

**A grounded theory model of the counselling referral process in
primary care methadone treatment in Ireland**

Kevin Kenny, M.Sc (Comp. Sc).

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**Dr. Christina Quinlan,
Research Supervisor**

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of MSc in Integrative Counselling and Psychotherapy is entirely my own work and has not been taken from the work of others, save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:

ID No.: 53156196

Date: 1st November 2007

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Abstract

In terms of the treatment of illicit drug abuse, methadone maintenance is a well researched and widely applied systematic response. The approach to primary care methadone treatment in Ireland is based on the methadone protocol. Primary care plays a central role in the delivery of methadone treatment.

Beginning with a view that a system evolves within the constraints and influencing factors of its context, the aim of this thesis is to model the process that has developed by which patients on primary care methadone treatment are referred to counselling. It investigates the role primary care practitioners perceive they have in relation to managing the psychosocial aspects of the methadone patient's treatment regime. It analyzes individual medical practitioner counselling referral mechanisms to determine what common processes operate across different practitioners. It identifies the factors that influence the use of counselling on primary care methadone programmes and structures these in a cause/effect model.

This research used interviews and documentary analysis to acquire grounded data. The sample consisted primarily of medical practitioners involved in the delivery of methadone programmes. Others closely involved in the implementation of drug treatment in the primary care context made up the balance of interviewees.

The study used a grounded theory methodology to induce the process that was latent in the grounded data. Concepts emerging were grouped under the headings of referral factors, decision making factors and factors related to the unique positioning of primary care at the interface between medicine and society. The core finding was that, in primary care in Ireland, there is no psychological model to complement the pharmacological intervention of methadone substitution.

The findings from this study offer insight into the factors at work and their impacts, in the context of the use of counselling in primary care methadone treatment. The study suggests a possible direction for further evolution of opiate abuse treatment in Ireland which would transform it from a harm reduction to a holistic patient centric paradigm.

CHAPTER 1

Introduction

This research project is a grounded theory study to model the process by which referrals to counselling are made on primary care methadone treatment programmes in Ireland. Primary care medical practitioners are responsible for the treatment of their methadone patients. The factors which constrain and influence the primary care practitioner's use of counselling on methadone programmes are identified. A network of influencing factors is constructed to describe the referral process to counselling.

1.1 Aims and objectives

The aim of this study is to model the process that has developed in primary care methadone treatment programmes in Ireland for the referral of participants to counselling, with a view to identifying how the psychosocial aspect of methadone treatment is implemented. Primary care has been the channel of delivery for long-term methadone treatment since the implementation of the methadone protocol. Using data grounded in the primary care methadone treatment setting, this thesis examines how psychosocial interventions are positioned within primary care methadone treatment and what are the factors that influence this positioning. Potential development directions for opiate treatment involving psychosocial interventions will be identified.

The objectives are :

- To investigate the role of the primary care practice in managing the psychosocial aspects of the methadone patient's treatment regime.
- To analyze individual medical practitioner counselling referral processes for methadone patients and to identify where commonality exists.
- To identify factors that influence the use of counselling on primary care methadone programmes.

1.2 Scope of research and definitions

The research is located in the consultation sessions that occur between the primary care medical practitioner, who regularly reviews the methadone patient's treatment regime, and the patient. It is restricted to the primary care setting and excludes specialised areas

such as the prison service. Kelly *et al* (2003) report that the majority of opiate users are located in the greater Dublin area. Primary care practices which conduct methadone treatment, and from which the interviewees for this thesis were drawn, were based in this geographical region.

The primary care medical practitioner who is responsible for the regular treatment consultation with the methadone patient holds a level 1 or level 2 methadone qualification (see Appendix D for more details of methadone treatment qualifications). Level 1 and level 2 qualifications refer to the training and experience the medical practitioner has, which dictates the number of methadone patients and type of treatment he/she can offer. Training and audit standards are maintained by the Irish College of General Practitioners and the local health authorities.

Methadone treatment has pharmacological and psychosocial components. Arriving at a definition of the meaning of ‘psychosocial’ treatment is important for the purposes of this research but is “something of a definitional minefield which no reviewer has yet successfully traversed” (Davidson *et al*, undated). Huibers *et al* (2007) acknowledge the difficulty in identifying a definition and suggest that psychosocial treatment is a “systematic treatment in which a psychological process is the central dynamic”. This thesis draws on an elaboration in the UK Department of Health report on Treatment Choice in Psychological Therapies and Counselling (2001) which states that

‘psychological therapy’, ‘psychological treatments’, ‘talking therapies’ and ‘talking treatments’ are interchangeable, representing the most generic terms. Within the broad family of therapies, there are two main traditions, psychotherapy and counselling. The distinction between the two is blurred, as they lie on a continuum.....The terminological confusion is exacerbated by the common practice of denoting all psychological therapy delivered in primary care as ‘counselling’.

The terms ‘counselling’ and ‘psychosocial intervention’ are used interchangeably throughout this thesis to encapsulate this concept. Note that there are multiple models of counselling such as motivational interviewing and cognitive behavioural therapy (see Appendix G for the range of counselling modalities used in Dublin drug treatment clinics).

‘Methadone patient’ describes an individual who is being treated on a methadone treatment programme. While ‘client’ is the preferred term from a counselling

perspective, 'patient' is more apt for the medical setting in which this research is located.

1.3 Background to the research

Drug abuse is an individual condition. Courtwright (1997) refers to psychological and biological models of addiction. Society's response to drug abuse varies. Lert (2001) describes the approach adopted in the US as centering on a "War on Drugs" strategy with low tolerance for individual drug abusers. In France, drug abuse is linked with changes in society; drug dependence is viewed as "merely one of the forms taken by social exclusion" (ibid.).

The widespread use of opiates in the US and Europe began in the 1960s. Opiates constituted over 73% of all problem drug usage recorded by Ireland's National Drug Treatment Reporting System in 2002 (Long, Lynn and Kelly, 2005). In the US in the late sixties, Dole and Nyswander discovered that substituting methadone, a synthetic opiate, for heroin satisfied users' craving and permitted them to restore normality into their chaotic lives. There is no 'standard implementation' of methadone based treatment for opiate abuse. Dole and Nyswander's formulation incorporated psychological and social interventions. Amato *et al* (2004) recommend that the systematic application of methadone therapy should involve psychosocial treatments. Methadone maintenance, involving the long-term substitution of methadone to replace the user's illicit opiate, has become a medical treatment of choice.

Methadone based treatment was introduced in Ireland in 1970 to address the increasing prevalence of heroin as a problem drug. Two decades later, in response to the rapid spread of HIV/AIDS which was facilitated by needle sharing amongst heroin users, a national methadone protocol was proposed. This involved primary care practices in the delivery of methadone therapy to patients who had been initially stabilised on methadone in specialised treatment clinics. With the implementation of the methadone protocol, a community level systematic treatment programme for opiate abusers was put in place, supported by pharmacists, primary care GPs and health authorities.

Medically, the International Classification of Disease of the World Health Organisation identifies opiate dependence as a disorder with chronic and relapsing characteristics. In Ireland, the methadone protocol emphasises the medical dimension of opiate abuse treatment through focussing on a pharmacological intervention, with only minor reference to psychosocial therapies. Primary care medical practice, at the interface between community and medicine, retains a holistic view of the patient (Tomlin, Humphreys and Rogers, 1999). This research looks at how primary care practice in Ireland uses psychosocial supports as part of methadone therapy.

Research has been conducted into GP experiences and perceptions of methadone treatment (Wilkinson and Mistral, 2003), the role played by counselling in drug and alcohol treatment services (Velleman *et al*, 2001) and drug users' views of counselling as part of the treatment services (Davidson *et al*, 2003). The particular context of the primary care implementation of methadone therapy and the use of counselling has not, to this researcher's knowledge, been the subject of previous research. Modelling the process which has evolved concerning the use of counselling and the influencing factors that have shaped this process is an important step to understanding how the methadone treatment process works at a primary care level. According to Creswell (2005), research which adds to the store of knowledge pertaining to a certain area of interest and which has potential to improve practice in a specific field is worthwhile. This researcher works as a psychotherapist at Dublin primary care medical clinic which offers a methadone treatment programme. The research topic emerged from discussions with GPs in this practice.

1.4 Selection of the research methodology

This research uses a grounded theory methodology. The objective of the research is to model a process which operates daily in primary care methadone treatment. Grounded theory methodology involves "...the discovery of theory from data – systematically obtained and analysed..." (Glaser and Strauss, 1967, p1). It is an appropriate mechanism to identify what is happening in the field and structure it into a descriptive framework.

Primary care medical practitioners are charged with delivering methadone to their patients, within the context of the methadone protocol, related systematic supports and their own management of patient care. Practitioners have evolved their own approaches to using psychosocial interventions as part of methadone treatment. Grounded theory offers an inductive methodology to identify the underlying process inherent in grounded data sources, in this case medical practitioners and others involved in the delivery of primary care methadone based treatment.

Grounded theory offers a systematic approach to analysing data and identifying concepts contained therein. This researcher has a background in computer science, involving system and process design based on logical and quantitative analysis. The methodological foundation of grounded theory provides an approach which has close parallels to the formal methodologies used in computer system design. This was of particular appeal to the researcher.

1.5 Population and sample

Methadone treatment in Ireland is structured in two-tiers. Specialist Drug Treatment Centres and associated satellite clinics provide a multi-disciplinary service, aimed at stabilisation and/or detoxification of the individual. The second tier is delivered through the primary care service which manages the care of the methadone patient and their ongoing drug treatment regime.

In order to manage methadone patients in primary care, a medical practitioner (typically a GP or Advanced Nurse Practitioner) must undertake relevant training and acquire specific experience of treating methadone patients. Approximately 10% of Irish GPs are qualified to run methadone programmes. Primary care medical practitioners who manage patients on methadone programmes constituted the population for this research. The sample consisted of nine methadone qualified primary care medical practitioners, one general practitioner who doesn't dispense methadone and four others directly involved in the primary care process, including practice nurses and counsellors. The inclusion of participants other than methadone qualified medical practitioners offered alternative perspectives on the referral process. They were also necessary for validation and triangulation of emerging concepts.

1.6 Data collection methods

Interviews and documentary analysis provided the grounded data sources. A ‘snowballing’ strategy was used to construct the interview sample. A short self-report questionnaire was prepared but was not returned by any participants.

Grounded theory advocates beginning the interview schedule with an open and non-directive approach. Britten (1995) points out the potential inefficiency of using a totally unstructured interview approach, as the data acquired may not relate to the research question. It was felt that, by indicating likely areas of focus in advance to the interviewee, the interview session could be used more efficiently. The interview schedule developed as the data acquisition process proceeded in order to saturate emerging themes. Appendices E and F provide examples of interview schedules and a comparison between the two illustrates the development of the schedule. Interviews were carried out using an open and non-directive technique, with opportunity for reflection and probing.

A short questionnaire was developed, to be completed by the primary care medical practitioner immediately after a consultation session with a methadone patient. The referrer was requested to submit a minimum of three questionnaires (Appendix A) prior to the research interview, and before any detailed explanation of the purpose of the research was given. The purpose of this sequence was to gain a ‘snapshot’ of the practitioner’s use of psychosocial interventions prior to their participation in the research interview process. The interview process would undoubtedly highlight their usage of psychosocial interventions and possibly lead to revision.

Documentary analysis, involving the national drug treatment strategy, methadone protocols, standard operating procedures and guidelines, audit processes and payment contracts provided valuable insight into factors which influence the primary care methadone treatment process.

1.7 Rationale for the research

The primary care health service is a key component in the delivery of methadone treatment in Ireland. Primary care medicine claims a holistic view of the patient's well-being. Methadone treatment has been criticised as being a "highly developed and organised methadone delivery service" (Keenan, 2005), suggesting that psychosocial treatment is largely ignored. As a counsellor/psychotherapist, this researcher is interested in how medical practitioners deliver the psychosocial component of methadone treatment and what informs and influences their decisions in this regard. From a service management perspective, it is strategically and operationally important to look at the processes that have developed in the implementation of a national treatment protocol and to identify the influencing factors at play.

Psychological and biological models apply to drug addiction. There is a lack of research into the use of psychosocial interventions in methadone based treatment. Those concerned with psychosocial treatments and methadone therapy have highlighted the lack of literature on the subject and the need for further research (Mayet *et al*, 2004; Amato *et al*, 2004; Lawless and Cox, 2003). This contrasts with the volume of research literature pertaining to the use of methadone as a substitution substance.

The philosophy underlying grounded theory is that individuals are constantly evolving ways of addressing the issues they encounter. In this case, the individuals are primary care medical practitioners. Their issues concern how they apply psychosocial interventions on their methadone programmes, within an environment where the value of psychosocial treatment is questioned and resources are constrained.

CHAPTER 2

Literature Review

2.1 Introduction

This chapter presents a review of literature relevant to the use of psychosocial interventions in primary care methadone treatment. It examines the role of methadone as a substitute opioid. It then details research into the application of counselling on methadone programmes. Finally it looks at the implementation of methadone therapy in Ireland and the role of primary care in delivering methadone programmes.

2.2 Methadone maintenance

Methadone therapy is a controversial and complex subject. Methadone is a synthetic opioid. The basis for methadone-based treatment is that opioids can be substituted for one another with differing effects (Courtwright, 1997; Jaffe, 1990). Methadone has characteristics that make it particularly suitable for use as a heroin substitute. Compared to heroin, the effects of methadone are longer lasting while its euphoric and withdrawal effects are attenuated (Farrell *et al* 2001). When used to replace heroin, it can reduce cravings and mitigate withdrawal symptoms, leading to a level of stability in the individual being treated (Latham, 2003). It is an opioid, however, and possesses the normal characteristics of that family of drugs, including being addictive. The expert group charged with defining the methadone protocol (Ireland, Department of Health, 1993) remarked that

Methadone, like any other addictive drug, is liable to abuse from a number of sources. Therefore, a number of safeguards must be introduced to avoid....its subsequent availability on the black market.

A factor that is rarely highlighted in the literature is that, as a synthetic opioid, the sources of methadone can be regulated and supply channels controlled. It is unclear whether the popularity of methadone therapy results primarily from particular properties which assist the addict in controlling his/her addiction or whether it is part of a mechanism to bring the addict into a controlled environment which contains the effects of opiate addiction on society.

The use of methadone as a heroin substitute was identified by Dole and Nyswander in the 1960s (Dole and Nyswander, 1965). They promoted a biological theory of opioid addiction to counter the prevailing psychological model. The psychological model saw addiction as arising from a sociopathic character defect. Dole and Nyswander concluded that there was no evidence of the existence of the phenomenon of ‘addictive personality’ (Courtwright, 1997). Methadone satisfied the biological cravings for opiates in a regulated way and facilitated the patient in stabilising his/her life to regain normal social functioning. The 1960s was a period of pre-eminence regarding chemotherapeutic solutions for medical and psychiatric conditions. Courtwright (1997) typifies it as an era when a “chemotherapeutic revolution overtaking psychiatry” (p262) occurred. He points out that Nyswander, a psychoanalyst, had previously used psychotherapy in the treatment of drug addicts, but was frustrated by the frequency of relapse. Dole and Nyswander’s work formed the foundation for methadone maintenance treatment. In doing so, they proposed a medical solution for what had been considered a psychological disorder.

Methadone maintenance is associated with a ‘harm reduction’ strategy where the objective is to reduce the negative effects of the drug on the individual and society.

In many countries around the world the recent focus of academics, clinicians and policy makers has been on reducing the harms associated with the use of psychoactive drugs and not necessarily on eliminating the drug use or dependence itself (Ward, 2002).

Reductions in illicit opiate usage and high-risk needle-sharing behaviour, and retention in treatment are the principal outcome measures of methadone maintenance programmes (Lawless and Cox, 2003, p94). The reduction in illicit opiate usage has a secondary effect in reducing drug related crime. The National Institutes of Health’s consensus statement (US, National Institutes of Health, 1997) concluded that methadone maintenance significantly reduced the mortality rate of those in treatment, decreased illicit opiate use and criminal activity, and reduced high-risk behaviours. Society is a major beneficiary of ‘harm reduction’ programmes, benefiting from reductions in drug related crime and the control of a vector for blood borne disease. Gossop (2005) reports a threefold return on investment in methadone maintenance based on the reduction in drug related crime alone. Sorensen and Copeland (2000) report that oral methadone has been observed to lead to a reduced needle sharing practice among patients who persist with injecting illicit drugs.

Methadone maintenance is not a panacea for opiate addiction and has been criticized on many fronts. Opiate dependence is recognised by the World Health Organisation as having “social, psychological and biological determinants and consequences” (WHO, UNODC and UNAIDS, 2006). Dispensing methadone, an addictive opioid, to drug addicts gives cause for questioning what is being achieved for the individual (Ward, 2002; BMJ Editorial, 1996). Methadone maintenance does not directly address the abuser’s addiction, contrary to the public perception of methadone maintenance as a treatment programme.

The community expectation of ‘treatment’ of drug dependence is, in general, that it will result in drug users achieving a drug-free lifestyle (WHO, 2003).

Approaches to drug treatment in Ireland show a lack of consistency in treatment objectives. The National Drugs Strategy 2001-2008 (Ireland, Department of Tourism, Sport and Recreation, 2001) sets its objectives as

To encourage and enable those dependent on drugs to avail of treatment.....with the ultimate aim of leading a drug-free lifestyle

and

to minimise the harm to those who continue to engage in drug-taking activities....

The role of methadone maintenance as the major structured component in a harm reduction strategy has been questioned. A number of submissions to the 2001-2008 National Drugs Strategy (ibid.)

....were opposed to the concept of methadone maintenance as a means of treatment. The point was made that methadone maintenance was keeping misusers within the user environment, with little focus on attaining a drug-free lifestyle....there was a general lack of understanding about the objectives of methadone maintenance.

Methadone may be used as an intermediate substitute in a detoxification process. This involves the patient transferring onto methadone which is gradually reduced until clean. Follow up studies have indicated that the relapse rate to heroin usage from detoxification programmes is extremely high. Simpson *et al* (1982) report that only 12% of the detoxification group remained abstinent. Lawless and Cox (2003) suggest that methadone detoxification “alone cannot be expected to lead to long term abstinence, or radical alterations in other outcome measures”. Amato *et al* (2004) highlight the role that the patient’s psychological, behavioural and social conditions

may play in causing relapse to opiate usage. A comparison of the effectiveness of methadone maintenance and methadone detoxification suggests that methadone is not a treatment *per se* for opiate addiction. It is a safe substitution opiate which brings the drug user into a controlled environment. The regular supply of an opiate substitute on methadone maintenance programmes may allow the user to ‘stabilise’ what was a ‘chaotic’ lifestyle centred around the acquisition of illegal opiate. There are benefits to society in terms of community health and reduced drug related crime. The individual change required to achieve abstinence may lie deep within the individual psyche (Miller and Rollnick, 1991).

There is no single protocol for methadone-based treatment. Lawless and Cox (2003) state that the definition of “what constitutes methadone treatment in addition to the content and structure of methadone programmes varies widely”. This limits the conduct of rigorous research or comparison between different pieces of research (Mattick *et al* 2003). Fiorentine and Anglin (1996) indicate that disaggregating the effects of a treatment from other components requires a quasi-experimental methodology which “is often difficult, expensive and sometimes impossible to implement in the drug treatment context”. Within the context of structured methadone programmes, there is a complex network of variables which can be difficult to control in order to identify the factors which are active in treatment.

2.3 Psychosocial interventions and drug treatment

The medical model favours the pharmacological component of opiate abuse treatment over psychosocial interventions.

Current evidence focuses on the beneficial role of pharmacological interventions concentrating on the physiological, rather than the psychological or social aspects of addiction (Mayet *et al* 2004).

There are psychogenic factors at work in drug usage, which are not addressed by substituting an illicit drug with another legal drug with similar if attenuated characteristics. Dole and Nyswander’s original programme of methadone maintenance included a comprehensive set of psychological and social services to assist the person reintegrate into mainstream society (Ward, 2002). However, pharmacological treatment

has been promoted to the detriment of psychosocial interventions. Dole and Nyswander's formulation of methadone maintenance

was a key step in the partial remedicalization.....of narcotic addiction that was such a conspicuous trend in the field in the late 1960s and 1970s (Courtwright, 1997, p260).

The treatment of drug addiction tends to fall under psychiatric and mental health services. The clinical director of the National Drugs Advisory and Treatment Centre, the first institution established in Ireland to focus on the treatment of drug abusers, was a consultant psychiatrist (Butler, 2002). While the pharmacological aspects of methadone substitution are highly researched, very little work has been done into the application of psychosocial interventions to drug abuse treatment, either alone or in conjunction with methadone. Mayet *et al* (2004) conducted a systemic review of the psychosocial treatment for opiate abuse and dependence. This was the first such review, despite the widespread use of psychosocial interventions in general clinical practice and the widely held perception that psychosocial treatment was a necessary part of drug addiction treatment. Mayet *et al* (2004) observed that the "psychosocial component of therapy is thought to be a critical component of the holistic treatment". They concluded, having failed to find adequate evidence of objective evaluation, that psychosocial treatments are not adequately proved as treatment modalities. This is explained to a large degree by the "heterogenous range of psychosocial interventions that are provided in the field of drugdependence" (ibid.).

The fault for this lack of research may lie both with those who provide psychosocial interventions and those who require an objective evidence basis. Psychosocial modalities don't lend themselves to uniform application and objective measurement, as each delivery occasion is a unique occurrence of participant, therapist and context. In counselling, the therapeutic relationship between two individuals is subjective and any attempt to objectively measure it is likely to encounter difficulty. Moodley (2001) expresses this dilemma eloquently

Practitioners have argued that the use of objective, rational and scientific methods which tend to be favoured by researchers, sits uncomfortably in a discourse which is essentially subjective, imaginative and psychic.

Amato *et al* (2004) examined the contribution of psychosocial interventions in conjunction with pharmacological treatment in opiate detoxification programmes. While many of the conclusions echo those of Mayet *et al's* (2004) review, in this case it was possible to identify eight qualifying studies. The availability of more detailed data in this research is intriguing and may result from the fact that it looked at the usage of psychosocial interventions *in conjunction* with pharmacological interventions, the latter of which tend to attract research focus. The conclusion was that psychosocial treatments are beneficial when used with substitution detoxification, in terms of completion of treatment, treatment compliance, and abstinence at followup.

Addressing the psychosocial aspects of drug addiction improves the treatment outcome in terms of reducing illicit drug usage. Fiorentine and Anglin (1996; 1997) used an experimental design to analyze the effects of increased counselling participation on outpatient drug treatment programmes. Having accounted for patient characteristics and other programme variables, they concluded that individual and group counselling had a direct and sensitive relationship with the level of relapse to drug use post treatment. In the six months between end of treatment and the follow-up survey, patients who averaged more group counselling and individual sessions per month while in treatment had a 40% lower rate of drug usage than the control group. This suggests that counselling has a carryover effect after treatment ends, which is beneficial in reducing patient relapse.

Gossop, Stewart and Marsden (2003) conducted a study of the effectiveness of counselling during methadone maintenance. One and six month surveys were carried out on 291 methadone programme participants. The findings were more specific than those of Fiorentine and Anglin (1996; 1997) and showed that counselling which focussed on drug problems and their resolution augmented the reduction in illicit drug usage during a six month follow up period, when compared to general or no counselling.

As well as the direct effects of counselling in addressing the psychosocial elements of drug addiction, it has an indirect effect in terms of patient participation in a treatment programme. Counselling has a positive influence on the patient's perception of the

treatment programme, which has been demonstrated to have a strong inverse relationship with use of heroin one month into treatment (Gossop *et al*, 2003). Patient participation in a treatment programme, in terms of duration and engagement, is an important factor in the effectiveness of treatment. Engagement is a foundation for the therapeutic alliance. According to Gilbert and Evans (2000), the therapeutic alliance is the active ingredient in the process of counselling. A small increase in the counsellor's rating of the alliance leads to a significant upwards shift in the probability of the patient completing treatment (Meier *et al*, 2006). This makes the case, not just for counselling at an early stage in treatment, but for experienced counsellors with a clear focus on the practice of counselling.

Counselling on drug treatment programmes has beneficial effects in terms of patient retention in treatment, reduced drug use and abstinence outcomes. In a comparison of three different levels of counselling on methadone programmes, an intermediate level of counselling was substantially more cost effective than minimal or intense levels (Kraft *et al*, 1997). As well as demonstrating the relative effects of different levels, this study quantifies the additive effect of counselling with methadone substitution. On a twelve-month follow-up, approximately 50% of those who received medium or enhanced levels of counselling intervention were abstinent from drugs, compared to 29% for minimal counselling intervention. Figure 2.1 displays Kraft *et al*'s findings.

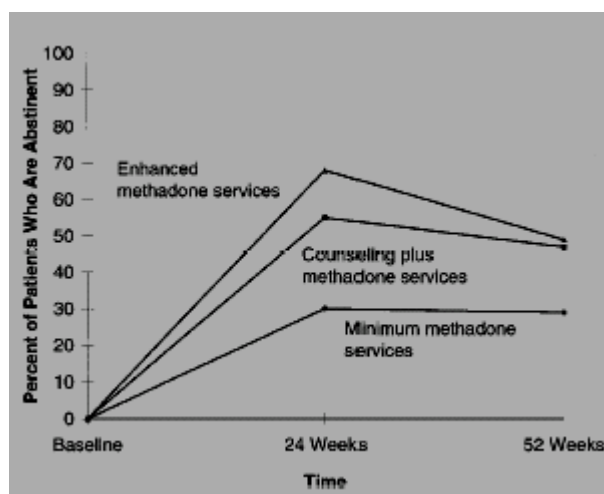


Figure 2.1 Drug Abstinence rates by level of treatment at baseline, 24 and 52 weeks (Kraft *et al* 1997).

The use of counselling in conjunction with methadone substitution is cost effective and increases the treatment effect in terms of treatment programme retention, participation in treatment and abstinence afterwards.

2.4 Methadone programmes in the Irish context

Methadone treatment was introduced in Ireland circa 1970. Over 70% of problem drug cases are located in Dublin and its immediate hinterland. Opiates are reported as the main problem drug in 73% of cases (Kelly *et al*, 2003). In 1969 the National Drug Advisory and Treatment Centre was established in Jervis Street Hospital. According to Kelly (1983), it was a clinical facility, operated on an abstentionist model offering a range of services including methadone detoxification for opiate abusers. It also provided “supportive psychotherapy, group therapy and counselling” for drug abusers (ibid.).

A heroin epidemic in the early eighties, followed by the rapid spread of HIV, put drug treatment centre-stage and highlighted the need for a medical and societal response. According to Barry (2002), drug injecting practice was a major causative factor in the spread of HIV. The response of the health authorities included the establishment of drug treatment centres and the promotion of methadone maintenance. Some significant changes in drug treatment strategy, organization and implementation occurred. Drug treatment policy changed, pragmatically, from abstinence to harm reduction; medical responsibility for implementing drug strategy relocated from psychiatry to public health; primary care was identified as a key component in implementing harm reduction and managing chronic opiate addicts in the community. The switch from abstinence to a harm reduction strategy, with methadone substitution as an important tactic to reduce heroin, indicated a change in focus from a patient centric to a societal view. In France, criticism of methadone substitution by drug addiction specialists centered on the notion of social control: the view was put forward that society conveniently overlooked the drug addict’s suffering in order to alleviate the social disorder associated with his condition (Lert, 2001).

The ‘Expert Group on the Establishment of a Protocol for the Prescribing of Methadone’ was established in 1992 to devise a practical protocol for the rollout of

methadone maintenance. The report prioritises the need for a response to the rapid spread of HIV. It describes the primary care medical practitioner's role in terms of patient management after stabilization on methadone within a support context of drug treatment centres, community drug teams, and statutory and voluntary addiction services. The expert group's approach to drug treatment was holistic. It recognized the "complexities of the medical and psycho-social issues involved in the treatment of drug use" and "considered the importance of a multidisciplinary approach should be emphasized" (Ireland, Department of Health, 1993). An appendix to the report noted that "Methadone should always be regarded only as an adjunct to treatment and not treatment per se". Butler (2002) quotes a Fianna Fail policy document, prepared in 1997, which states "Fianna Fail will give absolute priority to the detoxification and rehabilitation of addicts. Methadone maintenance will play a role, but only a secondary role" (Fianna Fail, 1997). Though methadone maintenance underpins a harm reduction strategy, the aspiration of a drug-free lifestyle remained on medical and political agendas.

In 1997, the 'Methadone Treatment Services Review Group' was formed by the Department of Health to move the earlier protocol proposal to implementation. The constitution of the Review Group changed from the earlier Expert Group, with the pharmaceutical profession forming 30% of the committee and no representation from the National Drug Advisory and Treatment Centre or the voluntary drug treatment sector. The constitution of the Review Group is reflected in its report (Ireland, Department of Health and Children, 1998) which describes the operational aspects of a methadone maintenance programme. It details the prescribing and dispensing of methadone, methadone supply and control and the structural relationships between the health boards, drug treatment centres, primary care GPs and pharmacists.

The Review Group's report (Ireland, Department of Health and Children, 1998) emphasized the pharmacological mechanisms of the GP's management of a patient on a methadone programme. In terms of psychosocial interventions, the content is sparse. It picks up on the recommendation of the Expert Group that "general practitioners should become involved by taking on the responsibility for the care of opiate dependent

persons who had first been stabilized at community drug treatment centres”. When dealing with the transfer of the patient to general practice, it states that

...where it is deemed necessary and if the patient so wishes, (the patient) will also have access to a community addiction counsellor.

Under the heading of “Future Plans For the Co-Ordination of Methadone Schemes”, it recommends that

...patients will be provided with support from health board counselling and outreach staff

and that

a comprehensive plan will be put in place in respect of each patient. This will include medical, social and psychological care.

The use of the third party, and the lack of attribution of responsibility when referring to psychosocial aspects of treatment contrasts with the level of detail attached to the pharmacological component in the report.

Given the lack of emphasis in the methadone protocol on psychosocial interventions, it is not surprising to discover that systematic support of psychosocial interventions is sporadic. Submissions to the Review of the Methadone Treatment Protocol (Ireland, Department of Health and Children, 2005) raised the issue of inadequate psychosocial care for drug users. The review committee accepted this, seeing it as an “area that needs to be addressed by the HSE”. Keenan (2005) illustrates the pharmacological/psychosocial imbalance that has arisen in the implementation of methadone therapy in Ireland when he suggests that critics of the approach may portray it as a “highly developed and organized methadone delivery service”. In Ireland, it appears that the systematic response to opiate addiction treatment involving primary care went no further than methadone substitution. This is consistent with a harm reduction ethos. Psychosocial interventions to complement pharmacological treatment were not underwritten by a protocol based approach.

2.5 Primary care and methadone programmes

Primary care is the gatekeeper between the individual and medical services. The setting of the general practice in the community promotes ongoing and holistic care, reinforced by the relationship between the individual and the doctor. Saultz (2003) talks about the longitudinal relationship which “...evolves into a strong bond between physician and

patient characterized by trust, loyalty, and a sense of responsibility”. Handover of the stabilized opiate user to primary care supports the reintegration of the individual into their community. Methadone maintenance can occur in the primary care setting, akin to the management of other chronic and relapsing conditions.

Initially, the thinking in Ireland was against the involvement of primary care practitioners in drug treatment. A 1984 Department of Health report stated that “We are not in favour of the treatment by general practitioners of drug addicts” (Ireland, Department of Health, 1984, p118). The methadone treatment protocol regularized a situation where some GPs were prescribing methadone as a response to the rapid growth in heroin usage and HIV in their communities (Wilkinson and Mistral, 2003). A 1996 health board pilot programme confirmed the appropriateness of primary care to run methadone programmes (Ireland, Department of Health and Children, 1998). Contemporary and recent research support this finding (Wilson, Watson and Ralston, 1994; Keen *et al* 2003; Simeons *et al* 2005). The primary care practitioner who provides methadone treatment is obliged to ensure “continuity of care” for the patient (GP Contract, 2007). The relevant contract between the medical practitioner and the health authority (HSE) states that the

HSE recognizes that the treatment provided by GPs in a primary care setting under the Methadone Protocol is an important part of the wider holistic care to individuals involved in drug use (GP Contract, 2007)

and specifies certain support services that the HSE will provide to GPs. There is no reference to provision of psychosocial services.

Primary care medical practitioners recognise the importance of psychosocial intervention to support methadone therapy. This is evident at a practical level in documentation developed to support medical practitioners who prescribe methadone. One such manual (Dublin Based GPs, undated) recognises that “Prescribing [methadone] on its own is unlikely to achieve optimum change”. It recommends that drug users be “strongly encouraged” to engage with a counsellor and points out that, “once stability is reached, it may be possible to explore and deal with ... underlying emotional problems”. It suggests other counselling-like tactics such as goal setting and lifestyle changes. A guideline document developed by the Irish College of General Practitioners (ICGP, 2003) positions primary care practice as having “unique

knowledge of the patient and their extended family”. This document defines the aims and objectives of primary care drug treatment as improving users’ “physical, psychological and social health” (ibid. p8). The importance of interacting with the patient beyond prescribing methadone is recognized. Stabilization is seen as an opportunity to “improve the overall personal, family and social functioning of the individual” (ibid. p18); destabilization may be triggered by a “stressful life event” (ibid. p21), with increased support being an appropriate response. Once destabilization has been resolved, there may be an opportunity to “encourage the patient to consider the ‘bigger’ picture of their addiction and accept referral to counselling.....” (ibid. p22). The gateway role of primary care in access to counselling services is clarified: “counselling.....as an outpatient or inpatient should be offered and made available to all patients as appropriate” (ibid. p12). The guideline document suggests that responsibility for provision of counselling services lies with the health authority.

Despite recognition of the role of psychosocial interventions in guideline documents and practice handbooks, the real life implementation of methadone based treatment in primary care tells a different story. In a review of the role of counselling in the drug treatment services, Velleman *et al* (2001) observed that there was “confusion” over the purpose of counselling. It was not clear whether the aim of drug treatment was harm reduction or movement towards a drug-free lifestyle, the latter based on a “counselling, personal development model” (ibid. i). Crucially, it was found that there was a “lack of clarity over the centrality of counsellingversus the centrality of methadone” (ibid. i). Velleman *et al* (2001) highlight the feedback from drug counsellors which indicated that the medical model dominated drug treatment with a negative effect on the provision of effective counselling (ibid. p21). The detail behind this indicated a medically driven regime with a focus on methadone to the exclusion of the psychological dimension of addiction, patient motivation and development. The authors highlighted the anomaly of “no, or very little counselling for drug problems within the community primary care setting” (ibid. p40). It was recommended that substantial counselling resources be deployed to the primary care sector. The provision of counselling resources gave rise to funding and accountability issues, with the health authority indicating it would provide resources; GPs considered that they should

employ them to ensure that “accountability remains within the primary care practice” (ibid. p41).

The absence of integrated counselling services in primary care methadone treatment protocols may be a result of a lack of ownership regarding responsibility for the provision of counselling resources. Primary care medical practitioners do not appear to have any philosophical problems concerning the use of psychosocial interventions as part of methadone based therapy. Wilkinson and Mistral (2003) report on an investigation into the attitudes of GPs who prescribe methadone. A majority of GPs supported a shared care approach to methadone maintenance treatment, involving specialists such as counsellors, psychiatrists and mental health nurses working with medical practitioners.

2.6 Summary

Methadone based therapy is widely used in the treatment of opiate abuse. The original formulation of methadone treatment contained pharmacological and psychosocial interventions. However, there is no common definition of what constitutes methadone treatment. The most common formats relate to methadone maintenance and methadone detoxification. The pharmacological component of methadone treatment involves substituting the opiate abuser from an illicit to a legal and controlled opioid. The benefits of methadone maintenance are reductions in drug related crime, less high risk behaviours and reduced illegal opiate usage. Detoxification from methadone to become ‘clean’ has a very high relapse rate back to using illicit opiates.

Researching the impacts of psychosocial interventions in conjunction with methadone treatment is difficult, leading to a lack of authoritative research in this field. What research there is suggests that the use of psychosocial therapy in conjunction with methadone increases the effectiveness of treatment programmes and substantially increases opiate abstinence rates after detoxification.

In Ireland, the methadone treatment protocol involves primary care in the ongoing treatment of opiate users who have been stabilised on methadone. The emphasis of the methadone protocol is on ongoing methadone maintenance with a dominant harm

reduction ethos. The protocol does not offer any psychological model to complement its pharmacological one, and there is no incentive or pathway for the further development of the opiate abuser beyond methadone maintenance.

The medical model dominates methadone treatment. Primary care is a unique setting that combines medicine with holistic patient care. The relationship between the medical practitioner and the patient is paramount. Primary care practitioners in Ireland recognise the importance of psychosocial treatment as a component of overall methadone based therapy. Despite this recognition, the evidence suggests that the use of counselling on primary care methadone programmes is sporadic and unstructured.

CHAPTER 3

Research Methodology

3.1 Introduction

This chapter describes the methodology employed when deriving a model of the process used for patient counselling referrals on primary care methadone treatment programmes in Ireland. Grounded theory methodology is described, followed by a discussion on the role of the researcher, sample selection and approaches to data collection. Finally, ethics and related issues are considered.

3.2 Grounded theory

It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts
Sherlock Holmes, "A Scandal in Bohemia"

‘Grounded theory’ is an appropriate methodology to model a process involving human interactions (Creswell, 2005). In the uneasy tension between positivist quantitative research and qualitative research, the discovery of grounded theory in the 1960s signalled a new departure with its roots firmly in the behavioural sciences. The emphasis of grounded theory is to generate theory, not to validate or retrofit existing theories. A theory may be superseded as other factors are incorporated in subsequent analysis, but not invalidated for the context in which it was generated (Glaser and Strauss, 1967, p19).

It is advantageous to draw on a range of data sources, documentary and fieldwork, in the generation of theory. Glaser and Strauss (1967, p163) emphasise that “sociologists need to be as skilled and ingenious in using documentary materials as in doing field work”. This argument extends beyond conventional sources and urges an open and eclectic approach. Researchers need to tap into their creativity when identifying and using sources. The use of multiple sources supports the inductive thrust of grounded theory. Beginning from a broad base, theory generation evolves through a series of

tentative proposals to a theoretical model of what is happening in the process under examination.

No limits are prescribed on the number of participants, interviews or data sources at the start of the study (Cutcliffe, 2000). The initial set of interviews is conducted on a purposeful sample of individuals who provide a broad scope of insight into the area of investigation. This is part of the discovery process of grounded theory, the researcher having "...some idea of where to sample, not necessarily what to sample for, and where it will lead" (Coyne, 1997, p625). Glaser and Holton (2004) indicate that the researcher must be aware of the human propensity to form pre-conceived hypotheses, consciously or subconsciously, and must minimise their influence.

'Constant comparative analysis' is the heartbeat which drives grounded theory. Strauss and Corbin (1998, pp65-68) suggest a very detailed analysis of the data, yielding code words to capture the meaning expressed therein. This approach has been criticised, notably by Glaser (1992, p40), as being excessively granular. Instead, an approach is recommended where key points are identified from the data. For this project, key point identification was found preferable to micro-analysis due to the volume of data. Allan (2003) highlights the time consuming nature of a detailed analysis approach. He cautions against losing focus of the objectives of the research when immersed in the minutia of micro-analysis.

The process of coding elevates the content and meaning of empirical data to an abstract and conceptual level. Areas of commonality are identified across different data sources. It becomes possible to recognise patterns emerging from the codes, and to relate codes to each other. Codes that pertain to similar general concepts can be further abstracted into 'categories'. This is never a final or complacent grouping as they must be constantly compared to ensure relevance as new data is acquired. While grounded theory is an inductive methodology, the identification of codes, categories and their relationships displays a deductive approach. Glaser and Strauss (1967, p32) indicate that it is deductive processes which guide the direction of theoretical sampling. Appendix H illustrates an example of theory generation as it was applied in this study.

As a tentative theory forms, the sampling mode changes from purposeful to theoretical (Coyne, 1997; Glaser and Holton, 2004). The change in emphasis is guided by the identification of a 'core category'. This is a pivotal category and is core to the framework which relates categories to each other. It seems to have "explanatory power" (Glaser and Holton, 2004, para 3.9) for the variation in the pattern of behaviour within the process being analysed. The stages of sampling, data analysis, emerging theory and verification are not sequential. They are dynamically connected by ongoing comparative analysis. In this project, interview transcription and initial analysis took place within days of an interview. Emerging themes were correlated to previous interviews and brought forward to the interview schedule of a following interview. Selection of subsequent interviewees was designed to explore emerging themes or fill gaps which were apparent in the emerging model.

The basic question in theoretical sampling is to what groups and subgroups does one turn to next in data collection – and for what theoretical purpose (Glaser and Holton 2004 para 3.7).

As new data emerges, it is possible to delimit what is relevant to the study as those categories which are relationally proximate to the core category. The process of reduction is important in what could otherwise become a growing mass of interrelated categories.

The term 'memoing' describes the unstructured recording of categories or concepts, their attributes and relationships, and researcher observations and thoughts. The research diary underpinned the process of memoing as its use was to record thoughts and ideas as they emerged. All the while the emerging construct must reflect the grounded data without any fitting into preconceived theoretical outlines. Graphic flow charts showing categories/concepts and their interrelationships are often used to illustrate the induced process model (Allan, 2003; Creswell, 2005, p417; Hanley-Maxwell *et al*, 2007).

The distinction between theory *as a process* and theory *as a finalised product* (Glaser and Strauss, 1967, p32) underlies the grounded theory methodology. The resultant theory is a momentary snapshot of a temporal conclusion, with recognition that it is continuously evolving.

3.3 Researcher role

The researcher acts as an instrument in the generation of theory. Strauss and Corbin (1994) point out that, contrary to most other research methodologies, grounded theory does not advocate a literature review prior to data collection. This helps to ensure that whatever emerges is rooted in the empirical data. The fact that this researcher has minimal background in the primary care methadone process and is approaching the field with a sense of discovery is advantageous. In order to get a general view of the area of investigation, form a scope and design the research project, it was considered necessary to review relevant literature in advance. This initial review provided clarity on the actors involved in primary care methadone maintenance and a view of the systematic influences likely to be encountered in the process. The use of literature as an overview of the research context concurs with Cutcliff's (2000, p1480) contention that it can

provide an understanding of the concepts and thus provide firm conceptual clarity and an understanding upon which the rest of the emergent theory can be built.

In grounded theory, the researcher is intrinsic to the process and must be cognisant of his/her influence on the conduct of the research. Reflection on the researcher's impact on the theory generation process, through prior knowledge, assumptions, expectations and beliefs is termed '*reflexivity*'.

Attention to reflexivity is particularly important because researcher assumptions and world views shape everything in the research process. (Hanley-Maxwell *et al*, 2007, p103).

Reflexivity is something psychotherapists, such as this researcher, are very familiar with as part of their practice where it is an important dynamic within a therapy session.

'Creativity' is a unique contribution of the researcher. The principles of qualitative investigation, where a reality is constructed and meaning is sought, are very different from quantitative research. The researcher is part of the process of constructing meaning from the data; by reflexivity, deductions remain grounded in the data, while creativity liberates the inductive process of finding meaning. The effect of this is to

legitimise the researcher's creativity as an integral part of the grounded theory inductive process, liberating the restrictions on the researcher's tacit knowledge that discounting such knowledge creates (Cutcliffe, 2000, p1479).

The researcher must trust the grounded theory process that works at a different rate and in different ways to other qualitative methods (Glaser and Holton, 2004). Glaser and Strauss (1967) emphasise that while the process is systematic, it is not logico-deductive. Thus, assertions that the core concept will become apparent through comparative analysis, or that a coherent theory will ‘emerge’ from the data cannot be experienced without upfront commitment and risk on the part of the researcher.

The researcher must trust his/her own judgement and analytic abilities. While it is fundamental that theory originates from the data, it remains for it to be interpreted and understood. Grounded theory encourages eclecticism and evolves in unpredictable ways. Glaser encourages the use of “tactics to maximise accidents” in locating relevant data sources (Glaser and Strauss, 1967, p174). Part of the creative process is that the researcher discards irrelevant categories and saturates relevant ones. Glaser suggests “the root sources of all significant theorising are the sensitive insights of the observer himself” (ibid.). Insights can manifest at any time “even when asleep. Generally we suppress themrather than looking at them as springboards to systematic theorizing” (ibid. pp251-252). Cutcliffe develops the role of researcher as instrument:

...choices of which facts and lines of enquiry to follow and which not to follow are guided, to some extent, by the subconscious perceptual and intellectual processes of the researcher’s mind (Cutcliffe, 2000, pp 1479-1480).

Within a context of emerging theories, it is necessary to control the scope of the research. This is fundamental to the efficient and effective use of the limited resources available, and increases the likelihood of attaining an end result within defined timescales. Scope control demands project management skills, also applicable to preparation, execution and timelines.

The range of acceptable data sources in grounded theory extends to researcher self-reflection, and observation of participants and their non-verbal behaviour in social interactions (Baker, Wuest and Stern, 1992, pp1357 –1358). Psychotherapists, such as this researcher, are skilled in the observation of non-verbal communication.

3.4 Population and sample

The population for this thesis consists of approximately 230 level 1 and level 2 qualified GPs and Advanced Nurse Practitioners who are responsible for the management of patients on primary care methadone programs (Central Treatment List, 2007). The identity of primary care practices that conduct methadone treatment programmes is not public knowledge. Mountjoy Medical Practice (Mountjoy St., Dublin 1), a primary care medical practice based in Dublin which treats methadone patients, agreed to act in an introductory capacity to relevant primary care practices.

An initial purposeful sample comprised three primary care GPs who treated methadone patients. Each was involved in a well established program, had long-term experience in methadone therapy and was familiar with the general application of counselling in primary care. Additionally, they were potential sources of references to other GPs and thus, a good starting point for a snowball sampling strategy. Glaser accepts that initial samples comprise those knowledgeable on the subject area, who can act as rich sources of data and provide leads to further sources of data (Glaser, 1978, p45).

The next phase involved interviews and documentary analysis to follow up codes that emerged in initial interviews, while remaining open to the introduction of new ones. Sampling, after the initial stage, followed a theoretical model, concurring with Glaser's (1978) definition of theoretical sampling as

the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides which data to collect next and where to find them, in order to develop the theory as it emerges.

During the interview process it became apparent that, to saturate emerging categories and for purposes of verification, the sample cohort would need to expand to other parties closely involved in the referral process such as practice nurses and counsellors. This design change was notified to the D.C.U Ethics committee. Coyne (1997) refers to the need to flex the sample in response to what emerges :

.....theoretical sampling in particular allows for considerable flexibility as the sampling is not pre-determined; rather it is ongoing throughout the study.

Table 3.1 summarises the constitution of the interview sample :

| Category | Number of participants | Comment |
|---|------------------------|---|
| Referrers (GPs and Advanced Nurse Practitioners) | 9 | Some participants re-interviewed for saturation and verification; |
| GPs (not involved in methadone treatment) | 1 | Theoretical saturation; |
| Counsellors / Practice Nurses involved in methadone programmes. | 4 | Triangulation, theoretical saturation and generation of codes; |

Table 3.1 Make up of interview sample and explanatory notes.

3.5 Data Collection

The ‘all is data’ principle of grounded theory (Glaser and Holton, 2004) supports an expansive view of the field of potentially relevant data. The initial range of data sources was related to the general scope of the area of investigation (Coyne, 1997, p629). Before going into the field, a pilot exercise was conducted to test the design of the interview schedule and questionnaire. When in the field, the researcher felt there was a high level of engagement in interviews but it is notable that no questionnaires were returned.

Table 3.2 gives a breakdown of the data sources and how the data yielded was used.

| Data Sources | Subgroup | Area of application |
|-------------------|---|--|
| 1. Documentation. | 1.1 Reference e.g. Substitution treatment; Evolution of methadone treatment; Addiction – pharmacological and psychosocial; | Initial understanding of the area to develop research topic; Literature review; |
| | 1.2 Operational e.g: Operational handbooks on methadone in primary care; Research into the operation of methadone treatment in Ireland; National Treatment List – statistical information; Methadone protocol reports; HSE/GP methadone service contracts; | Data input into data analysis and development of categories. |
| 2. Interviews. | 2.1 Referrers in primary care setting; | Data directly relevant to referral process; |
| | 2.2 Parties peripheral to, but involved in methadone treatment in primary care i.e. addiction counsellors, Drug treatment counsellor, practice nurses in primary care practices which provide methadone treatment; GPs who <u>do not</u> provide methadone treatment; | Saturation of developing grounded theory categories; Triangulation and verification of emerging concepts; |
| 3. Questionnaire | 3.1 To determine referral process prior to interview and immediately after consultation session with patient. | No questionnaires were returned. |

Table 3.2 Data sources and usage of data.

Pilot : A pilot exercise conducted with two primary care GPs yielded information about engaging with those involved in patient treatment in primary care practices. The

findings indicated that primary care practitioners have busy schedules and many alternative draws on their time. Email or mobile phones are acceptable routes of contact. Interviews should be scheduled to occur in breaks during the working day (e.g. lunch), immediately after the end of work, or during the weekly timeslot which many practitioners include in their schedule to deal with paperwork. Interviews are best conducted in person, but could be done by phone for practical reasons. Introductory material provided in advance should be brief and to the point. No assumption should be made that it will be read. To maximise the chance of getting an interview, the time period from initial engagement to interview should be short.

Documentary Sources : Documentary materials “are as potentially valuable for generating theory as ...observations and interviews” (Glaser and Strauss, 1967, p163). The absence of detailed knowledge of methadone therapy on the author’s part created a significant discovery challenge. Moving from a position of detached observer to appreciation of the process and the forces which shape it brought together the researcher’s journey of discovery and acquisition of data for the purpose of theory generation. A significant source of data was the research journal.

The Health Research Bureau/National Documentation Centre on Drug Abuse (Health Research Board, Dublin 2) maintains a library focussed on national and international publications relevant to drug use. This was useful as a source of articles on the evolution of methadone treatment generally, and in Ireland in particular. Of interest were guidebooks and manuals written by GPs with experience of running methadone treatment programmes. The comparison and contrast between the systematic methadone protocol and the working guides fed into the development of theory. The Central Treatment List (Central Treatment List, 2007) proved to be a helpful resource for quantitative data on methadone treatment in Ireland.

The Health Service Executive provided the researcher with copies of its contractual agreement with medical practitioners who run primary care methadone treatment programmes. This was source information for an assessment of the medical practitioners motivation to run treatment programmes, a code which emerged from interview data. Mountjoy Medical Practice (Mountjoy St., Dublin 1) provided research

reports, some unpublished, which were commissioned by the health authorities since 2001 to look at various aspects of methadone treatment programmes.

Questionnaires : A questionnaire was devised to capture how the medical practitioner incorporated counselling in a consultation session with a methadone patient (Appendix A). The medical practitioner was requested to complete the questionnaire immediately after a consultation session. This activity was scheduled after participation was confirmed by the medical practitioner but before the interview took place to avoid bias which might be introduced as a result of the interview and consideration by the referrer of his/her process. No questionnaires were returned. This concurs with the findings of the pilot exercise in terms of busy schedules, reluctance to read material provided, and the advantage of face to face interviews.

Interviews : Grounded theory interviews are flexible and dynamic. An interview schedule was drawn up for initial interviews (Appendix E) and modified for subsequent interviews to saturate emerging theory (Appendix F). The schedule was not sent in advance to the interviewee, unless specifically requested, which occurred on one occasion.

Interviewees will talk about the issues of concern and how they try to resolve them (Glaser, 1967). The researcher acquires data while simultaneously analysing it. Indeed, the analysis can start during the first interview as concepts emerge (Allan, 2003). Before commencing the interview, time availability and confidentiality of setting were established. The questioning method was open and non-directive, allowing exploration of what the interviewee said in detail. There was no expectation of adherence to the interview schedule. A typical opening question was “In relation to your methadone patients, tell me your understanding of patient care?” From his psychotherapy training and experience, the researcher had the skills to actively listen, analyse, probe and maintain awareness of his own feelings. The flow and content of the interview followed the interviewee’s direction, with areas of focus introduced by the interviewer when a stalling point was encountered (Johnston, 2006).

The researcher opted to transcribe the interviews himself as he felt this would aid the process of data analysis. A digital recorder proved useful for transcription purposes with no data loss due to pausing/playing as occurs in mechanical devices. Transcription activity occurred in parallel with interviews, with one feeding the other in terms of concepts to be explored and theoretical sampling strategy to be pursued (Baker, Wuest and Stern, 1992; Coyne, 1997).

Validity : Five interview transcripts, chosen randomly, were returned to interviewees to verify the content. The recursive data collection and analysis methodology that is employed in grounded theory has an inherent “self-correcting nature” (Charmaz, 2000 as quoted by Hanley-Maxwell *et al*, 2007). Emerging theory is verified in subsequent interviews and documentary data, and further developed. The acid test for grounded theory is that it originates from the grounded data and has interpretative, explanatory and predictive value within that context (Glaser, 1978). Gehart (2001) suggests that “participant verification and feedback” are “the most commonly used procedures” for establishing validity and reliability. This approach was used in this project throughout the recursive process of theory development.

Triangulation : The triangulation process involves crosschecking findings using various data collection techniques and/or data sources (LeCompte and Preissle, 1993). Documentary analysis complemented much of the interview material. A particular example was the suggestion which arose in interview that methadone programmes were financially lucrative for primary care medical practitioners. The GP/Health Authority contract payment rates did not give clear support to this theory. Questionnaires would have performed a valuable crosscheck role, but proved inapplicable as none were returned. Interviews with non-referring individuals who were closely involved with methadone programmes in primary care formed a basis for triangulation (see table 3.1).

3.6 Ethical considerations

Ethical approval was granted by two different Ethics Committees in DCU. Howard (2004) suggests that the process of preparing submissions for such committees assists in clarifying the scope and methodology of the research.

The UK Department of Health (2003), quoted by Howard (2004) states that

Research which duplicates other work unnecessarily or which is not of sufficient quality to contribute something useful to existing knowledge is in itself unethical.

To the author's knowledge, no research has been conducted into the detailed workings of the referral process to counselling for primary care methadone patients.

Non-maleficence and beneficence are important ethical considerations. The conduct of the research guaranteed the confidentiality of participants. It also looked at the operation of a process, and not individual medical practitioner practice, which ensured it could not form a basis for cross comparison or criticism of individual practitioner approaches. The value of this research is that it develops an understanding of a core process in the treatment of drug abusers and looks at how the evolved practice is shaped by professional, societal, and political influences and constraints. This is of relevance for any review of how the implementation of methadone therapy at a primary care level compares with best practice and supports the strategic objectives of drug treatment.

Publication and dissemination of the research is an ethical expectation of researchers (Bond, 2004, para 4.2) which makes the process of the research transparent and promulgates findings that may be of interest to other parties. This thesis will be accessible in the libraries of the institutions to which it is being submitted. In addition, it will be available to Mountjoy Medical Practice (Mountjoy St, Dublin 1, Ireland), the National Documentation Centre on Drug Abuse (Health Research Board, Dublin 2, Ireland) and to research participants who have requested it.

The project was undertaken with the encouragement and cooperation of Mountjoy Medical Practice. Apart from initial introductions to other primary care medical practitioners as potential interview participants, no support was received from this quarter. Initial introductions were necessary due to restrictions on information regarding the identity of primary care medical practices which offer methadone treatment.

Participants were furnished in advance with a plain language statement describing the research and their role should they wish to participate (Appendix B). They were supplied with a consent form (Appendix C) which detailed the confidentiality and retention policy of their data. Contact details for an independent body to whom queries or complaints could be directed (Bond, 2004, para3.1) were supplied. Before commencing the interview, consent was obtained.

Interviews were recorded and transcribed onto password protected computer files. On completion and verification of the transcription, the original recording was destroyed. Transcriptions, securely stored, will be destroyed a year after publication of this thesis.

3.7 Summary

This study required a methodology which induced descriptive conclusions from the field. Grounded theory fitted this requirement and appealed to this researcher due to its systematic approach. Documentation and interviews comprised the data sources. The interview sample comprised those managing the methadone patient's treatment regime and others closely involved with the counselling referral process. There was a particular challenge regarding access to a sample cohort in a situation where the identity of those delivering methadone treatment programmes is not publicly available. This was overcome by using a gatekeeper organisation as an access point.

The grounded theory methodology has inbuilt checks to ensure the quality of data acquired and analysis conducted. The researcher is central to interpreting and analysing the data, identifying concepts and structuring these into a model. The researcher holds the tension between the systematic approach and creative input and must constantly exercise reflexivity to ascertain his impact. The sequence of research follows an evolving pattern as the theoretical framework emerges.

Ethical considerations guide the selection of the research topic, the conduct of the research and dissemination of results. In preparing the project proposal for evaluation by the ethics committees, the researcher is forced to clarify his research aims and objectives and to generate a project plan covering all aspects of his research.

CHAPTER 4

Data Analysis

4.1 Introduction

This chapter is an analysis of data from interviews conducted with medical practitioners, practice nurses and counsellors involved in the delivery of methadone maintenance treatment in the primary care setting. Interviews have been analysed systematically. Categories and sub-categories have been identified by a recursive process of generalisation and abstraction, beginning with the grounded data. This ensures that the process model constructed from the interplay of categories reflects the real world context. The categories form the framework of the referral process to counselling used by primary care medical practitioners.

4.2 Principal categories, themes and attributes

The use of psychosocial interventions on primary care methadone programmes is at the discretion of the primary care medical practitioner who controls the patients' methadone regime. This section identifies common themes which arose from interviews with primary care medical practitioners and other people closely associated with primary care methadone treatment. The themes are grouped into three categories which together cover the end-to-end counselling referral process. Themes are presented within these categories with supporting quotations from interviews.

Category 1 – Referral processes : These are factors relevant to the making of a referral to counselling. There is large variation between different medical practitioners in their use of counselling as a component of methadone treatment.

Interviewer : **Would you positively refer somebody to counselling?**

Interviewee: **Yes, every client....I would bring it up again at intervals and I would always explain to them that there are kind of different strands and different areas to the counselling** (*Interview B, Primary Care Medical Practitioner*).

Interviewer : **Why would you refer someone to counselling? What are your beliefs or understandings around it?**

Interviewee: **That actually a very good question, and it's not one I have ever thought of – why you do? I suppose it's like prescribing, there are probably many reasons why. Some people would ask you for it.** (*Interview C, Primary Care Medical Practitioner*).

Really, for the most part, they [methadone patients] don't really need skilled counsellors, or somebody with a psychotherapy background. What they need is somebody with a bit of common sense..... (*Interview K, Primary Care Medical Practitioner*).

One GP interviewed saw methadone substitution alone as being adequate treatment for patients on treatment programmes.

.... I think the methadone is wonderful actually, and the methadone does 80% of the work even if there is no support – no counselling, nothing else, not even me....Everything else is icing on the cake.... (*Interview K, Primary Care Medical Practitioner*).

Within medicine, the use of counselling in primary care methadone treatment without a protocol structure is surprising. With one exception, the medical practitioners interviewed had no protocol to cover the use of counselling. There is no formal definition of the interface between the medical practitioner and the counsellor.

But traditionally, all counsellors are kind of reluctant for various reasons to communicate. They kind of feel that this is their own personal relationship....I mean, I'll go on with my end of it and I just hope the client and counsellor will get on with it and that it works out. And if it doesn't, there isn't a whole pile I can do to fix it. (*Interview K, Primary Care Medical Practitioner*).

.... someone attending a counsellor as part of the local adult mental health services, you will often get communication back from the consultant to say 'Joe Bloggs is now attending and has done very well with counselling'. Now, you don't know what's happened, what has been discussed, what progress has been made, what the plan for progressing things from the patient's point of view is.... (*Interview W, Primary Care Medical Practitioner*).

But again, it is quite sporadic – there is no pro-forma to which I can refer – like this is the problem and we can slant over that way. ...But in answer to your question, there is no real structured process there to deal with psychosocial issues.(*Interview G, Primary Care Medical Practitioner*).

Unlike other referrals which medical practitioners make, there is little expectation of the patient's progress or follow up regarding the counselling referral.

My expectation is that clients don't follow through. They go for one or two sessions and that's it. (*Interview K, Primary Care Medical Practitioner*).

No, I don't tend to follow up....I may check on it every now and again but I don't regularly check up. (*Interview A, Primary Care Medical Practitioner*).

The practitioner who had developed a protocol had made a conscious effort to learn how to use counselling effectively and incorporated those learnings in the protocol.

But we did not have a defined [counselling] service. Now that we do have, and we have learned what that defined service is, we really value it. And the patients do as well (*Interview L, Primary Care Medical Practitioner*).

The role of the medical practitioner in prescribing methadone confers a significant 'power' element on the practitioner in the relationship with their patient.

.... from the patient's point of view, they're here for their methadone, first and foremost. That there is the issue. ...Like, the power is really in the medication (*Interview X, Drug Counsellor*).

....they've [medical practitioners] got the power at the end of the day. They're prescribing, and the book stops with them (*Interview S, Primary Care Practice Nurse*).

Medical practitioners are aware of this element of their patient relationship. As a result, patients may want to 'please' medical practitioners to get methadone. Medical practitioners expressed caution when referring to counselling as the patient may see attendance as a precondition to getting methadone.

....counselling can be part of the power relationship in terms of the client going to the counsellor to please the doctor to get the methadone that they want. And I'm just wary of it being used as that, whereas now I think it should be just a voluntary thing and if they offer it voluntarily and they go, then that's fair enough (*Interview A, Primary Care Medical Practitioner*).

....some people come because they have been told and they feel threatened by it. They aren't really here because they want to make changes, they are here because "this is what I have to do to get my methadone" (*Interview X, Drug Counsellor*).

Medical practitioners adopt a passive stance regarding counselling referrals. They may offer the counselling service, leaving it up to the patient to request it.

Then again, you don't really get people coming in asking for counselling per se. I think if people want counselling, they self-refer...(*Interview G, Primary Care Medical Practitioner*).

Also, this person in particular would have said – " I really do think it is time now [for counselling]". And I would have waited and said – "do you think it is time to discuss this?" And so, I'd say "ok, we'll refer then". And they'd say "I don't think I want it this week", and finally the patient would say – "ok, I'm ready now" ...(*Interview L, Primary Care Medical Practitioner*).

Primary care medical practitioners recognise counselling as an important intervention in the holistic treatment of methadone patients. It is evident that medical practitioners conduct their own informal counselling with patients during consultations. Some recognise it as part of the primary care practitioner role.

....the role of counsellor is huge for the primary care physician or clinician, which is part of our role (*Interview L, Advanced Nurse Practitioner*).

I would check their [the patient's] perception of how big of a problem it is for them, where they are at in their life, what they want, how did they come to be on methadone here....(*Interview C, Primary Care Medical Practitioner*).

It's a gradual process and it's heavily dependent on them engaging with you, not just coming in, giving you the urine and hare-ing out the door. There has to be an element where they actually chat to you about what is going on (*Interview G, Primary Care Medical Practitioner*).

There is limited availability within the psychosocial support services provided by the health authorities. The referral routes are complex.

And there was a psychiatrist there, and the psychiatrist who had looked after the patient had to see the patient again. It was a difficult pathway, it wasn't straightforward. Hard to get that patient back into, to get them linked in (*Interview J, Primary Care Practice Nurse*).

But what I think GPs find on a practical level is that they can't, or it's not easy to access the psychosocial supports. Number 1, they may not know what the range is, what is available and number 2, trying to access that ain't easy (*Interview I, Primary Care Referrer*).

....the only way I know to access counselling for them is through a psychiatrist. I have to ask a psychiatrist to ask a psychologist to see this person, because the only way I know to get them a free psychologist (*Interview C, Primary Care Medical Practitioner*).

Medical practitioners see significant disadvantages when referring patients back to drug treatment clinics to access psychological/counselling services. It is a negative direction back to a setting that the patient has worked to leave behind.

The other psychosocial end is much more difficult. It's not really a specific service. Theoretically, it gives you addiction services, psychiatric addiction services, but again, I think it is too closely linked to the clinics and that has a negative connotation, particularly in the stable methadone patient's mind because it is going back to the clinic (*Interview G, Primary Care Medical Practitioner*).

The trouble is that, once patients have been discharged to level 1 GPs, well then it is very difficult for them to continue benefiting from or maintaining the contact with the addiction counselling services because it involves them going back to their addiction clinic which a lot of people are resistant to....(*Interview W, Primary Care Medical Practitioner*).

My view of that is it is 100% totally less than ideal because what happens is the individual goes back to the level 2 initial clinic, they are referred principally for the psychiatric services there, but then they are exposed to a destabilised group of methadone patients who are perhaps occasionally using....there are a lot of unstable individuals there and they might end up dabbling because they know them (*Interview G, Primary Care Medical Practitioner*).

Co-dependency is common amongst drug users. Many of the support services available to the primary care referrer have specific entry criteria which rules out patients who use alcohol or other drugs. The services are therefore not available, in many cases, to methadone patients.

I suppose the other problem arises is there is a lot of co-dependencies and multi dependency....Because they fall between two stools because the traditional alcohol services

won't see them because of the methadone and the methadone services will only see them for methadone and not the alcohol and psychiatric services won't see them because they are dependent on alcohol (*Interview G, Primary Care Medical Practitioner*).

In fact, the local psychiatry service has almost stopped seeing any methadone patients – all the problems, as far as they are concerned, are labelled as being drug related and therefore not in their realm.... (*Interview K, Primary Care Medical Practitioner*).

Category 2 – Decision process : This section describes the framework within which the medical practitioner makes decisions about counselling interventions as part of the patient's methadone treatment. Primary care medical practitioners seek evidence on which to base their practice. They are aware of the research which exists concerning the effectiveness of counselling in a methadone treatment environment.

..... I am aware of the evidence on it [use of counselling in methadone treatment]. I suppose a lot is coming out of the US, I accept that. But there is evidence that pharmacological intervention plus psychosocial support gives a better outcome (*Interview I, Primary Care Medical Practitioner*).

The success rate of people [detoxing] who see a counsellor is much higher. You are taking on a very difficult task that you probably have less than a 30% chance of succeeding anyhow, so you can double it by going to see a counsellor (*Interview K, Primary Care Medical Practitioner*).

Interviewer : You would refer people then, at some stage, to the counselling psychologist?

Interviewee : Yes, if they want to be. There are many who don't. And there is quite a lot of evidence that people who are addicted to heroin don't want counselling, and don't necessarily benefit (*Interview L, Primary Care Medical Practitioner*).

The decision to refer the patient to counselling depends on the referrer's opinion of counselling and sense of the patient's needs. This shows a departure from evidence-based practice to a personal experience basis.

Just by communicating with them [patients on methadone], you know they would benefit from counselling. But it's informal, you know, I have no objective measure, I do it on my own sense of their needs (*Interview C, Primary Care GP*).

I'd always suggest counselling to them in the beginning, and if they're keen for it, then great- off they go. But if they're not keen for it, I leave it alone until I think they're feeling more secure in the clinic (*Interview B, Primary Care GP*).

....I'm not sure with counselling particularly as these problems are so rooted in the social situation, how can counselling help a person off that as much....(*Interview A, Primary Care GP*).

A range of factors influences the medical practitioner's opinions of psychosocial interventions when treating methadone patients. They see that psychosocial interventions have a lot to offer as a component of drug treatment.

Oh, I think it [psychosocial treatment] is absolutely essential. Because all we are dealing with is the effects of the psychosocial poverty, basically. The heroin came from the poverty cycle. The individual got linked into it through the situation they were in, and it continued unabated. And we're just treating the symptom....but we're not treating the problem in the first place *(Interview G, Primary Care Medical Practitioner).*

But to me, it's completely obvious, when you are sitting talking to somebody who has an addiction problem, they need a lot more time and a lot more skills than I can give them. *(Interview B, Primary Care Medical Practitioner).*

Then there are others who have a lot of mental health issues or coping skills or life skills in general who are going to need that additional support or intervention and you know, with mutual agreement, we refer [to counselling] *(Interview I, Primary Care Medical Practitioner).*

Despite being open to counselling, medical practitioners find it difficult to understand counselling specialities and qualifications. In many cases, this leads to reluctance to refer.

And I think there is a lot of people going around calling themselves counsellors and they are not formally qualified and I have no idea who they are. But my guess is that some of them are drugs counsellors – I don't see how you can be just a drugs counsellor, it doesn't make sense, it's such a broad thing – I don't see how you can say, "I just do drugs". And they are not trained broadly. So, I have to say, my confidence in counsellors or so-called drugs counsellors has diminished *(Interview K, Primary Care Medical Practitioner).*

The difficulty is when you want to initiate a referral to counselling, counselling is so sporadic and the services that are there are so different in terms of costs, expertise and so on, it's so difficult, and personally, you don't even know whether the counsellor has done a 2 month diploma in counselling or whether they are actually officially accredited and have done whatever it is that they do *(Interview G, Primary Care Medical Practitioner).*

Harm reduction and ongoing methadone maintenance is the initial outcome sought for a patient on primary care methadone treatment. Some medical practitioners are happy to stop at this stage and just continue with maintenance, while others see abstinence as the desired outcome.

Certainly, there are come people and abstinence is unrealistic. It's unrealistic, so you're looking at how can harm reduction levels best work with this person *(Interview S, Primary Care Practice Nurse).*

I keep the opportunity for a patient to reduce their dose always on the agenda. So that's something like"how would you feel about coming down this week, are you ready?" or whatever. Now, some GPs don't believe in that. As long as the patient is doing ok and nobody is asking any question, then that is ok *(Interview I, Primary Care Medical Practitioner).*

I think that in reality a lot of doctors try to see if they can get as far as they can get, to see if they can get them off it altogether, off drugs *(Interview A, Primary Care Medical Practitioner).*

The primary care referrer will vary the nature of counselling offered depending on the presenting issue. Addiction is an initial issue. Once the patient is stabilised on methadone, existential issues may surface, including events in his/her past that may connect with the use of opiates.

I think there are two strands to the counselling – the addiction one and the deeper, more difficult bit. I think both of those are very valuable, but I think its years often before somebody is ready for the deeper, potentially more painful counselling. They really need to be off heroin and stable, off benzos and stable, on methadone (*Interview B, Primary Care Medical Practitioner*).

....if the addiction is there, it's very hard to work around and pretend it's not there. And I mean, clients who actually work with their addiction and have the sense of some power in moving away from it, and feel that power, then there's the detox,... And it's still present to still continue visiting it [the source of their opiate usage], to still continue working with it, but hand in hand with the addiction and the problems and how it has affected their lives as well, and maybe the initial reason (*Interview X, Drug Counsellor*).

To participate in methadone treatment programmes, practitioners must undertake a short training course. While the emphasis of this course is on the mechanics of methadone prescription and control, the range and applicability of psychosocial interventions forms part of the syllabus.

There are GPs coming on board who are just starting out on their methadone treatment protocol career if you like, and they are offered a module on counselling when they are doing their training.... But it is the GPs who are already in the system..... there's very little for them in terms of up-skilling(*Interview I, Primary Care Medical Practitioner*).

Psychological treatment and counselling interventions are not covered in general medical training. With one exception, all GPs who discussed the topic at interview were of the opinion that their formal training did not give them insight into the role of counselling. They had picked it up through applied routes. None of the medical practitioners interviewed quoted personal experience of counselling.

....we have quite an active continuing medical education group in our practice where we look at the whole area of addiction and psychological problems because it is so common among our patients on an ongoing basis. The formal training and informal professional support amongst colleagues would be the two major areas (*Interview W, Primary Care Medical Practitioner*).

In medicine, you don't get any formal psychological training. I've done six months of psychiatry, but very little of that was psychological (*Interview C, Primary Care Medical Practitioner*).

.... the psychosocial bit is never touched on. But it's always the same, it's never touched on in methadone courses, or in college and it's never touched on in GP training. It is a little bit, but not really officially. And there should obviously be more psychosocial, and particularly psychotherapy training.... (*Interview G, Primary Care Medical Practitioner*).

Many of the GPs interviewed had undertaken training courses in psychosocial interventions, principally CBT and brief intervention strategies, to augment their skillset.

Naturally, I'm interested in the psychological side of things, from personal training and a few short courses. I would do that informally (*Interview C, Primary Care Medical Practitioner*).

I do a lot of brief interventions myself. I suppose that is my orientation anyway, my style of consulting. So, I feel I would offer a lot of brief interventions.... (*Interview I, Primary Care Medical Practitioner*).

...I just wanted to kind of get a few simple interventions through CBT. And I found it very useful (*Interview G, Primary Care Medical Practitioner*).

Category 3 – Primary care as a setting for methadone treatment : The primary care setting allows medical practitioners to build up a strong relationship with methadone patients, their families and community.

A lot of patients relied heavily on the GP, regarding sitting down and chatting with them, what was going on in their lives and confiding things (*Interview J, Primary Care Practice Nurse*).

I would always look at somebody's mood, are they depressed or are they anxious, and as you get to know them and build up a trust with them, try and talk to them about their feelings and emotions and where they are in life and what emotions are beginning to surface (*Interview B, Primary Care Medical Practitioner*).

I feel that drug users are ideally better treated at primary care because we might have known them from when they were in the pram, right the way through their life cycle. And we know their family and their extended family.... (*Interview I, Primary Care Medical Practitioner*)

The deep commitment that primary care practitioners feel towards their patient community was apparent during the interviews. They take responsibility for treating the patient holistically.

...I almost have an obligation to look after my patients. The fact that they have an opiate problem is their problem, but, they are my patient, this is the illness they have and I have a commitment to them and I have an obligation to them (*Interview I, Primary Care GP*).

The way I would put it, the definition of a GP is that we look after the physical, social and psychological health. So, the psychosocial side is definitely the GP's responsibility, but there is no measure for that (*Interview C, Primary Care GP*).

Medical practitioners see their treatment of methadone patients as highly rewarding, personally and professionally.

It's easily the most professionally satisfying condition I've had to treat, and people do remarkably well. People's lives are transformed There is no other condition that I treat – me and the methadone transforms these people's lives, and gives them a second go and

without it, the vast majority of them are just destined for the gutter and death (*Interview K, Primary Care Medical Practitioner*).

I find this one of the most rewarding professional experiences of my career. I feel that the interventions I make in a drug user's life pay much more dividends than, say, other interventions that I do in practice....If you don't intervene with a drug user, the ramifications of that health-wise and socially and in every other aspect of their lives are huge. And yet the reward, the professional reward for me as a practitioner to make a very simple intervention, to support that individual, offer them ongoing care, and to see that person turn their life around, I find that professionally very rewarding....I would still do it even if I wasn't being paid (*Interview I, Primary Care Medical Practitioner*).

Primary care medical practitioners see their approach to treating the patient as holistic, extending beyond methadone substitution. They use basic counselling skills to build and maintain relationships with patients.

Interviewee : And in general, we would do their methadone and their GP needs as well. We would encourage that. In fact, all of them come to us for their GP and methadone needs.

Interviewer : Why do you try to encourage that?

Interviewee : Continuity. Because it is a holistic approach, looking after the different facets of their health....you're seeing the whole picture. You've seen the kids a few days before and you know what the problems are and so on (*Interview G, Primary Care Medical Practitioner*)

Even patients who weren't on methadone maintenance, they [medical practitioners] might have looked after families who were drug users....so they saw a lot of it.... A lot of patients relied heavily on the GP, regarding sitting down and chatting with them, what was going on in their lives and confiding things (*Interview J, Primary Care Practice Nurse*).

You can make yourself not have any leeway and not tolerate anything and just completely ignore the other aspects of their [methadone patients] lives they might be going through and that is why they might be having problems. Or you can sit down and hear 'I have this, I have separated from my girlfriend etc etc' and you can go into it that way (*Interview G, Primary Care Medical Practitioner*).

Primary care referrers indicated that the only systematic psychosocial services available to them were those located in the specialist drug clinics. Primary care practitioners are practically unsupported in terms of availability of psychosocial support services.

They [primary care medical practitioners] don't feel that the HSE ever comes up with the goods. Now, the protocol was set up and the deal was that the patients would be referred to them stable and the counselling could be continued on through the clinics or whatever services referred them back. That really didn't happen. (*Interview I, Primary Care Medical Practitioner*).

....they [primary care methadone patients] might come from the security of a clinic where all of the services are available.... So, then they will go to primary care, and all of those services are gone....So there is a gap there, there is definitely a gap there, where those clients would have to source the counsellor through the doctor or themselves (*Interview X, Drug Counsellor*).

Primary care can present itself as fragmented to the methadone patient. This can lead to breakdowns in communication and places extra demands on patients who may have had little previous connection with the health services.

This is a problem across the health services, there is that sort of disconnect between where the ultimate governance relationship exists and the difficulty is when a lot of people are involved in an individual's care, it can be very difficult for that person because its not inconceivable that a patient attending any GP who is on methadone might actually have a couple of doctors and a nurse in the practice looking after them; there may be another clinic that they might attend, another two clinics perhaps, and then to go back to another clinic in order to access counselling, it's very difficult (*Interview W, Primary Care Medical Practitioner*).

One practice with a co-located counsellor benefited from the integration of services which facilitated the medical practitioner in following up counselling referrals.

.... if they don't turn up for the counselling, the counsellor will tell me and we say " why did you not turn up?". And they may say " because I didn't want it anymore". And we say "fair enough". We provide it, if they don't want it, that's fine (*Interview L, Primary Care Medical Practitioner*).

4.3 Summary

Primary care practitioners have complete freedom in their use of psychosocial interventions for methadone treatment. The influences on their use of psychosocial interventions arise from referral factors, decision-making factors and the primary care setting.

Medical practitioners accept the role of psychosocial interventions in holistic methadone treatment. Their medical training gives them a very limited basis in counselling and psychology. Some GPs have, on their own initiative, undertaken training in psychological therapies, particularly CBT and brief intervention modalities. Strong human relationships underpin the connection between the primary care practitioner and their methadone patients. Medical practitioners recognise this as an essential part of their holistic practice and engage in what could be termed 'informal counselling' in their patient consultations. Practitioners who run methadone programmes expressed a strong vocational commitment to their patient community. In turn, they get deep professional satisfaction from the constructive effect their intervention can have on the methadone patient, his/her family and the community. The role of the primary care practitioner in managing the patient's methadone regime creates a power relationship between the practitioner and the patient. This limits the practitioner's potential involvement in delivering psychosocial interventions. The relationship between the primary care practitioner and the counsellor is unstructured

and undefined. The lack of appreciation of counselling as a profession allied with the shortcomings of counselling in presenting itself as a profession gives rise to confusion and mistrust.

Opiate treatment structures appear to be geared towards a harm reduction outcome. Psychological support services are concentrated in the drug clinics that initially stabilise the chaotic patient on methadone. Primary care practitioners feel unsupported in terms of psychosocial services. The systematic route to access services via the drug clinics has treatment drawbacks and negative impacts on the patient. In general, there are issues with accessing psychosocial services from a primary care methadone programme in terms of knowledge of what is available, access to the services and service availability. While systematic methadone treatment may effectively stop at harm reduction in primary care, individual practitioners are vigilant for opportunities to attain an abstinence outcome where practicable.

CHAPTER 5

Discussion

This grounded theory analysis of the counselling referral process in a primary care methadone treatment setting has identified multiple influential factors. These are discussed under four headings – referral factors, decision making factors, factors specific to the primary care setting and general factors. Appendix H presents a consolidated cause/effect diagram of the factors discovered in this research.

5.1 Referral factors

Factors included under this heading are those that influence the primary care medical practitioner in considering a referral to counselling for the methadone patient. Figure 5.1 illustrates these factors and their cause/effect relationships.

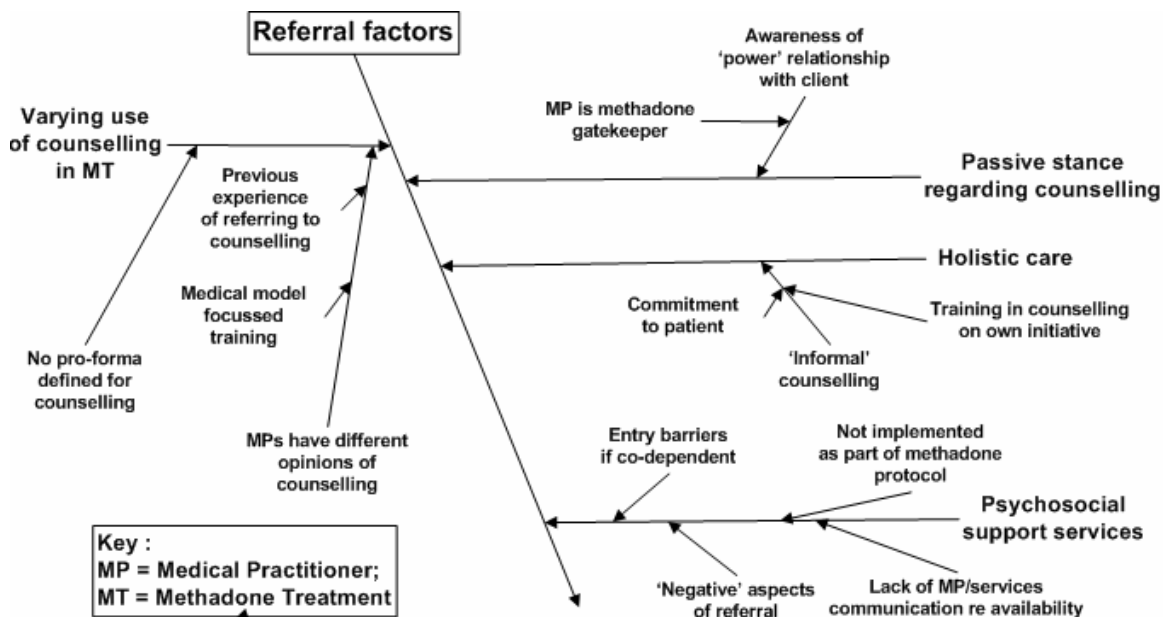


Figure 5.1 Counselling referral factors

The implementation of the methadone protocol in primary care focuses on pharmacological interventions, largely ignoring psychosocial supports. The methadone protocol established primary care as the delivery channel for ongoing methadone maintenance. It outlined the pharmacological regime for patients who had been

stabilised on methadone and transferred to the primary care system. The advice of the expert group, seminal to the development of the methadone protocol (Ireland, Department of Health, 1993, Appendix A) was that methadone be regarded as “an adjunct to treatment and not treatment per se”. The focus on methadone prescription and control systems has resulted in resource being concentrated in these areas. The experience of primary care medical practitioners is that accessing psychosocial services is complicated with limited availability. There are negative treatment aspects when referring patients from primary care to psychosocial services in drug clinics due to the reintroduction of the patient to other chaotic drug users. The patient may perceive it as a retrograde step.

Where psychosocial interventions are applied by the primary care practitioner, it generally is circumstantial and without practice guidelines. Without guidelines, there is poor communication between the medical practitioner and the counsellor regarding the patient, leading to a breakdown in understanding between the various practitioners. Davidson *et al* (undated) point out that systematic protocol approaches to counselling improve outcomes. Only one practitioner who participated in this research had developed a practice protocol that included psychosocial interventions for methadone treatment. This practice was structured according to the emergent primary care strategy (Ireland, Department of Health and Children, 2001) and has a co-located counselling service. The primary care strategy recognises the shortcomings of fragmented services in existing primary care structures. The lack of engagement between medical practitioner and counsellor results in a counselling referral which displays the characteristics of a ‘handoff’ rather than an integrated referral as part of the patient’s care plan.

Medical practitioners who manage primary care methadone programmes lack formal training in psychology or counselling. Hunsberger (2007) criticises the medical model as not having the language and tools to understand the fundamentals of psychic life. Velleman (2001) concluded that counselling is not considered an integrated part of the treatment of a methadone patient.

Primary care medical practitioners see counselling as a valid intervention for some methadone patients. They recognise the importance of psychosocial interventions to complement pharmacological treatment on methadone programmes. Medical practitioners see it as an important part of their role to provide counselling. Many have augmented their skills with training on specific, usually brief, counselling interventions. Davidson *et al* (undated) point out that psychosocial interventions with methadone treatment cannot be considered as 'quick-fix'. Kraft *et al* (1997) discovered that a moderate amount of counselling (3 sessions per week) in conjunction with methadone maintenance was most cost effective. The extent to which medical practitioners should be directly involved in counselling therapy is open to debate. A consideration is the potential to introduce confusion into the medical practitioner/patient and the counsellor/patient relationships. The independence of these relationships was recognised by research interviewees as being important. Huibers *et al* (2007) were non-committal regarding the use of psychosocial interventions by medical practitioners, primarily due to lack of research on the subject.

Interviewees differentiated between addiction counselling, necessary when the user was detoxing from heroin, and generic counselling where patients could explore existential and change/development issues. Velleman *et al* (2001) links the counselling modalities required for stabilisation with the late contemplation and action stages of the trans-theoretical model (Prochaska and DiClemente, 1982). It appears that the application of counselling therapy is a specialist role where the counsellor is sensitive to the patient's psychological positioning and can draw on relevant strategies to support the patient's development.

5.2 Decision making factors

The referral to counselling is the result of a decision making process on the part of the primary care medical practitioner. This section explores those factors which influence this process. Figure 5.2 presents these factors and their cause/effect relationships.

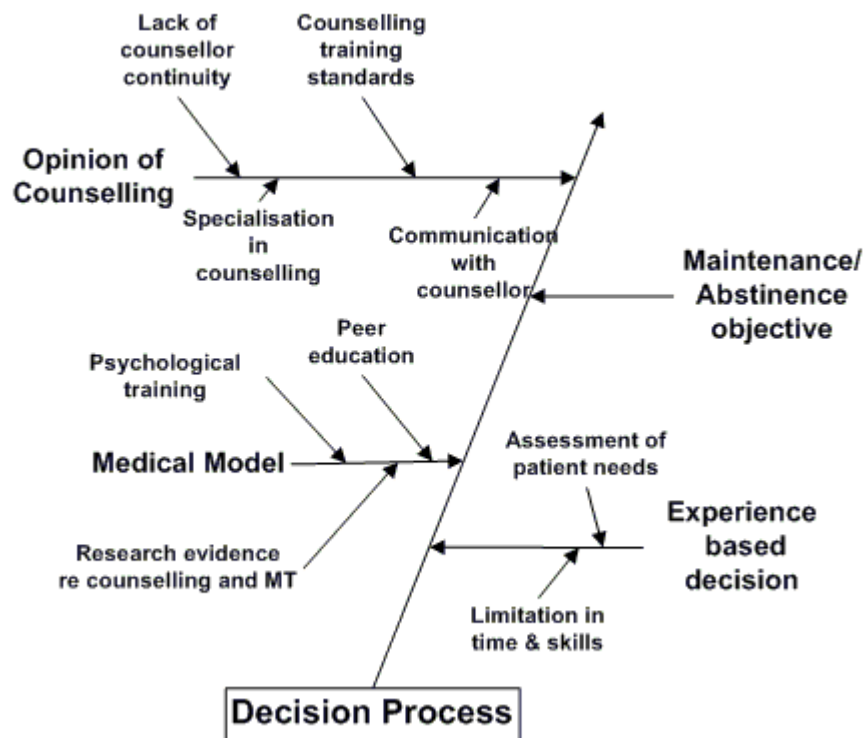


Figure5.2 Decision process factors.

Medical practitioners have no systematic basis for assessing the patient’s psychological position. Medical training involves minimal psychological training while the experiential aspects of counselling are not addressed. As a result, practitioners devise their own bases for assessing the patient psychologically. Building trust, observation of the patient’s mood and finding out what is going on in the patient’s life and in the lives of others in the patient’s wider network were quoted as approaches used. The methods include dialogue, involving the patient in their own treatment choices and exploring the patient’s feelings and emotions. These approaches do not fit the classic evidence-based practice model that is closely associated with medical treatment. Tomlin, Humphrey and Rogers (1999) recognised that the decision-making processes demanded by evidence-based medicine do not fit easily into the primary care setting, where the practitioner/patient relationship is a crucial factor. The humanistic approach of primary care referrers when assessing methadone patients is based on personal experience and evidence gained from clinical practice, an example of ‘practice-based evidence’.

A wide range of existential issues may arise for the stabilised methadone patient, such as dealing with past emotional crises, building self-esteem, progressing through development stages, self-empowerment, overcoming feelings of exclusion and relating to authority figures in an adult way. There is evidence that stability acquired through detoxification onto methadone provides sufficient basis for some patients to develop without any external support. Medical practitioners expressed the opinion that specialisation does not work in the field of counselling and quoted examples of counsellors lacking a range of interventions appropriate to patient needs. Research has indicated that the ability to build and maintain a therapeutic relationship is of more importance in counselling than the application of a particular counselling modality. Hubble, Duncan and Millar (1999) calculate that 70% of the effects of counselling come from client factors and the therapeutic relationship. Giovazolias and Davis (2005) suggest that the ability of the therapist to assess the patient's stage of change and flex his/her interventions to match is an essential factor when counselling drug users. Davidson, Velleman and Mistral (2003) reported lack of counsellor continuity as a concern among drug users in receipt of counselling. Establishing and using a good therapeutic relationship appears to be of central importance in the application of counselling in methadone therapy.

Lack of standardisation of counselling training makes referrers cautious when dealing with counselling. Referrers feel unsure regarding counsellor qualifications and are without a basis for assessing counsellor competence. Medical practitioners are familiar with a referral model where the qualifications and reputation of the provider are important factors in the decision to use the service.

The outcome of methadone treatment, maintenance or abstinence, appears to be a function of patient motivation and medical practitioner aspiration. The mid-term review of the National Drugs Strategy (Ireland, Department of Community, Rural and Gaeltacht Affairs, 2005) alludes to concerns about the effects of prolonged methadone use and the need for planned progression through to rehabilitation for the methadone patient. Relapse prevention after detoxification from methadone was highlighted by practitioners as a potential area of counselling focus. Research indicates that counselling can contribute to a lower relapse rate (Kraft *et al*, 1997; Fiorentine and

Anglin 1996; 1997). The referrers who participated in this research seek an abstinence outcome where practicable.

5.3 Methadone treatment in the primary care setting

Certain factors that influence the counselling referral for methadone patients pertain to the primary care context. The depth of commitment of primary care practitioners to the physical, social and psychological welfare of their patients is noteworthy. Figure 5.3 puts the primary care factors that were identified into a cause/effect framework.

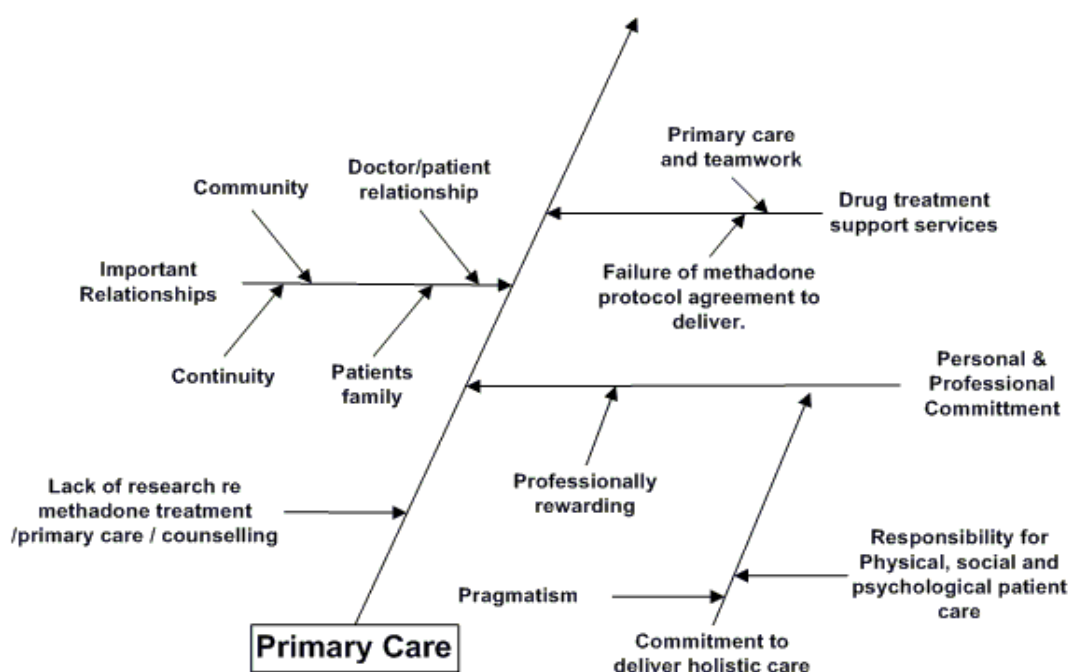


Figure 5.3 Primary care setting factors

The approach of primary care medical practitioners to counselling referrals is pragmatic. A balance is struck between a commitment to the patient and their wider family, a desire to offer the best treatment, and the practical realities of accessing counselling services. Primary care medical practitioners highlighted the lack of psychosocial supports available to them. One practitioner felt that the health authorities had broken trust with primary care medical practitioners by not delivering on undertakings regarding provision of psychosocial support services. As background to recommending multi-disciplinary, colocated primary care practices, the primary care strategy (Ireland, Department of Health and Children, 2001) suggests that the current primary care practice structure is fragmented service-wise, with little integrated

teamwork evident. The mid-term drug strategy review addresses availability and access to appropriate treatment services (Ireland, Department of Community, Rural and Gaeltacht Affairs, 2005).

Methadone treatment in the primary care context in Ireland emphasises pharmacological intervention over psychosocial treatment. The medical practitioner/health authority contract (GP Contract, 2007), under which primary care methadone treatment is offered, makes no reference to the provision of psychosocial treatment services. The expert group for the establishment of a methadone protocol explicitly stated that medical practitioners should satisfy themselves regarding the adequacy of supports available to them before prescribing for patients (Ireland, Department of Health, 1993). A possible conclusion is that a harm reduction outcome from methadone substitution is the underlying objective of the protocol.

Primary care is a principal interface point between the community and medical treatment, estimated as the appropriate setting for 90%-95% of health and personal social service needs (Ireland, Department of Health and Children, 2001). Dealing with human life issues from beginning to end, the primary care practitioner's engagement extends beyond the individual, to family and the wider community. From the grounded data, the principal incentives for medical practitioners to progress patients beyond methadone maintenance arose from a commitment to caring for the patient and professional satisfaction. Where these factors arose in interviews, they were clearly very important to the medical practitioner. The medical model of evidence based practice, scientific research and increasing specialisation in the delivery of health care challenges the primary care practitioner's view of the patient (Tomlin, Humphrey and Rogers, 1999). The primary care medical practitioner sees his/her duty of care as going beyond the patient's physical welfare to their social and psychological well-being.

5.4 General factors

The so-called medical mindset favours evidence-based practice that considers randomised controlled trials (RCTs) as a superior base for clinical practice evidence (Grossman and Mackenzie, 2005, p517). 'Cochrane Systematic Reviews' were cited by one interviewee as examples of the type of research that influence his practice. RCT

research into psychosocial interventions and drug treatment programmes is practically non-existent and may not be appropriate methodologically. Cochrane Reviews on the subject (Amato *et al*, 2004; Mayet *et al*, 2004) remark on the shortage of relevant RCT trials, the small number of trial participants and the heterogeneity of psychosocial interventions.

Crisis points were identified by referrers as openings for the introduction of counselling support. Crisis points were categorised as negative or positive. Negative crises, for example, the death of a relative, tended to lead to negative outcomes such as depression and relapse to drug usage. Positive crises, such as the birth of a child, could be supported by motivational interview techniques and create a platform for further patient change in terms of drug usage. Gaining a sense of power and control as they bring structure to their chaotic lives is a catalyst for the patient in changing drug usage behaviour. These findings concur with those of a twenty-five year follow-up study where patients identified establishing a family and personal achievement as the two factors which made the greatest contribution to breaking their drug habits (Gjeruldsen, Myrvang and Opjordsmoen, 2003). Some interviewees in this research reported experiences of patient 'burn-out' where patients detox themselves on reaching a certain life stage. The suggestion that development can be triggered by crisis points fits within psychological models of development such as that of Erikson. These life events, which are potential change catalysts, are accessible to psychosocial interventions and not pharmacological treatment.

5.5 Summary

The basis for the factors outlined in this chapter are the experiences, thoughts and opinions of medical, nursing and counsellor practitioners who are involved in the treatment of primary care methadone patients. The structure used to present these factors reflects the real-life stages of the process leading to the making of a counselling referral. The factors identified and their inter-relationships are all relevant in the course of a primary care medical practitioner/methadone patient consultation. When using grounded theory methodology, theory is discovered from the grounded data. The discussion throughout this chapter illustrates this process in action as factors and effects emerge from the content of participant interviews by means of systematic analysis.

CHAPTER 6

Conclusions and Recommendations

The evolved process that governs the use of counselling on primary care methadone treatment programmes has been derived in this research from grounded data. The objective of the research was to identify the influencing factors and model the resultant process. It was not to delve deeply into the individual factors. The conclusions and recommendations in this chapter arise from a review of the process and its influences.

6.1 Conclusions arising from this research

The principal conclusion of this research is that **there is no psychosocial protocol for methadone-based treatment in primary care in Ireland.** As a consequence, psychosocial interventions in primary care methadone treatment are used in an inconsistent way. There is no systematic psychological development path for the patient once stabilised on methadone. Without a psychosocial protocol, there is no basis for systematic development of psychosocial therapy. This is in contrast to pharmacological interventions that are directed by protocol and subject to audit. The absence of a psychosocial model has many explanations. There is a lack of research into the use of psychosocial therapy in conjunction with substitution based interventions in the treatment of opiate abuse. The methodological difficulty of conducting research into psychosocial treatment has been identified by researchers including Mayet *et al* (2004), Moodley (2001) and Fiorentine and Anglin (1996). Methadone treatment in Ireland has been delivered within a medical framework. Lert (2001) observed that methadone maintenance had led to the ‘medicalisation’ of opiate treatment. In the primary care methadone treatment context, it appears that the sporadic use of psychosocial treatments is more by omission than commission; psychosocial treatments are difficult to fit into a medically driven treatment model.

Other significant conclusions emerged from this research. **Psychosocial interventions are important in primary care practice and as a complement to methadone substitution treatment.** The relationship between medical practitioner and patient is a key factor in primary care practice. The relationship is an input to the holistic view that

the medical practitioner holds of his/her patient. Saultz (2003) concurs with this finding and sees the medical practitioner/ patient relationship as having characteristics of trust, loyalty and responsibility. Some of the medical practitioners interviewed had addressed the lack of psychological training in the medical career through undertaking courses in specific counselling modalities. An interesting dilemma arose where medical practitioners were often unconvinced by the research and practice basis for counselling while simultaneously practicing 'informal' counselling themselves.

Primary care practitioners are unsure of the quality and content of the counselling services accessible to them, resulting in counselling not being considered as a known and predictable intervention. Referrals to counselling, made on primary care methadone maintenance programmes are at the discretion of the medical practitioner. Factors which influence the practitioner's perceptions, beliefs and experiences of counselling as part of methadone treatment form the framework within which the referral is considered. Medical practitioners expressed reservations when referring to counsellors. Their approach to using counselling as a treatment modality lacks engagement and expectation of results.

The programmatic approach to opiate treatment in Ireland aims for a harm-reduction outcome. Once stabilised on methadone, there is no planned development path for the patient on a primary care methadone programme. Methadone substitution does not in itself address the psychological, social and behavioural aspects of opiate addiction (Amato *et al* 2004). Accessing psychosocial treatments from primary care is difficult, with limitations on access to and availability of support services. Treatment options generally come down to methadone and what little psychosocial support the primary care practitioner can offer in the consultation. This shortfall in psychosocial support services has been recognised in the review of the National Drugs Strategy (Ireland, Department of Community, Rural and Gaeltacht Affairs, 2005).

There is no systematic incentive for the primary care medical practitioner to progress the patient beyond methadone maintenance. However, **individual medical practitioners hold an abstinence agenda where they consider it attainable.** This research found that where further progression does happen for the patient, it is

circumstantial and largely down to the individual patient and medical practitioner. The potential of psychosocial intervention to complement the stabilisation aspect of methadone substitution and as a support for further personal change is appreciated by those involved in primary care methadone treatment. Research findings support the view that the use of psychosocial interventions to complement pharmacological treatment may make the methadone detoxification process more effective (Amato *et al* 2004), cost efficient (Kraft *et al* 1997) and could be a key ingredient in promoting individual psychological change required to address drug dependence (Farrell *et al* 1994).

The existing system of methadone treatment centres on structures which have power and control over the patient's treatment regime. The power imbalance in the primary care practitioner/patient relationship was highlighted in this research. The role of the primary care practitioner as gatekeeper to methadone dominates the practitioner/methadone patient relationship. Miller and Rollnick (1991) point out that the perception of choice directly relates to motivation for change. It could be argued that a regulated and controlled methadone supply program reinforces institutional authority and assumes power and control over what is 'good' for the patient. This runs counter to the individual development required for the patient to acquire a sense of self-esteem and personal responsibility.

Primary care medical practitioners who offer methadone treatment have a deep commitment to their role in their communities. Primary care practice has roots in the social and psychological concerns of communities as well as in clinical medicine. This research found that a commitment to delivering ongoing care to its community is particularly evident in primary care practices that run methadone programmes. Medical practitioners interviewed accepted responsibility for providing care for the social, psychological and medical issues within their communities. The depth of this commitment, as expressed by medical practitioners in the course of this research, was unexpected. Perhaps this should not have been surprising given the minority of practitioners who offer methadone treatment and the issues to be considered before enrolling a practice for methadone treatment. As this research focussed on a particular

cohort of practitioners who offered methadone treatment, caution must be exercised in extending this conclusion to other medical practices.

Evidence based practice requires repeatable treatment based on a body of research. The evidence from the grounded data acquired in this research indicates that **the majority of primary care methadone programmes apply psychosocial interventions in an individual and situational way, with little consistency of approach.** Such variability presents an obstacle to the primary care practice in learning how to use psychosocial treatment, and in the development of practice guidelines. Amato *et al* (2004) highlight heterogeneity in the content and usage of psychosocial interventions as presenting difficulty when conducting research into psychosocial interventions on methadone substitution programmes.

Recommendations : The **methadone treatment protocol should be reviewed and revised.** The existing methadone treatment protocol traces its origins to the early 1990s when it was shaped by contemporary health concerns and structures. Health and societal factors which were dominant at the time of its introduction have been superseded. The factors which influenced its implementation could be reassessed for relevance, leaving scope for reformatting with potential effectiveness and efficiency gains. The objectives of methadone based treatment in primary care need to be clarified. The inclusion of psychosocial interventions and the provision of accessible resources as part of the systematic delivery of methadone treatment in primary care should be considered within a broader protocol.

A revised opiate treatment protocol could consider person-centered versus systematic methadone treatment. The principal of prioritising treatment around patient needs and not those of programmes or providers has been recognised by the National Drugs Strategy Mid-term review (Ireland, Department of Community, Rural and Gaeltacht Affairs, 2005). It is necessary to re-orientate opiate addiction treatment around the optimum outcome realistic for the patient. It also must be recognised that addiction has a psychological component and the patient objective may change during treatment. **Counselling should be considered as an agent of personal development**

and included as a treatment modality to facilitate patient change and maximise the effectiveness of a patient-centric treatment model.

The lack of a treatment progression path and concerns about the long-term effects of methadone usage are recognised in the identification of rehabilitation as a strategic principle of drug treatment policy in Ireland (ibid.). **There is a need to identify how primary care methadone programmes can extend to address such an objective.** A rehabilitation objective provides a basis for the development of opiate treatment beyond methadone maintenance to support reintegration of the patient into their community. This offers an opportunity for counselling to establish its contribution as a support of the patient along a change and development path.

Medical practitioners find it difficult to incorporate counselling into treatment due to its lack of standardisation and structure. **Counselling must establish itself as a recognisable profession with regulation according to a well-understood set of professional standards.** With this basis established, it can offer itself as a defined component in the holistic treatment of patients on primary care methadone programmes. The application of psychosocial interventions as part of opiate addiction treatment can be underpinned by evidence based research and practice based experience. **The development of better role understandings between medical practitioners and counsellors in the treatment of opiate abuse is necessary if they are to work in an integrated fashion.** One practice surveyed in the course of this research had progressed the integration of psychosocial and pharmacological treatments for methadone patients. The practice reflected the co-location principles contained in the primary care health strategy (Ireland, Department of Health and Children, 2001). This medical practice had consciously observed the benefits of its onsite counselling psychologist and “learned” how to use this service effectively. The rollout of the primary health care strategy may present an opportunity for integration of counselling services with other treatment modalities.

Primary care practices should be encouraged to develop guidelines around the use of psychosocial interventions on methadone programmes. The lack of structure in the use of psychosocial interventions across practitioners mitigates the development of

best practice usage of psychosocial interventions within and across practices. One practice encountered in this research had developed a practice protocol for methadone therapy which incorporated pharmacological and psychosocial components (Latham, 2006). Primary care practices should actively manage their guidelines and evolve treatment in consultation with other practitioners. Extending the existing audit of methadone treatment practice to include the application of psychosocial support would provide a useful source of baseline information and a platform for the development of psychosocial intervention protocols.

More research is needed on the application of psychosocial interventions as part of opiate addiction therapy. Methodological limitations are encountered in researching the contribution of psychosocial interventions. These are particularly evident when contrasted with the use of randomised control trials (RCT) in medical research. However, this is an unbalanced comparison. The primacy of the RCT in evidence-based medicine has been questioned (Grossman and Mackenzie, 2005). Just because a particular research methodology does not readily apply is not sufficient reason to discount a treatment modality that has ‘practice-based evidence’. It is worth noting that internationally, there are significant differences in opiate treatment regimes that limit the general applicability of research (including this research). The challenge is to develop an appropriate research methodology for psychosocial interventions in general and in the opiate treatment setting in particular.

6.2 Conclusion to the study

This grounded theory thesis has developed a model of the application of psychosocial interventions to methadone patients in the primary care setting. The inputs to the research were data grounded in the implementation of primary care methadone treatment. The resulting model is derived directly from the data through a grounded theory methodology. This model has been verified with primary care practitioners who run methadone treatment programmes as an accurate description of the prevailing process. The referral model reflects the origin and statutory basis of primary care methadone treatment which lie in the methadone protocol. The methadone protocol was developed primarily in response to the rapid spread of HIV/AIDS. A harm reduction outcome, achieved by transitioning opiate users from illicit drugs onto a legal

controlled substitute met the protocol objectives. Primary care became the delivery channel for the ongoing maintenance of the patient on methadone and the management of their general health.

However, the role of primary care is more than one of maintenance and management of individual patients. Primary care medical practices are embedded in their community. Their concern and commitment to the community goes beyond offering medical responses. Finding opportunities to improve the patient's social, psychological and physical health is an imperative of the primary care medical practitioner. Medical practitioners, in their role of managing the methadone patient's treatment regime, often do not have the skills, experience or time to deliver psychosocial interventions. There is no protocol to structure psychosocial inputs for opiate treatment in primary care.

In the 1960's the discovery of methadone as an opiate substitute moved the spotlight from the psychological model of opiate addiction to a metabolic model. Methadone substitution has been successful in delivering a harm reduction outcome. In Ireland, there is no psychological treatment model to take the stabilised patient forward from where methadone maintenance leaves them. A psychological change model may hold the key to evolving treatment to a point where individuals regain control of their lives.

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| | |
|--|---------------------|
| | Any other comment : |
|--|---------------------|

Appendix B :

Plain language description of research.

Title of Research :

A description of the process by which Primary Care Methadone Treatment Programmes make counselling referrals for methadone patients.

Researcher :

Name : Kevin Kenny.

Phone: **086 8528724**

eMail : kennykevin@gmail.com

I am a student at The Irish Institute of Counselling and Psychotherapy Studies at Turning Point and am undertaking an M.Sc degree in Integrative Counselling and Psychotherapy through Turning Point / DCU School of Nursing. This research relates to my M.Sc. programme.

If you choose to participate..... :

- Indicate your willingness to take part by emailing or phoning the researcher (details above);
- I will contact you by phone within two weeks of your expression of interest to arrange an interview about your understanding of your role in relation to psychosocial aspects of the methadone programme client's treatment, and the processes you use when deciding on and making a referral to counselling;
- I want you to complete a short questionnaire on a minimum of three sessions you have with methadone treatment programme clients before we have our interview. I will supply these to you after initial phone contact.
- Any information you supply will be treated in the strictest of confidence (within prevailing legal limitations) and will not be used for any purpose outside of this research. Your answers to my questions will be combined with those of others and it will not be possible to identify who took part in this research. Interview records will be retained securely, with no participant identification, and will be destroyed after a year.

Description of the project :

Primary Care medical practices are responsible for the care of clients on their Methadone Treatment Programmes (MTP). Research indicates that counselling used in conjunction with methadone interventions may yield benefits in terms of the client's participation in the treatment programme and their ability to remain 'clean' afterwards.

As someone involved in managing and/or treating clients on an MTP, I want to research your beliefs, experiences and opinions about the application of counselling on MTP programmes.

To acquire the necessary information, I will use an interview. The interview will take approx 45 minutes. While I would prefer to do it in person, it can be conducted over the phone. Note that the interview may be recorded to facilitate transcription, after which it will be destroyed.

My findings will identify how counselling/psychotherapy are currently used on Primary Care Methadone Treatment Programmes.

Finally.....:

You can change your mind at any stage and decide not to take part, in which case any of the data you supplied which hasn't already been included in the research will be destroyed. If you have concerns about this research, contact the Secretary, Research Ethics Committee, Office of the Vice-President for Research, Dublin City University, ph: 01-7008000; fax 01-7008002.

Thank you for taking time to read this,
Kevin.

Appendix C:

Consent form to Participate in Research

Title of Research :

A description of the process by which Primary Care Methadone Treatment Programmes make counselling referrals for methadone patients.

Purpose of Research :

- To investigate the understanding, in Primary Care, of its role in managing the psychosocial aspects of the methadone client's treatment regime.
- To identify commonality and difference between different referral processes to counselling used by Primary Care practices to determine what common (in)formal processes operate.
- To describe the referrers' decision making processes when deciding on the methadone programme client's referral to counselling.

Researcher :

Name : Kevin Kenny, phone 086 8528724.

Supervisor : Dr. Christina Quinlan, DCU.

This research is being conducted as part of an M.Sc. submission to DCU School of Nursing.

Note :

Interviews may be recorded; once transcribed the recording will be destroyed. All records (initial recordings, transcriptions and questionnaires) will be treated in the strictest of confidence and held without identification as to origin, until destroyed.

Confidentiality :

Your identity and any information you supply will be treated as confidential. The results of the study may be published for research purposes but will not give your name or include any identifiable references to you.

Any records or data obtained as a result of your participation in this study will be securely stored for a period of one year, after which they will be destroyed. These records will be kept private in so far as permitted by law, and will only be used by those directly involved in this research (the named researcher and his supervisor).

Your Choice to Participate or Not :

You are free to choose whether or not to participate in this study.

AUTHORIZATION

I have read and understand the project description and this consent form, and I volunteer to participate in this research study. I understand that interviews will be recorded for transcription purposes and that all interview records will be retained for one year from date of completion of the research project and then destroyed.

Participant Name (Printed or Typed):

Participant Signature:

Date :

Researcher Signature :

Date :

Appendix D :

Methadone treatment qualification levels (Ireland Department of Health and Children 1998)

Level 1 Contract: This level would relate to doctors treating stabilised opiate dependent persons referred from health board drug treatment centres. The contract would include the following elements:-

- * the general practitioner should have adequate training in the knowledge, skills and attitudes required to manage opiate misusers in general practice. This would require completion of a recognised training programme agreed between the Irish College of General Practitioners and the Eastern Health Board;
- * the general practitioner should ensure that any opiate dependent person he/she is treating is registered on the Central Treatment List (currently held at the Drug Treatment Centre, Pearse Street);
- * the general practitioner should satisfy him/herself as to the identity of any opiate dependent person he/she is treating- He/She should also ensure that the person has a treatment card with a recent photograph, name, signature and date of birth, the correct pharmacist's name and address and that this treatment card is not out of date. He/She should also make contact with the pharmacist at an early stage in order to make appropriate arrangements regarding dispensing- This contact should continue during the course of treatment;
- * the general practitioner should agree to provide services to a maximum of 15 patients;
- * the general practitioner should agree to liaise with a "keyworker", as set out in the Protocol, for each patient;
- * the general practitioner should agree to a regular audit/evaluation of his/her practice by an Irish College of General Practitioners/Eastern Health Board team;
- * the general practitioner should agree to regular educational updates as arranged by the Irish College of General Practitioners / Eastern Health Board team;
- * treatment should be provided in local areas as recommended by the Medical Council of Ireland and the Pharmaceutical Society of Ireland,
- * the general practitioner should agree that no fees will be accepted from a patient, or any source other than the Health Board, for providing this service;
- * prescriptions for methadone should not enable supply for a period greater than seven days, in the course of a single dispensing. Other arrangements may be necessary in exceptional circumstances. In all cases the general practitioner must be satisfied that it is safe to issue the prescription concerned;

Level 2 Contract would involve general practitioners who had more training and experience of working with opiate dependent persons. These general practitioners could initiate treatment of opiate dependent persons.

The terms of the Level 2 Contract would include all of the Level 1 terms and in addition:-

- * the general practitioner should have undergone a more advanced training programme as agreed between the Irish College of General Practitioners and the Eastern Health Board (including supervision by an experienced general practitioner for 1 year in a treatment centre setting);

- * the general practitioner should agree to an annual refresher course and regular evaluation of the practice;
- * the general practitioner should treat up to a maximum of 35 patients in his or her own practice;
- * general practitioners in a practice with 2 or more doctors could cater for a maximum of 50 patients;
- * in certain exceptional circumstances general practitioners may, following consultation with the health board's consultant psychiatrists, be approved to treat a greater number of patients.

This may be necessary, particularly in the short term where there is still a difficulty in recruiting new general practitioners to become involved in treatment;

It is intended that only general practitioners who conform to the criteria set out above should treat opiate dependent persons.

Appendix E:

Initial interview schedule.

Note : Grounded theory advocates 'open interviews', so the following schedule should only be read as indicative of areas of focus.

- 1 General – referrer and methadone treatment:
 - 1..1. What aspects of the client's 'treatment' are you responsible for ?
 - 1..2. Do you see Methadone Maintenance as offering a complete 'treatment' for your clients? If 'yes' elaborate on what it offers? If 'no', what else is required?
 - 1..3. What is the basis for payment for methadone clients seen by you?
- 2 Referrer opinion of counselling in methadone treatment environment :
 - 2..1. Do you think counselling is a beneficial intervention for methadone treatment clients? Why / Why Not?
 - 2..2. What informs your opinion of counselling in the methadone environment;
- 3 Referrer knowledge of the counselling process – in general :
 - 3..1. What experience / training have you of the counselling process?
 - 3..2. Did training for participation on Methadone Treatment Programmes cover psychosocial counselling therapy?
- 4 Referrer knowledge of the available counselling resources – specific :
 - 4..1. What counselling resources are available for you to refer clients to?
 - 4..2. How did you find out about these resources / how do you keep up to date with services available locally?
- 5 Referrer expectations from counselling for clients;
 - 5..1. What do you expect from counselling for the client?
 - 5..2. What is a successful outcome from counselling, in your opinion?
 - 5..3. Have you modified your use of counselling based on experiences with previous clients? How?
- 6 Process applied by referrer to counselling referral:
 - 6..1. Do you apply a process which includes consideration of counselling when meeting a client on the methadone programme?
 - 6..2. Do you assess the client for counselling? What model / how?
 - 6..3. What information do you give the client on counselling?
 - 6..4. Typically, do clients ask questions about counselling; are they encouraged to do so? What sort of questions? How are they answered?
 - 6..5. What would you do/say if the client refused a counselling referral?
 - 6..6. What would you do if the client requested/demanded counselling?
 - 6..7. Do you deal with counselling in the client meeting before or after assessing the client's methadone regime?
 - 6..8. Are you assessed by anyone/in any way regarding your methadone programme? Does this assessment include usage of counselling? What metrics are measured?
- 7 Ongoing interaction between referrer and client's counselling regime:
 - 7..1. How do you monitor the client's counselling progress?
 - 7..2. What do you do if a client fails to attend counselling? How do you find out? How do you address it (if at all) with the client?

Appendix F :

Interview schedule designed to 'saturate' emerging concepts

Interview schedule. Note : Grounded theory advocates 'open interviews', so the following schedule should only be read as indicative of areas of focus.

1. GPs motivation :

1.1 Why do you run a methadone treatment programme in your practice / why did you get involved in methadone therapy?

1.2 Why can GPs opt out of methadone? They can't opt out of diabetes etc.

2. Treatment in Primary Care

2.1 In the primary setting, what are your thoughts on how methadone patients should be treated?

- should they be treated as anyone else with a chronic condition (e.g. diabetes)?
- Reasons for differentiation?
- Demand on resources?

2.2 When treating a methadone patient, what is your goal (abstinence / maintenance / other)?

3. Psychosocial Supports :

3.1 Are psychosocial supports important in treating methadone patients?

3.2 Is there enough research info to rule in / out?

3.3 What are your thoughts on psychosocial supports available to primary care practitioners?

3.4 What basis does a GP use when forming their opinions of the value of psychosocial supports?

3.5 Comment on Counselling /psychotherapy standardisation and training.

3.6 What about 'micro' methadone as a target? Evidence suggests people find value in GP system and still come back for micro doses. Maybe GP is playing a modified role for patient.

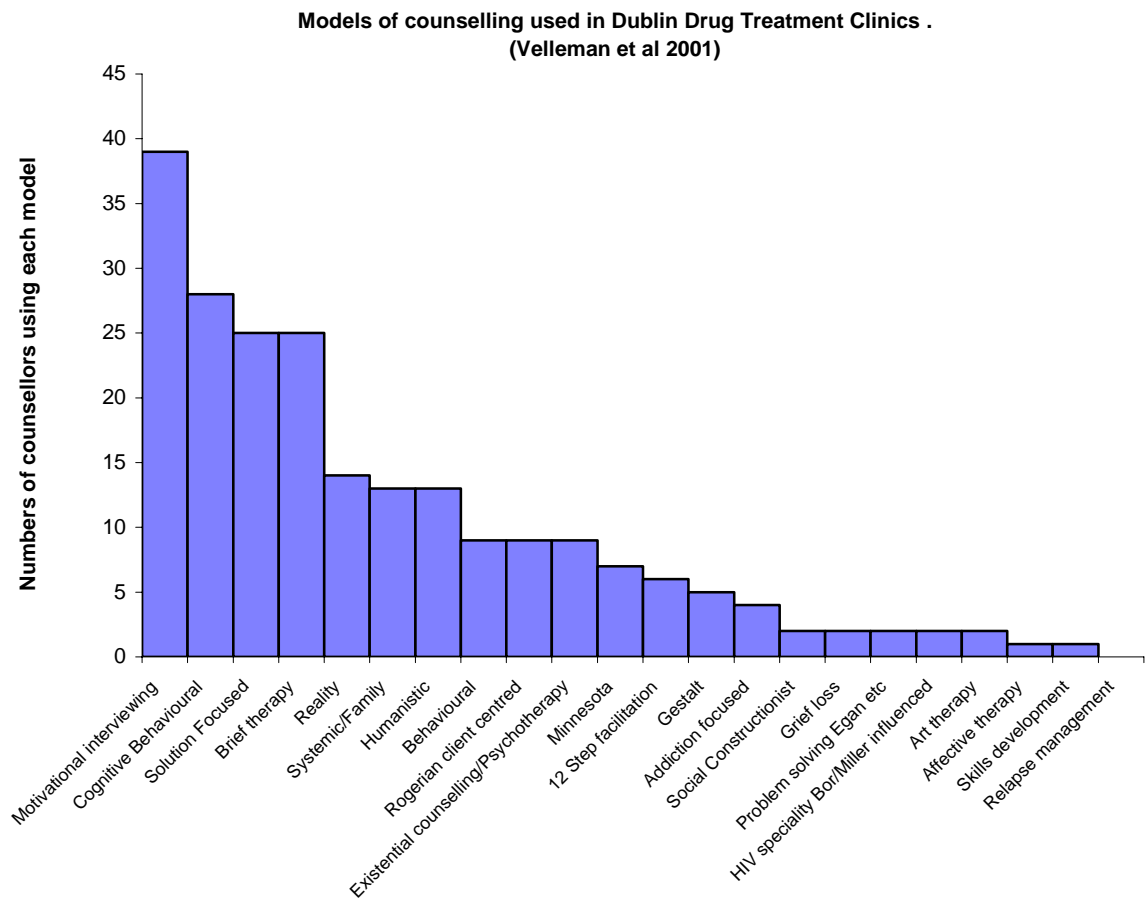
4. Other

4.1 Would you agree that the focus of methadone treatment in Ireland is harm reduction / maintenance?

4.2 Training of GPs for level 1 / level 2 – are psychosocial supports covered?

4.3 Are individual treatment programmes constructed for patients?

Appendix G:
Counselling modalities



Appendix H :

Example of theory generation process used in this research.

| Ref : | Interview data | 1 st Level Codes | Categories | Position in counselling referral process. |
|-------|--|---|--|---|
| C90 | <p>Interviewer : Formally or informally, would you assess where they are psychologically?</p> <p>Interviewee: oh definitely, but not formally. In medicine, you don't get any formal psychological training. I've done six months of psychiatry, but very little of that was psychological. Naturally, I'm interested in the psychological side of things, from personal training and a few short courses. I would do that informally</p> | <ul style="list-style-type: none"> Formal GP training has no psychological element. GPs skill themselves with counselling interventions | <ul style="list-style-type: none"> Psychological assessment of methadone patient by GP; Medical training; Informal counselling by GPs | <ul style="list-style-type: none"> GP's appreciation of psychological therapy (referral); No formal psychological assessment of patient (decision process) Importance of counselling in GP practice; |

Interview C – Primary Care Medical Practitioner.

| Ref : | Interview data | 1 st Level Codes | Categories | Position in counselling referral process. |
|-------|--|--|--|---|
| G30 | <p>Interviewee: I've never had formal training in CBT or psychotherapy or counselling at all.....</p> | <ul style="list-style-type: none"> Formal GP training has no psychological element. | <ul style="list-style-type: none"> Use of counselling by GP, formally or informally; Medical training; | <ul style="list-style-type: none"> GP has no basis for appreciation of counselling (referral); GP and patient's psychological care (primary care) |

Interview G - Primary Care Medical Practitioner.

| Cross-Refs to base data: | Concept | Implications for referral process |
|--------------------------|---|---|
| C90 G30 | <p>During medical training, primary care medical practitioners receive no psychological training.</p> | <ul style="list-style-type: none"> insight into psychosocial therapy (referral); ability to assess patient psychologically (primary care practice); psychological model of addiction (decision process); |

Description of systematic analysis process :

- (1) Interviews are subdivided into segments (sentences / phrases) which deal with identifiable areas. Segments are coded with a statement that captures its essence (1st Level Code).
- (2) 1st Level Codes are abstracted into categories and related to the referral process.
- (3) Categories are related and abstracted into a conceptual statement, which is cross referred back to the grounded source. The implications of the concept on the primary care counselling referral process are identified, creating a link from the concept to the process that is being studied.

Appendix I :

Consolidated model of the counselling referral process on primary care methadone programmes in Ireland.

