher doses of methadone, and attempting to seek out short term treatment modalities, despite research showing that longer duration treatment, and higher methadone dosage along with psychosocial intervention is associated with improved addiction and psychosocial outcomes (Sees *et al.*, 2000; Kakko *et al.*, 2003; Gerra *et al.*, 2003; Mattick *et al.*, 2009). Fear of methadone detoxification is reiterated in the research (Leaver *et al.*, 1992; Van Hout and Bingham, 2011; McDonnell and Van Hout, 2010; 2011).

MMT has a well established ability to reduce opiate overdose fatalities by stabilising the addicts lifestyle, and reducing poly drug use and harms associated with intravenous use (hepatitis and HIV) (World Health Organisation, 2004). Continued use of other drugs and alcohol can occur, as methadone does not have a specific pharmacological effect on non-opioid drug use (Schuckit, 2006; Cox *et al.*, 2007; Kelly *et al.*, 2009). Research by Bennett and Wright (1986) reported on the high rates of continued illicit drug use among methadone attendees. Other researchers comment on the need for research on methadone diversion and factors implicated in enabling or reducing this behaviour, within the context of supportive MMT therapeutic relations (Gabbay *et al.*, 1999). Poly drug use whilst engaging in MMT was mentioned by several participants, and included alcohol and drugs such as cocaine, cannabis, amphetamine, ecstasy, anti anxiety medication, new psychoactive substances (such as mephedrone) and heroin. In

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particular, the emergence of mephedrone and other synthetic stimulants was observed to create difficulties, due to the lack of available screening mechanisms and clinical information available. Research has highlighted that clinical research on emergent new psycho active substances is scant (LGC Standards, 2010; Long, 2010; Pillay and Kelly, 2010; Van Hout and Brennan, 2011; Van Hout and Bingham, 2012). Research commentaries show that abstinence based models MMT incurs greater rates on poly drug use (Caplehorn *et al.*, 1996; Caplehorn *et al.*, 1998). Participant views on continued drug and alcohol use whilst in MMT were mixed, with some participants accepting of continued licit and illicit drug use whilst on methadone, and others strongly opposed to supplying methadone (particularly takeaways) in these circumstances. They described dealing with positive opiate urine screens by increasing methadone dosage to try and keep patients from using heroin, probing their patients about discontinuing the programme, and working towards a harm reduction dose. In many cases, MMT patients reduced and ceased heroin use over time. The majority of participants stated that excessive alcohol consumption, and alcohol dependency was common amongst their patients, observed that problematic alcohol use was difficult (and in some practices impossible) to screen for, and appeared restricted to the substitution treatment of opiate dependence via MMT. In addition, benzodiazepine dependence also contributed to problems in MMT.

Self detoxification attempts are frequent in opiate dependent populations (Noble *et al.*, 2002; Dennis *et al.* 2005; Hopkins and Clark, 2005; Ison *et al.*, 2006), with a majority of opiate dependents remaining on the periphery of treatment systems (Friedman *et al.*, 2004; Bobrova *et al.*, 2006; 2007; Petersen *et al.*, 2010; McDonnell and Van Hout, 2010; 2011). Mixed feelings were recorded with some participants describing a reluctance to encourage full detoxification, due to the high rates of relapse, and others encouraging patient detoxification. In all instances, client requests to reduce or increase methadone were heard and facilitated within a supportive patient led approach, and when stable social circumstances such as housing were in place. This was done in order to avoid potential overdose and destabilisation. All participants described instances of successful patient detoxification from methadone, but also observed patients reducing to 40mls or less, and then destabilizing. The revolving door of relapse and MMT uptake was common, particularly among young dependents attempting fast reduction of methadone, in some instances resulting in high rates of mortality. Research indicates that between on average 40 and 60% of MMT patients drop out of treatment within 12 to 14 months with relapse to heroin use (Nosyk *et al.*, 2010). However, research shows that detoxification and the achievement of abstinence is possible without formal treatment (Ward *et al.*, 1999, Bobrova *et al.*, 2006, Ison *et al.*, 2006, Bobrova *et al.*, 2007), and is often preferred with community based supports from local GPs, family and other users (Hartnoll, 1992, McElrath, 2001a; b, Appel *et al.*, 2004, Hopkins and Clark, 2005, Grella *et al.*, 2009).

The majority of participants observed difficulties in the prescribing of methadone as per the national Methadone Protocols advised by the methadone implementation protocol committee, and described this

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scenario as *'big brother looking over you'*. Participants highlighted the need to measure MMT in relation to its outcomes, and not the MMT process as advocated by the Methadone Protocols. Several participants described the methadone protocols as a policing system rather than therapeutic intervention for opiate dependents, with little evidence consulted in the design of specified guidelines or the evaluation of individual outcomes. It is evident that MMT outcomes are dependent on timely treatment entry, adequate medication dosage, duration, support and continuity of treatment, levels of engagement in concurrent counseling and presence of cohesive support networks of adjunctive medical, social and community services, and successful detoxification (World Health Organisation, 2009). Issues in the auditing of prescribing doctors, doctor adherence and non adherence to the protocols, variation in doctor approaches to MMT, and levels of patient centredness in the MMT treatment pathway were mentioned. Wynne-Jones et al (2010) identify such barriers to good general practice both within and outside of the healthcare system. The requirement for regular urine screening was observed by most participants to be degrading and unnecessary. The management of methadone prescribing was observed to be restrictive and related to the 7 day methadone prescription pads provided by the Methadone Protocol, and observed to contribute to patient institutionalisation, and in some instances unequal power differentials between doctor and patient. The Methadone Protocols appeared to place unnecessary and unwanted restrictions on their freedom to prescribe as normal GP, particularly in the case of prescribing doctors placed in addiction clinic settings, as opposed to doctors operating in general practice. Several participants described ignoring the methadone protocols or not reading them. Regulations around Level 1 and Level 2 patient numbers also appeared to restrict numbers of treatment places. Participants described the difficulties of classification as Level 1 or Level 2 as difficult to implement in practice, and particularly given the nature of relapse where unstable patients necessitate greater levels of support within an interagency support network.

Chapter 5. Conclusion

The research, however small scale, exploratory and confined to a convenience sample of methadone prescribing doctors in the Dublin area, represents an important description of prescribing doctors experiences of MMT and their relationships with their patients. . The researchers wish to sincerely thank the participants for their involvement in the research, and recognise that the findings cannot be representational of all prescribing doctors in Ireland Observations around MMT were positive in both reducing harm and presenting an important turning point for opiate dependents. It is important to underscore that doctor efforts to assist their MMT clients were grounded in positive, empathic relationships with their patients, and in many cases surpassed their roles as methadone prescribers. Concerns are evident with regard to the impact of the National Methadone Protocols, on two levels, namely the preoccupation with the methadone prescribing process as opposed to MMT patient outcomes, and the restrictions imposed on both Level 1 doctors, and the number of resulting treatment places available. Policy makers would be advised to consider the expansion of MMT provision to include alternative substitution drugs, improved interagency community based psychosocial supports, treatment for poly drug and alcohol use, and the development of a network of community nurse prescribers. Concerns remain in the form of alcohol and poly drug taking, and pervasiveness of benzodiazepine misuse. Community detoxification protocols must continue to be implemented in all areas.

Appendices



Waterford Institute *of* Technology

Information about the Research and Informed Consent Statement

You are invited to participate in a qualitative study that seeks to learn more about your experiences as General Practitioner involved in the provision of methadone maintenance treatment for clients resident in the Dublin area. Research consistently highlights general practitioners' training needs in this area, alongside efforts to reduce health professional negative stereotypical opinions and attitudes toward problematic drug users.

The research builds on an earlier study in the Dublin North East area which underscored the need for improved doctor and service user consultative relations in MMT (Van Hout and Bingham, 2011). We wish to explore prescribing doctor attitudes, experiences and opinions toward methadone maintenance treatment in the Dublin area.

Methods

Ethical approval for the study was granted by Waterford Institute of Technology in October 2011. The methodologies were conducted in accordance to standards set by the European Monitoring Centre for Drugs and Drug Addiction, and the research protocol of the National Advisory Committee on Drugs. General ethical principles of the Economic and Social Research Council were also adhered to throughout all research phases [ESRC Research Ethics Framework: 22-26].

I (Tim Bingham) am the researcher and I will be interviewing people for this study.

The interview will last about 1 hour. I am not collecting names or other personal identifiers – people's identities will remain anonymous. Your participation in this study is voluntary. You can withdraw from the interview at any time. If any criminal activity is disclosed during the course of the interviews, I will encourage you to report this.

I am asking for your consent for us to tape the interview. If you are uncomfortable with having the interview taped, you can say so and I will take notes during the interview. If names appear in the tape, I will omit this information shortly after the interview. I will transcribe the tapes shortly after an interview is completed and I (Dr Marie Claire Van Hout) am the only person who will have access to the tapes which

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will be in a locked cabinet. The tapes will be destroyed post transcription. The transcribed narratives will be stored on a password protected computer at Waterford Institute of Technology. Once all the interviews are completed and transcribed, I will write a report for the DNEDTF.

I have received ethical approval for this study from Waterford Institute of Technology in the South East of Ireland. If you need any further information on the study, please contact Marie Scally, DNEDTF 01-8465072.

Thank you.

I consent to participating in an interview _____

Mark

Date

I consent to having the interview taped _____

Mark

Date

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Interview Guide

- Are you a level 1 or 2 prescribing doctor?
- What is your perception and knowledge of problematic alcohol and drug use in the area where your practice is located?
- Do you view drug dependency as a social or medical issue?
- What is your opinion on methadone maintenance treatment (MMT)?
- Can you describe your patient client relationships with methadone maintenance clients?
- Can you describe any issues regarding methadone maintenance treatment (MMT) in your practice?
- Are you confident in your ability to provide quality methadone maintenance treatment (MMT)?
- What is your preferred course of action in relation to methadone dosage?
- What is your preferred course of action when a client requests to reduce their dosage?
- Have you assisted clients in detoxifying? If so can you describe these experiences?
- Have you come across many instances of home detoxification?
- What is your opinion on continued heroin and other drug use whilst on methadone maintenance treatment?
- Do you prescribe anti anxiety medication to your patients on methadone maintenance treatment?
- Does the current methadone protocols restrict your work with clients
- What in your opinion is the best form of treatment for minors dependent on opiates?
- Do you work closely with the local pharmacists?
- What is your opinion on shared treatment care approaches?
- Can you describe any gaps in treatment service supports?
- Can you identify any training needs in relation to methadone maintenance treatment?

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