Survey of General Practitioners Participating in the Methadone Treatment Programme

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Executive Summary

Drug misuse and particularly heroin abuse is a growing problem throughout Ireland. As a response Methadone Treatment is a well evaluated, cost-effective intervention which has been consistently shown to saves lives and improve the health and well-being of patients who become dependent on heroin.

The role and benefits of GPs providing treatment services to drug users is well documented. The Irish College of General Practitioners (ICGP) has played a central role in developing a protocol for the delivery of methadone treatment in primary care in the Irish context. Best Practice Guidelines for GPs have been published and GPs participating in the MTP have received training provided by the ICGP.

This report carried out by the ICGP, outlines the results from a postal survey to all GPs on the ICGP Drugs Misuse Database. The questionnaire was designed to explore GP attitudes to the Methadone Treatment Protocol (MTP) and what additional services might support GPs in their work with opiate users. It also aimed to explore levels of satisfaction with training received and to assess whether any obstacles or barriers exist to taking patients on the MTP.

Summary of Survey Results

Out of the 600 questionnaires sent, 207 responses were received, giving a response rate of 34.5%. The majority of respondents (72%) already had patients on the MTP at that time while less than a third (28%) did not.

GP attitudes to MTP

Attitudes which focused on the benefits of methadone treatment suggest that GPs overwhelmingly believe that it is an essential service to drug users (95%), that it improves the health of patients (96%) and that it reduces criminality (96%).

Furthermore the majority (96%) felt that the structure of the MTP provides a regular opportunity to review patient's progress to allow a good relationship with the patient.

Obstacles to taking on patients

In general, very few obstacles to GPs taking on patients were identified. The most common response was that the GPs had not been asked to take on patients (30%). For GPs who already had patients on the MTP, 33% could see no obstacles to taking on more patients and of this group, 92% said they would be willing to take on more patients. Having reached the maximum numbers allowed was a reason given by 26% of respondents, while a further 16% stated that they felt they had enough patients already. There were 47 respondents (28%) who currently had no patients but were eligible to take patients on the MTP.

These responses would suggest that there is an untapped willingness on the part GPs to be involved in the MTP.

Additional Support Services

When asked what additional services would enhance the care they could provide for patients, 52% of respondents chose addiction counseling as their first choice. Inpatient detoxification beds were also a popular choice.

Satisfaction with Training

There was a high level of satisfaction with the training provided by the ICGP and 96% of respondents stated that it had adequately prepared them for managing a stable patient in primary care. Some respondents however felt that additional training was required in the management of patients who had co-existing alcohol or benzodiazepine problems. Making continuing medical education more accessible was another issue which was explored by the questionnaire. The existing format for CME, run by the ICGP for its general membership was seen as the preferred method of keeping appraised of new developments and a forum for discussion of problem cases. As a result of this survey, the ICGP has undertaken to review the current format for Level 1 and Level 2 training.

Recommendations

Based of the results of this survey, the ICGP can make the following recommendations to:

- Inform the wider body of GPs of the high satisfaction levels amongst GPs currently participating in the MTP.
- Inform the wider body of GPs on the evidence base surrounding the benefits of Methadone Treatment.
- Explore methods to more fully utilise GPs who are willing to become involved with the methadone treatment programme.
- Explore opportunities to transfer stable patients to GPs who have completed the training and are eligible to the take on patients.
- Develop of Level 1 training to strengthen modules on working with people with continued illicit drug use, alcohol use and concurrent benzodiazepine problems.
- Explore the feasibility of making addiction counselling services available to patients on the MTP particularly in the primary care setting
- To train GPs on how to help patients come off Methadone if the patient wishes to.

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Introduction

Methadone in opiate dependency has been an internationally recognized treatment intervention for many years. It has a strong evidence base and two decades of randomised studies of methadone maintenance demonstrate consistent, positive results over vastly different cultural contexts. A number of comprehensive literature reviews support the benefits of methadone [1-4] including the National Treatment Outcome Research Study (NTORS), which monitored the progress of 1075 clients in the UK over five years[5]. The Farrell et al[3] review of maintenance treatment in opiate dependence concludes that the major challenge in reducing the public health burden of opiate addiction is to deliver safe and effective maintenance treatment to as many people as will benefit from it. They recommended a community based approach where GPs prescribe methadone. They have shown that this results in significant improvements on a range of outcomes many of which affect the wider society as well as the drug user themselves. Clearly any support which will allow a methadone patient to live in, engage meaningfully and hopefully work in their community will have the best possible outcome.

The benefits of substitute prescribing with methadone are:

- Improvement in health and social functioning.
- Reduction in opiate related deaths.
- Reduction in illicit heroin use.
- Better retention in treatment.
- Reduction in criminal activity.
- Reduction in transmission of HIV.
- It is cost effective.

These benefits are found consistently and are independent of the model of delivering methadone treatment. The literature also supports the view that if practitioners are properly trained, methadone maintenance can be effectively and safely delivered in a wide range of settings, including primary care.

In the light of the strong evidence base for methadone as a treatment option, the ICGP wished to explore the attitudes of all GPs on the college drug misuse database of GPs who had attended for Substance Misuse Training. A postal questionnaire was designed to explore attitudes to accepting patients and identify barriers if any to this process, given that one of the aims of the MTP is to move stable patients from treatment clinics back to primary care. Satisfaction levels with the MTP and how well the current training programme equipped GPs to manage their patients on methadone maintenance were also explored.

Background: The Methadone Treatment Programme in Ireland

In January 1998 the Methadone Treatment Services Review was published by the Department of Health and Children. This report recommended a change in the regulation in how Methadone could be prescribed and dispensed. Based on the blueprint submitted by the ICGP, it also outlined a scheme for general practitioner involvement in treating patients on Methadone. The structure of the MTP allows for patients to be assessed, commenced on treatment and stabilised at a Health Services Executive (HSE) treatment centre or by a more experienced colleague (Level 2 GP). The patients are usually referred back to their own G.P, for continuance of the maintenance script when they are stable on their methadone dose. Since the introduction of this protocol in October 1998, GPs from around the country have been participating in the Methadone Treatment Programme (MTP). The numbers of GPs participating in the scheme has been increasing steadily year by year: 247 GPs were participating in the MTP at the end of 2007.

Table 1: Number of GPs on the programme in each region, and the number of patients involved*.

	GP Distribution				
	Dublin Mid Leinster	**Dublin North East**	**HSE West**	**HSE South**	**Total**
Total GP's	146	61	28	12	**247**
Total Patients	1849	1015	91	92	**3047**

Table 2: Number of patients for the period January 2007 – December 2007 in the same regions as above*.

	Total Patients
HSE Dublin Mid Leinster	2067
HSE Dublin North East	1177
HSE West	107
HSE South	99
Totals	**3450**

***Compiled by CTL 26 February 2008**

GP Training Requirements

In order to participate in the MTP, a general practitioner must receive training in substance misuse and the management of opiate misusers and agree to regular audit. Regular training courses are provided by the ICGP throughout the year which are open to all GPs. Doctors completing their training in general practice should ideally have received Level 1 training before graduating from their training programme. There are currently two training programmes:

Level One Training

Level 1 training provides the foundation for treating stable methadone maintained patients in general practice. Having completed this training a GP may accept up to fifteen patients for methadone maintenance treatment in the primary care setting. Stabilisation usually takes place in a health board treatment centre but may also be offered by a suitably trained GP colleague (Level 2). Inter-referral between Level 1 and Level 2 GPs is encouraged where this option is available.

Level Two Training

Before progressing to Level 2 training the following criteria must have been fulfilled by the GP:

- The GP should have managed at least five patients on the MTP for a minimum of one year.
- The GP should have successfully completed an external clinical audit conducted by the ICGP to ensure best practice at Level 1.

Following the training which currently requires 13 clinical sessions supervised by a GP mentor, a Level 2 GP may initiate treatment, stabilise doses and provide ongoing maintenance treatment to a drug user in the primary care setting. A successful external Level 2 audit completes the accreditation process.

Continuing Medical Education

GP's participating in the MTP are expected to engage in regular continuing medical education. In these sessions a wide range of issues relating to community based drug treatment are addressed and updates on guidelines or changes in practice are discussed.

Annual Audit

Regular audit is provided by an ICGP/HSE appointed audit nurse. The format for the audit is regularly updated and revised as appropriate. The range of care provided by the GP to his/her methadone patients is reviewed and referenced to the current best practice guidelines issued by the ICGP.

THE SURVEY

A Survey of Attitudes of GP's to the Methadone Treatment Protocol

In the light of the strong evidence base for methadone as a treatment option, the ICGP wished to explore the attitudes of all GPs on the ICGP drug misuse database. Doctors entered on this database have participated in Level 1 or Level 2 training, however, not all GP's on the database were actively participating in the MTP at the time. The survey was designed to explore GP attitudes to accepting patients and to identify barriers if any to this process given that one of the aims of the MTP is to move stable patients from treatment clinics back to primary care. For GPs already participating, the survey explored satisfaction levels with the MTP and how well the current training programme equipped GPs to manage their patients on methadone maintenance.

Method

In 2006, the ICGP undertook a survey of all GPs who were on the college drug misuse database. This database includes all GPs who at some stage have undergone training at Level 1 or Level 2 through the ICGP Drug Misuse Programme. All GPs on the database were surveyed regardless of whether they had patients currently registered on the Central Treatment List.

Response Rates

There were 207 responses from 600 questionnaires sent, giving a response rate of 34.5%. Reminder questionnaires were sent and a reminder notice was placed on the drug misuse section of the ICGP website.

Results

Profile of Respondents

The majority of respondents were between 35 and 60yrs. The remainder were equally divided between the younger group under 35 age and an older over 60 years. (Table 1)

71% of respondents were male and 29% female. (Figure 1)

The majority, 57%, of practices were described as being in urban areas with 24% described as mixed urban/rural and 9% as rural. (Table 2)

Perception of Scale of Problem

When asked how big a problem illicit drugs are in their practice, 42% felt there was a major problem in their practice area and 15% felt it was a minor problem only. A further 42% felt that the problem was small or minimal. (Table 3)

When perception of the scale of the problem was examined in reference to location, it was found that the majority of GPs who reported that illicit drugs were a major problem in their practice area were in an urban location (Table 2). The majority of GPs from rural areas reported little or minimal problems with illicit drug use in their practices.

Table 1: Respondents Age Group

Age	N	%
<35	26	12.7
36-45	54	26.3
46-60	102	49.8
>60	23	11.2
Total	205	100

Figure 1: Gender

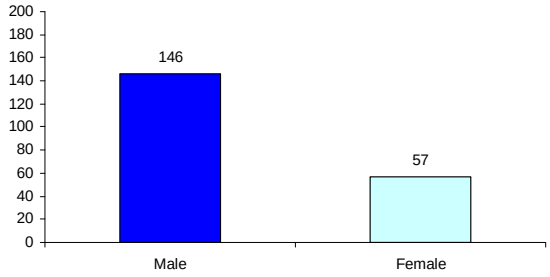


Table 2: Practice Location

Area	N	%
Urban	136	66.3
Rural	19	9.3
Mixed	50	24.4
Total	205	100

Table 3: Scale of Problem

Size of Problem	N	%
Minor Problem	31	15.8
A Little	43	21.8
Minimal	40	20.3
Major Problem	83	42.1
Total	197	100

Table 4: Location: Scale of Problem

Size of Problem	Urban	Rural	Mixed
Minor Problem	21	4	6
A Little	21	6	16
Minimal	20	6	14
Major Problem	67	2	14
Total	128	18	50

Patients on Methadone Treatment

72% of the respondents had patients on the methadone treatment protocol, while 28% did not (Figure 2). Those who had patients on the protocol were asked how many patients they had. The responses are illustrated in Table 5 below.

Figure 2

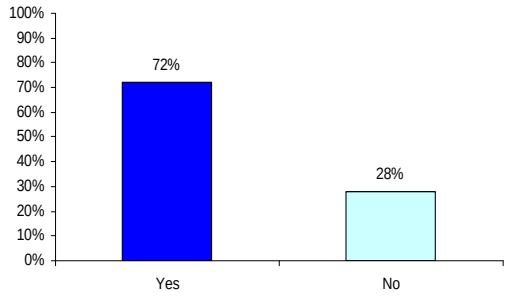


Table 5: Number of Patients

Number of Patients	N	%
1 – 10	59	55
11 – 20	21	20
21 – 30	6	5.6
31 – 40	15	14
50	3	2.7
80	1	1.5
100	1	1.5
Total	107	100

Obstacles

GPs who were currently managing patients or the MTP were asked what obstacles there were to them taking on any patients. The results are outlined in Table 6

Table 6: Obstacles to taking on more patients; GPs who currently have patients

Obstacles	N	%
No obstacles	50	32.7
Have reached protocol maximum	41	26.8
Have enough already	25	16.3
Never been asked to	25	16.3
Practice staff don't want any more	10	6.5
Other patients don't want more	2	1.4
Total	153	100

Of those who had responded that there were no obstacles to them taking on more patients, 92% said they would be willing to take on more patients, while 8% said they would not.

GPs who were eligible to take on patients but who currently were not managing patients on the MTP were asked if there were any obstacles to them taking on any patients. The results are outlined in Tables 7

Table 7: Obstacles to taking on any patients; GPs who currently have no patients

Obstacles	N	%
Other	35	32.1
Never been asked to	33	30.3
No demand in the area	19	17.4
Fear of violence	10	9.2
Fear it would put off private patients	10	9.2
Practice too small	2	1.8
Total	109	100

Where 'other' was given as a response, respondents were asked to specify what other barriers they had encountered to taking on patients. The following areas were identified by two or more respondents:

- Patients dropped out of programme or moved away from area.
- Size/location of premises.
- Inadequate back up.
- Heroin abuse not a problem in the area.
- Work load involved/ time constraints.
- Lack of knowledge/training.
- Personal reasons e.g. no empathy with addicts/not enjoyable work.
- Other partners not keen.

Attitudes to the Methadone Treatment Programme

Respondents were asked to rate a number of statements with regard to the Methadone Treatment Programme on a scale from Strongly Agree to Strongly Disagree. The results are outlined in the Tables below.

7A. Allows good relationship with patients		
	N	%
Strongly Agree	64	31.6
Agree	127	62.8
Disagree	10	5.1
Strongly Disagree	1	0.5

The majority of respondents agreed (62.8%) or strongly agreed (31.6%) that the MTP allows a good relationship with patients. Only a small number disagreed (5.1%) or strongly disagreed (0.5%) with this statement.

7B. Provides regular opportunity to monitor progress with patients		
	N	%
Strongly Agree	75	37.1
Agree	124	61.4
Disagree	2	1
Strongly Disagree	1	0.5

The majority of respondents agreed (61.4%) or strongly agreed (37.1%) that the MTP provides regular opportunity to monitor progress with patients. A very small percentage disagreed (1%) or strongly disagreed (0.5%) with the statement.

7C. Essential service for drug users		
	N	**%**
Strongly Agree	94	46.8
Agree	97	48.2
Disagree	8	4
Strongly Disagree	2	1

The majority of respondents either agreed (48.2%) or strongly agreed (46.8%) that the MTP is an essential service for drug users. A small number either disagreed (4%) or strongly disagreed (1%) with this statement.

7D. It is an overly rigid protocol		
	N	%
Strongly Agree	11	5.5
Agree	28	14
Disagree	14	73.6
Strongly Disagree	14	6.9

A small percentage of respondents either agreed (14%) or strongly agreed (5.5%) that it is an overly rigid protocol. However, the majority disagreed (73.6%) with this statement, with a small percentage strongly disagreeing (6.9%).

7E. Eliminates chance of double scripting		
	N	%
Strongly Agree	54	26.9
Agree	124	61.7
Disagree	21	10.4
Strongly Disagree	2	1

The majority of respondents either agreed or strongly agreed that the MTP eliminates the chance of double scripting. Some disagreed with this statement (10.4%), while two people strongly disagreed (1%).

7F. Improves health of patient		
	N	%
Strongly Agree	68	33.6
Agree	127	62.9
Disagree	7	3.5
Strongly Disagree	0	0

The majority (62.9%) agreed or strongly agreed (33.6%) that the MTP improves the health of the patient. A small percentage of respondents disagreed (3.5%) while none strongly disagreed with the statement.

7G. Reduces criminality		
	N	%
Strongly Agree	66	32.7
Agree	128	63.4
Disagree	8	3.9
Strongly Disagree	0	0

Once again the majority agreed (63.4%) or strong agreed (32.7%) that the MTP reduces criminality. There were a small number who disagreed (3.9%) and none who disagreed strongly.

7H. Supervised daily dispensing prevents patients from working		
	N	%
Strongly Agree	19	9.6
Agree	81	40.9
Disagree	94	47.5
Strongly Disagree	4	2

Opinions regarding this statement were divided. Just over half of respondents (50.5%) agreed or strongly agreed that supervised daily dispensing prevents patients from working, while just under half (49.5%) disagreed or strongly disagreed with the statement.

7I. It is difficult to get off Methadone		
	N	%
Strongly Agree	45	22.6
Agree	119	59.8
Disagree	34	17.1
Strongly Disagree	1	0.5

A strong majority either agreed (59.8%0 or strongly agreed (22.6%) that it is difficult to get off Methadone. A smaller percentage either disagreed (17.1%) or strongly disagreed (0.5%) with the statement.

7J. Keeps patients addicted to a substance		
	N	%
Strongly Agree	21	10.5
Agree	105	52.8
Disagree	66	33.2
Strongly Disagree	7	3.5

There was a more divided opinion regarding this statement. A majority (52.8%) agreed or strongly agreed (10.5%) that the MTP keeps patients addicted to a substance, while 33.2% either disagreed or strongly disagreed 3.5%.

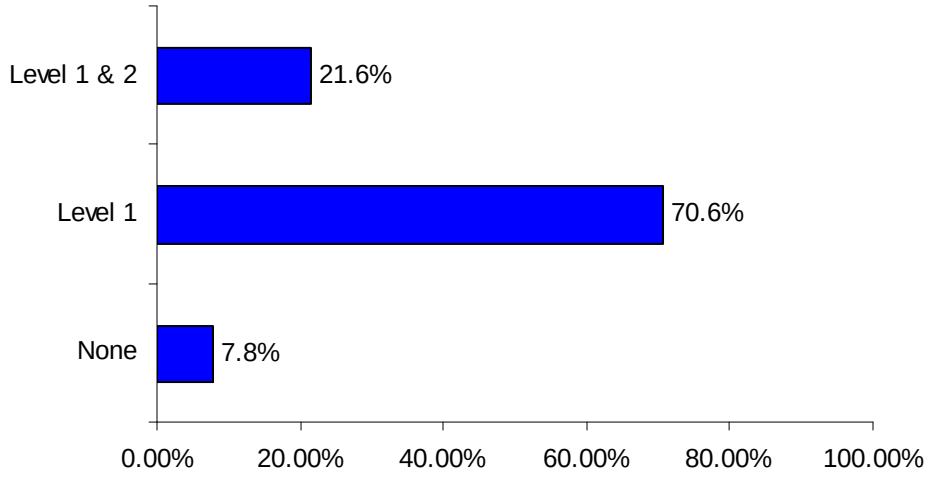
Respondents were given the option to comment on the MTP at the end of the statement section. Other comments/suggestions given were:

- Need a shorter waiting list.
- Need a system for crisis intervention.
- MTP a little too vigilant for long term patients/protocol should be more relaxed for clean and stable patients.
- Little help to get patients off Methadone.
- Impression is of long duration maintenance.
- Allows time to grow and be decoupled from heroin if so desired.

Training Attended

Respondents were asked to indicate what level of training, if any, they had attended. Responses are illustrated in Figure 3 below.

Figure 3: Level of Training

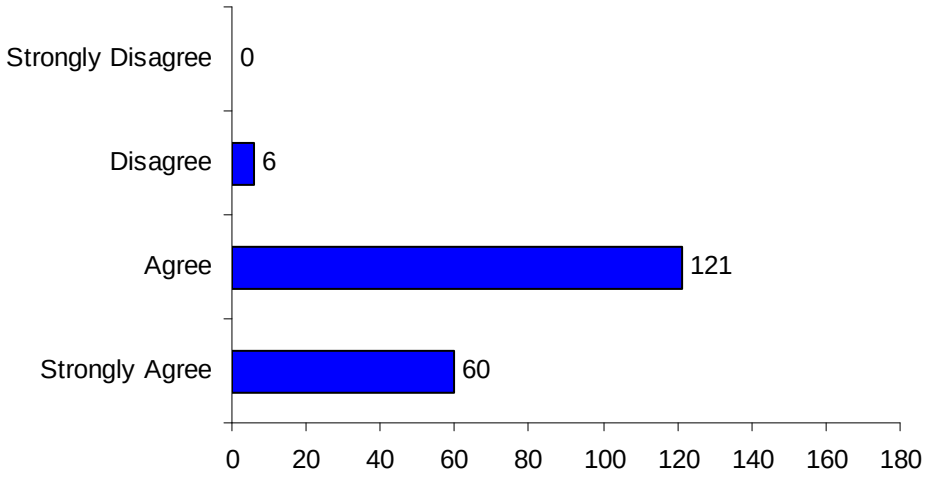


Skills

Those who had attended training were asked to rate a number of statements in order to ascertain whether they felt they had been provided with satisfactory skills to manage key areas. The results are outlined in the Figures below.

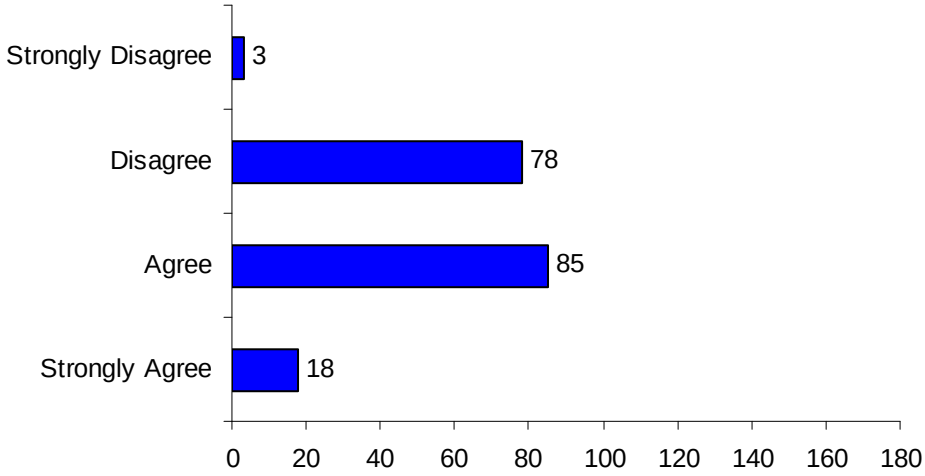
Do you feel the training provided you with satisfactory skills to manage:

Figure 4.1: Stable patients on methadone maintenance



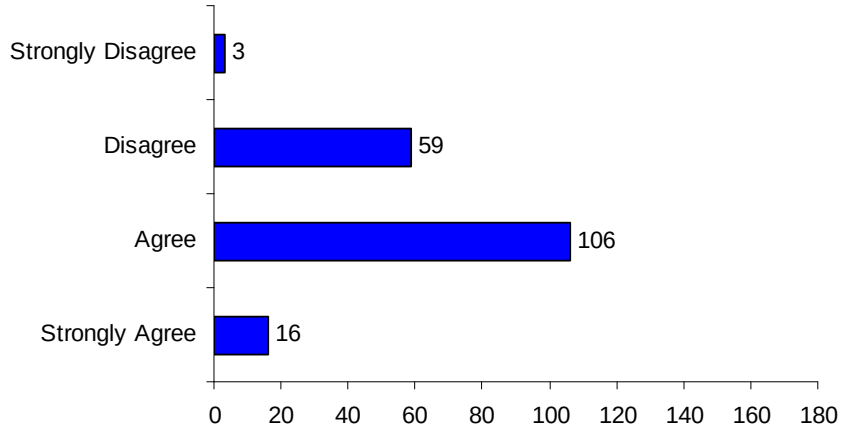
The majority of respondents either strongly agreed (32%) or agreed (64.7%) that their training had provided them with satisfactory skills to manage stable patients on methadone maintenance. A small number (3.3%) disagreed.

Figure 4.2: Patients who continue to use illicit drugs



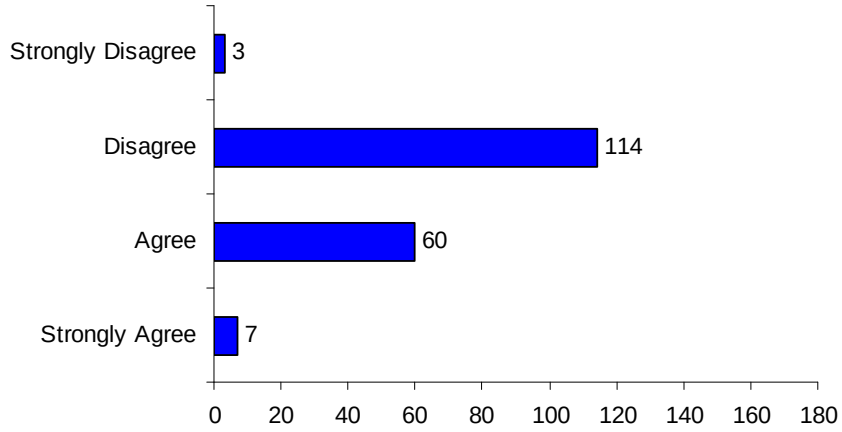
There was more divided opinion on this statement. A slight majority either agreed (46.2%) or strongly agreed (9.8%) that their training had provided them with satisfactory skills to manage patients who continue to use illicit drugs. However, 42.4% disagreed with this statement, while 1.6% strongly disagreed.

Figure 4.3: Complications of drug use



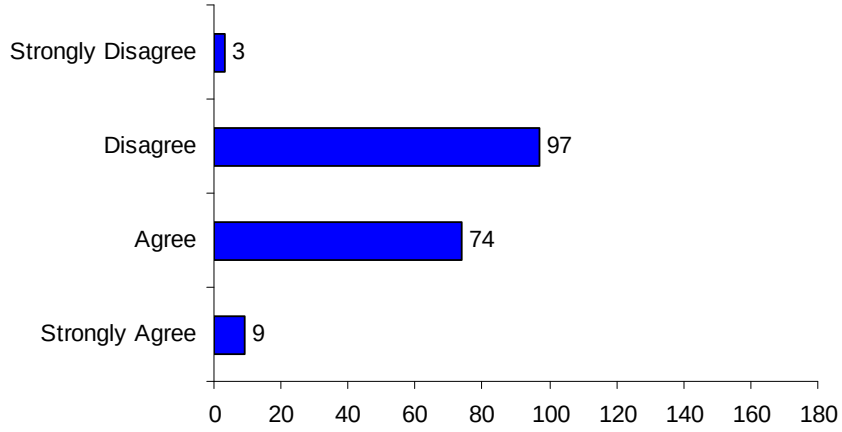
The majority of respondents either agreed (57.6%) or strongly agreed (8.7%) that their training had provided them with satisfactory skills to manage complications of drug use. A smaller percentage disagreed with this statement (32.1%) while a few people strongly disagreed (1.6%)

Figure 4.4: Patients on the MTP with alcohol problems



As can be seen above, the majority of respondents either disagreed (62%) or strongly disagreed (1.6%) that their training had provided them with satisfactory skills to manage patients with alcohol problems. Some respondents felt they had the necessary skills, with 32.6% agreeing with the statement and 3.8% strongly agreeing.

Figure 4.5: Patients on the MTP with benzodiazepines dependency



Similar to the previous statement regarding alcohol, a majority felt that they did not have the skills to manage patients with benzodiazepines dependency. A majority of 53.1% disagreed with the statement, while 1.6% strongly disagreed. There were some who felt they had the requisite skills, and 40.4% agreed with the statement while 4.9% strongly agreed.

Further Training

Respondents were asked to rank (1, 2 and 3) which type of training would be most useful to them. Responses are outlined in Table 8 below.

Table 8: Further Training

	1st Choice	2nd Choice	3rd Choice
Small CME Networks	78 (43%)	48	15
Individual GP Tutor/Mentor	37 (18%)	45	21
Distance Learning	35 (19%)	26	32
Annual Conference	14 (8%)	22	37
Drug Misuse Web Page	12 (7%)	17	24
Annual Audit	4 (1.5%)	8	16
Newsletter	2 (1%)	19	31

The most popular first choice was small CME groups, next was distance learning and individual tutor, which were equally popular, followed by annual conference and a drug misuse website.

Small CME networks were also the most popular second choice, followed closely by individual GP tutor. Distance learning and annual conference were the following two most popular choices.

An annual conference was the most popular third choice, with distance learning and newsletter following closely.

Additional Services

Respondents were asked to rank (1, 2 and 3) which services they would choose to further enhance the services provided to their patients. The results are outlined in Table 9 below.

Table 9: Additional Services

	1st Choice	2nd Choice	3rd Choice
Addiction Counselling	103 (52%)	33	27
In-patient Detoxification Beds	50 (25%)	38	24
Employment Schemes	17 (8.5%)	33	45
In-patient Rehabilitation Service	14 (7%)	42	31
Consultant Psychiatric Services	13 (6.5%)	22	22
Drop-in/ Social Centres	2 (1%)	22	28

The most popular first choice was addiction counselling, next was in-patient detoxification beds, followed by employment schemes and consultant psychiatric services.

The most popular second choice was in-patient rehabilitation schemes, next was in-patient detoxification beds, followed by addiction counselling and employment services, which were equally popular.

The most popular third choice was employment schemes, followed by in-patient rehabilitation service and drop-in/ social centres.

Comments/Suggestions

Respondents were given an opportunity to record any comments or suggestions they had about the Methadone Treatment Programme. Comments received have been classified under a number of headings:

Length of Time

A number of respondents expressed concerns regarding the length of time patients stayed on methadone. Some are concerned about long term reliance.

"I have patient stable for over 10 years….must still attend every 2 weeks, this is crazy!"

Alternatives

Some respondents suggested that alternatives such as buprenorphine should be available. One person suggested that *"saliva sampling kits should be made available as urination is not supervised."*

Communication

It would appear that further communication is required, between GPs and with hospitals/registrars. One GP was not aware that a patient was on the MTP.

Patient Support

Some respondents identified the need for more support for patients. Rehabilitation, psychological counselling in the community, dedicated psychiatric services were all identified. Problems with current service structures were identified.

"local psychiatric service won't see patient with addiction, theyonly send them to drug associated counselling. Many patients say this puts them back to where drugs are being dealt".

GP Support

Some GPs commented that they felt they did not have adequate support/information on the programme. More up to date information and guidelines on detox of stable patients were requested. A newsletter was suggested as a means of keeping up to date.

"I would welcome guidance from more experienced GPs as practicals are fine but on the ground relationships etc tend to be more complex".

Training/Education

Two respondents identified the need for more level 2 GPs in their areas. Others identified the need for more level 1 and level 2 GPs. The shortage of doctors prescribing methadone has led to long waiting lists, causing serious concerns.

Some felt that there is a lack of ongoing training/education. One respondent commented that *"it would be beneficial to hold training outside of Dublin"*.

Another commented that *"skills tend to fall off when not used enough therefore there is a need for ongoing training/education."*

Discussion

This survey has been informative in exploring the attitudes of GPs who are already participating or who are eligible to participate in the Methadone Treatment Protocol. Ireland has developed a model of care for delivering methadone treatment which acknowledges the central role GPs play in delivering care. GPs who participate in the programme have a contract for service and agree to practice according to the ICGP Best Practice Guidelines. They also agree to have regular external audit which assesses the level of care they are providing to patients on methadone.

Of the doctors who responded to the survey (72%) had patients currently on the MTP, and 28% did not have patients. All GP's who had participated in training and are therefore eligible to take on patients were surveyed so it is particularly important to know that 28% of trained GPs had no patients and to explore the reasons why this might be.

GP attitudes to the MTP

While there is an abundance of evidence to support the efficacy of methadone treatment, the survey explored the general attitudes of Irish GPs to methadone as a treatment option. Attitudes which focused on the benefits of methadone treatment suggest that GPs overwhelmingly believe that it is an essential service to drug users (95%), that it improves the health of patients (96%) and that it reduces criminality (96%). GPs also responded that it is more difficult to get off methadone (82%) and that it keeps patients addicted to a substance (63%). It is impossible to determine from these responses whether this is simply a statement of fact or whether these reflect a negative attitude to this aspect of methadone treatment. Overall however, the attitudes of doctors who already had MTP clients were very positive.

With regard to the structure of the MTP, attitudes to some of our Best Practice Guidelines were explored. The guidelines recommend that patients are seen weekly, have a urine sample done weekly and have one methadone dose supervised in the pharmacy per week. The GP's surveyed seemed very clear in their positive opinions regarding the ability to have a good relationship with the patients (94%) and that the structure of the programme allowed them to monitor the patients progress (98%). They did not agree that it was an overly rigid protocol (80%) however there was almost equal division on the question of daily dispensing and whether it might prevent patients from working (50.5%/49.5%). Daily dispensing is recommended during the initiation phase of the programme or during periods of instability and while it is no doubt "inconvenient" for the patient to attend the pharmacy daily, these recommendations are made in the interest of patient safety. Once the patient stabilises the need for daily supervision diminishes and take away doses can be given safely to the patients.

Obstacles to taking on patients

GPs with patients currently on the MTP were asked if there were any obstacles to them taking on more patients. A third (33%) of GPs could see no obstacles to taking on more patients while a further 27% said they had reached the maximum numbers allowed under the MTP. Another group (16%) said they had not been asked to take on more patients. These responses indicate that there is significant scope for increasing the numbers of MTP patients in primary care if doctors were approached by the relevant agencies. The issue of increasing maximum numbers (15 patients for Level 1 and 35 for Level 2) allowed under the

terms of the MTP is currently being addressed and a mechanism for allowing GPs to apply to have additional numbers will be put in place. Perceived obstacles such as fear of violence and fear that such patients may 'put off' private patients were not cited as a barrier amongst the majority of GPs. This information can be encouraging for GPs who have yet to come for training and are perhaps wary of taking patients on.

Of the respondents who were not willing to take additional patients 16% said they had enough patients already and 6% stated that the practice staff did not want any more.

There were 47 respondents (28%) who had completed Level 1 Training and who were eligible to take patients on the MTP but who currently had no patients registered. In response to the question "what obstacles if any are there to you taking any patients" 30% of these respondents said they had not been asked and a further 17% felt there was currently no demand in their area to take patients. Again it would seem reasonable to conclude from these findings that most GPs who have presented for training have a willingness to participate in the programme if requested to do so or are referred back one of their own patients. More active efforts could be made in encouraging or simply requesting GPs to manage their patients as there appears to be an untapped willingness to get involved. A mechanism for regular communication between the GP Co-ordinators and treating GPs with regards to taking new patients could also prove effective.

Satisfaction with Training

The majority of respondents, 70% had received training to a Level 1 standard while 21% had progressed to Level 2 training. A small proportion of GPs stated that they had never received training even to Level 1 standard although they were listed on the ICGP database. One explanation for this could be that they were doctors who were actively treating patients at the time the MTP was introduced and were given a "grandfather" status at that time and exempted form the official training programme.

Doctors were asked if the training had adequately equipped them to manage stable patients and the range of issues which arise frequently with MTP patients. At Level 1, GPs are trained to manage a stable patient on the programme and the majority (96%) agreed or strongly agreed about this. However when it came to dealing with problem patients, doctors were less satisfied with the training. 56% of GPs felt that the training provided them with the skills to manage patients who continued to use illicit drugs while 42% disagreed and 2% strongly disagreed. Similarly with the management of patients with complications of drug use 66% felt adequately skilled while the remainder did not. The majority of respondents (64%) either disagreed or strong agreed with the statement that the training had not provided them with the skills to deal with patients with alcohol problems on the MTP.

In the management of MTP patients with a concurrent benzodiazepine problem, only 45% of the doctors felt the training had prepared them satisfactorily. Benzodiazepine use is a significant problem in the drug using population where some 70% of patients are known to take this medication along with their methadone Benzodiazepines are addictive, subject to abuse and diversion and should be prescribed with caution in drug misusers. It is essential that doctors have good guidelines on how to manage drug misusing patients with benzodiazepine problems and along with the guidelines issued by the Department of Health and Children, the training needs to focus clearly on this issue. [7]

The ICGP is currently reviewing the training programme for both Level 1 and Level 2 training. The results of this survey will inform the review and appropriate changes will be

made in the training. Lack of training may lead to fear and prejudices, which in turn fosters negative responses towards this patient group.

Maintaining skills and keeping appraised of current best practice is a requirement under the MTP GP contract. Continuing medical education (CME) is provided by the ICGP in Dublin where the majority of GPs are based. GPs were asked which CME format best suited their needs. The majority, 43% favoured a small CME group format which replicates the existing small group model which GPs participate in for other areas of practice. There was interest also in a distance learning format (19%) or an individual GP tutor/mentor (18%). In the U.K distance learning in the form of web pages and newsletters from the Royal College of General Practitioners are well used. Currently there are GP co-ordinators for each /HSE area with a National GP Co-ordinator for outside of Dublin who will provide advice and support to mange situations. The least popular form of CME is the audit which may seem threatening but is designed to be supportive to the GP by measuring progress and advising any ways to facilitate further improvements in their service. The feasibility of these options will be examined by the ICGP.

A system of "shared care" has also been devised by the ICGP which allows for an in-experienced GP to be mentored in managing an individual patient for a period of time. This system has been very well received by GPs involved with it.

Additional Support Services

When asked what additional services would enhance the care they could provide for patients, 52% of respondents chose addiction counselling as their first choice. It is known that psycho-social interventions have a direct bearing on treatment outcomes[8]. While even low intervention methadone programmes (i.e. the provision of methadone without supportive services) has some positive effect, services which have good counselling and psychosocial support have much better outcomes.

Inpatient detoxification was also a popular choice as an additional support. While both inpatient detoxification and inpatient rehabilitation undoubtedly have a role to play in recovery, the good outcomes from this form of intervention depends on careful patient selection. Inpatient treatment is considerably more expensive than treatment in the community however it has not been shown to more effective in terms of outcomes. While an in-patient admissions can sometimes be life saving, can interrupt a period of escalating use and are useful for medical reasons e.g. detoxification in pregnancy. Periods of treatment of 3 months or less do not increase the persons chances of becoming abstinent. Furthermore there is an increased risk of death from accidental overdose on discharge. In the face of such evidence there is at best a limited place for inpatient treatment. Families may have an unrealistic expectation of detoxification and many professionals who are not familiar with the success of maintenance treatment may be tempted to encourage this idea as the option of first choice.

Conclusion

GPs are a key resource in the treatment of drug misuse. In addition, there are considerable advantages for treating opiate dependency with substitution treatment in the community by GPs. Patients can be seen close to where they live and the treatment can become part of their general medical care. To a large degree GPs have responded to the challenge of managing drug users and are recognised as an essential part of the drug misuse treatment services.

It is encouraging that GPs view methadone treatment as being such a positive intervention for patients and that those participating in the MTP view it as a very positive experience overall. It is also encouraging that many GPs are willing to take additional numbers onto the programme if asked and similarly those without patients do not appear to have any major objections to taking patients on the programme. This information should assist GP Co-ordinators and Level 2 doctors in placing stable patients with their own GP. It is evident from this survey that with appropriate support and further education many more GPs might be stimulated into participating in the MTP.

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