Opioid substitution therapy

A study of GP participation in prescribing

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Background

Opioid substitution therapy (OST) is the most commonly provided treatment for heroin dependence in Australia and has been shown to be effective. Access to OST outside of specialised public clinics and prisons relies on the participation of general practitioners. In Australia there is a shortage of GPs available to prescribe OST, which results in an unmet need for OST services. Studies have reported barriers to GP involvement in drug and alcohol work and there is little research looking at the perceptions and experiences of GPs involved in prescribing OST.

Method

Semistructured qualitative interviews were conducted with eight experienced prescribers of OST in general practice settings in South Australia.

Results

All participants described similar positive and negative aspects associated with prescribing OST. Some participants commenced prescribing in such a manner as to limit the scope of their involvement. Ceasing OST prescribing was not necessarily linked to negative experiences. Exprescribers indicated that they were unlikely to recommence prescribing.

Discussion

This study has limited generalisability due to the small sample size but it does highlight some insights that can be gained from talking to experienced OST prescribers.

Keywords: substance related disorder; delivery of health care; health services

Opioid substitution therapy (OST) with either methadone or buprenorphine is the most commonly provided treatment for heroin dependence in Australia[1] and has been shown to be effective.[2–4] In Australia, OST is delivered in specialised public clinics, prisons and general practice settings (including community and private general practices).[1] Importantly, there is an unmet need for OST services in Australia, including in South Australia (SA), where this study was conducted.[1] To address this demand, variations on a community based model for service delivery, via general practice settings, have been adopted throughout the country[5] and several states have invested significant effort to increase the workforce base of general practitioners prescribing OST.[1] In SA, GPs must actively 'opt in' to become involved in OST and participation rates remain low. There were approximately 2000 GPs practising in SA in 2008.[6] Using the national method of data collection, the Drugs of Dependence Unit (DDU) of Drug and Alcohol Services SA (DASSA) has estimated that only 55 SA GPs prescribed OST to 1599 patients in 2008.[7]

Studies in Australia[8–11] and overseas[12,13] have reported barriers to GP involvement in drug and alcohol work. These include a perceived lack of confidence, knowledge, time, and remuneration to carry out the work;[8,9,11,13] negative views of patients who have drug and alcohol issues;[8,10,11,13] and concerns about exposing other patients and practice staff to this group of patients.[8,13]

There is, however, little research looking at the perceptions and experiences of GPs who are involved in treating drug and alcohol misuse and prescribing OST and the factors that encourage this participation. A notable exception is a qualitative South London study by Groves and Strang,[14] which reported that GPs who participated in the treatment of opioid dependant patients had an increase in their personal knowledge about addiction, a more positive attitude toward opioid substitution as a treatment, and a change in attitudes toward patients with addiction problems.[14]

In Australia, it has been proposed that there is a need to retain trained and experienced community prescribers in order to reduce the unmet need for OST services.[5] However, the views of the OST prescribers themselves have not been investigated. The aim of this qualitative study is to report on the experiences, perceptions and insights of experienced current and exprescribers of OST, and explore what factors affect their participation in the program. These insights could be used to suggest directions for further research with a view to a possible modification of recruitment and retention strategies, and to improving the experience of GPs involved in prescribing OST.

Method

Exprescribers (n=6) and current prescribers (n=58) of OST in SA were identified from the 2007 records of the DDU of DASSA. This sample was contacted via a mailout and three exprescribers and 38 current prescribers responded. All three exprescribers who agreed to participate in the study were interviewed and five current prescribers were selected based on the fact that they had variable levels of involvement as represented by the number of OST patient authorities held by each. The final sample included participants of both genders, of a range of ages (approximately 40–86 years), from rural and metropolitan practices and with variation in the length of time involved in OST

prescribing and the number of patient authorities held (current prescribers: 19, 58, 68, 107 and 137; exprescribers: 2, 10 and 80). (The authors recognise that further demographic details of the participants would be of interest to readers, however, it was felt that due to the small sample size and the small number of GPs participating in OST in SA, disclosure of these details would jeopardise the confidentiality of participants.)

After obtaining signed informed consent, semistructured qualitative interviews were conducted with the eight selected GPs. The interview schedule covered the participants' experiences of prescribing OST, reasons for becoming involved in and (if relevant) ceasing OST prescribing, perceptions of aims and success of OST treatment, perceptions of OST patients, and supports and barriers to their work.

After transcription and de-identification, a thematic analysis[15] was performed using NVivo 7.[16]

Ethical approval for the study was granted by The University of Adelaide Human Research Ethics Committee.

Results

The major themes that emerged from this study related to factors leading to initiation and cessation of prescribing and perceptions and experiences of being a prescriber.

Initiation, continuing or ceasing OST prescribing

Three of the GPs interviewed (two current, one exprescriber), did not appear to consider the limits of their involvement before initiating prescribing. Instead, these GPs prescribed OST to patients presenting at their practice on a needs basis.

'I had people coming to me who wanted help and I wasn't able to give it to them.' (Current prescriber)

These three GPs each held a high number of patient authorities (range 68–107). The two current prescribers said they would stop prescribing only if they retired or had to reduce their hours significantly. The exprescriber reported that, while he was prescribing, he felt pressured to take on more patients and could not cope with the OST patient load along with other pressures.

'I just couldn't cope with the volume of patients that I had and their dysfunctionality and my own at that time.' (Exprescriber)

Four prescribers (including current and exprescribers) said they began prescribing because of the needs of a particular subpopulation of their patients.

'The existing opioid prescriber approached me directly and said that he was moving away from the town.' (Current prescriber)

'So it [initiating OST prescribing] was a direct result of community angst about heroin overdoses in that particular community.' (Current prescriber)

The level of involvement of these four prescribers was partly determined by the size of their population, and retention in the program was linked with their involvement with the particular subpopulation.

'I would only cease prescribing OST if I left the area, ultimately I will be going on to doing other things, but that's just a life direction, not to do with that [OST prescribing].' (Current prescriber)

One exprescriber prescribed in a rural area to a low number of patients, constituting a low proportion of his overall practice. He ceased prescribing OST when he moved to a different rural region as he felt that it might take over his other general practice work.

'I didn't want to reinvent myself as the methadone prescriber of the region, because I wanted it to be a small part of my general practice.' (Exprescriber)

Another exprescriber had treated patients on their release from prison and ceased his involvement with OST prescribing when he stopped working at the prison and moved practice. He noted negative aspects of prescribing such as the scrutiny from the medical board and coroner but promoted involvement in this work.

'You tell people you don't have to be a prescriber forever, because it is a difficult job and it is hard to do forever. Do it for 6 months, it is better than nothing.' (Exprescriber)

Two exprescribers reported that during their involvement they acquired knowledge and skills that were useful independent of prescribing OST.

'What my involvement though has done is given me a framework in which to try to assist these people, which I don't think I would have had otherwise.' (Exprescriber)

One current prescriber was attracted to the work as he thought it appeared interesting. He indicated that he would prefer to continue prescribing and even increase his involvement. He was critical of the bureaucracy involved in OST prescribing and believed that involvement led to increased exposure to medical board scrutiny compared to other areas of practice.

Perceptions and experiences of being a prescriber

The positive and negative aspects of involvement with OST prescribing described by all participants were similar, and responses were not distinguishable based on whether participants were current or exprescribers. The negative aspects of prescribing described in this study match the perceptions of GPs that have been reported in previous studies that examined barriers to GPs becoming involved in drug and alcohol work.[8–13] In the present study, however, these negatives were balanced with the positives that participants reported gaining from their OST prescribing experience.

Positive aspects

Several participants stated that before becoming involved with OST, they were reluctant to work with patients with drug misuse issues and held negative views of OST but that these views changed after initiating prescribing.

'I was totally against the methadone program, had been against it forever. What the hell are we doing that for? And then I, you know, it became seemingly obvious once I got involved that that was the only way to go and then I kept trying to convert other people.' (Exprescriber)

Participants reported that they were more able to understand, diagnose, and offer treatment options to patients with opioid dependence through their involvement in prescribing OST. They reported that this helped them develop management strategies for new patients presenting with drug abuse issues at their practice – that is, they felt able to offer treatment to those at a stage of trying to stop illicit opiate drug use, rather than simply submitting to advances from patients seeking drugs to continue misusing them.

'It has given me some tools. I can do a fairly good assessment of the point at which someone is [if they are] wanting to change their life... I can offer them my opiate substitution program as an option.' (Current prescriber)

Several participants specifically commented that difficulties with providing OST were often improved when patients became stable, both in their doses of opioids and other aspects of their lives. It was observed that most of the time, the majority of OST patients behaved in a similar manner to other patients in the practice.

'The majority of people are normal, and the people coming for the program are less problem than the drug addicts coming to try their luck.' (Current prescriber)

Participants described developing an understanding and some acceptance that patients may experience setbacks, saying they recognised several challenges for patients staying in treatment, including that patients' chaotic lifestyle made it difficult for them to organise attending appointments, and other barriers such as pharmacy costs and access to transport.

'It's only about a quarter of our [OST] clients who are in that sort of… still that bit of a crazy mixed up not quite connected yet, not quite ready yet or still too many other things happening in their lives for it to be a success yet.' (Current prescriber)

Several participants, including an exprescriber, reported their enjoyment in seeing the positive outcomes for patients with OST, and in the long term, satisfying relationships formed with OST patients.

'My greatest satisfaction, and successes, has been with these people rather than people with ordinary and commonplace illnesses.' (Current prescriber)

'That [participant reads from a wall hanging] was actually a Christmas gift from a couple who were heroin addicts, lovely, lovely people... they had turned around their lives... and it still speaks volumes to me and the fact that it's there after all these years. I mean it's one of the very few adornments I carry.' (Exprescriber)

Negative aspects

Although participants described positive aspects of their involvement, they also expressed feeling extra pressure in their role as OST prescribers in addition to the already stressful role of a GP. Participants described OST patients who were difficult at times due to their ability (or lack thereof) to attend appointments or pay bills, their behaviour in waiting rooms, and attempts to manipulate the GP.

'I might lose half a day, at least a couple of times a month, just because these people are chaotic.' (Current prescriber)

Participants reported feeling pressure from within their practices to be expert in all aspects of assessment and management of drug and alcohol problems as well as other pain and mental health issues.

'Some of the other doctors here have also been sending me the chronic pain patients because they think that [as] an opioid prescriber that I must know about that too, so I do know more about that too now.' (Current prescriber)

As described, participants also expressed frustration with the bureaucracy involved with being an OST prescriber and with the perception of increased scrutiny compared to prescribing other drugs with the same safety profile.

'If anything would shit me off about it [prescribing OST], it would be not being allowed the freedom to work within the framework.' (Current prescriber)

Discussion

This study has limited generalisability due to the small sample size. However, it highlights the insights that can be gained from talking to experienced OST prescribers. Information gathered from semistructured qualitative interviews included factors that led OST prescribers to initiate their prescribing, factors that determined the scope of their involvement, and perceptions and experiences of being a prescriber. While exprescriber participants expressed negative opinions of OST and OST patients, it was found overall that negative experiences were balanced by an appreciation of the benefits gained through involvement, including increased ability to assess and manage patients with drug issues.

According to participants, ceasing OST prescribing is not necessarily linked to the GP's negative experience of their involvement. The study did not explain why some GPs were happy to have this work form a large proportion of their practice, while others preferred to keep their OST work limited to a small proportion of their patients.

Some participants reported that, before they made the decision to prescribe OST, they wanted to know that the number of requests for OST treatment would also be limited by external factors (eg. limited local pharmacy places or transport options for patients to access their practice). This suggests that GPs' willingness to prescribe OST may be affected by their perceived ability to control the proportion of patients they will see for OST. At the time of the study, over half of the current prescribers held authorities for fewer than 20 OST patients, indicating that it is possible for OST prescribing to be kept as a small part of a GP's overall work. Experienced prescribers may have useful skills and techniques to manage the pressure of accommodating the unmet need for OST. Further studies should be aimed at canvassing these techniques so they can be incorporated into training for OST prescribers.

The negative experiences described by participants in this study were similar to those reported in studies into barriers to participation in OST prescribing.[7–12] However, study participants saw these experiences as representing just one aspect of their experience of prescribing OST. Prescribers described that most patients receiving OST were no different to the rest of their patient population. However, it was reported that a minority of patients occasionally exhibited difficult behaviour. Further observational studies to examine the effects of the behaviour of OST patients in general practice settings may support OST prescribers' perceptions and be used to challenge nonparticipating GPs' views.

Participants reported that after their experience of working with OST patients, they found they were able to respond more appropriately to other patients with drug abuse issues. They reported an enhanced ability to differentiate between patients with different drug issues, to detect different stages of readiness to change, and to firmly reject requests by patients seeking prescriptions to abuse. Some participants perceived that they had fewer requests for prescriptions to abuse because of their involvement as OST prescribers. Further studies may support these perceptions, and materials used to recruit GPs to OST work could emphasise the learning opportunities inherent in OST work.

Studies have proposed that prescribers may cease prescribing due to the effect of negative experiences.[9] This study found that additional reasons may be at play, including a desire for a

career move or to develop new and different skills. Possible options for increasing the OST workforce could be for GPs to prescribe for a defined period of time or for a set number of patients. Promoting the opportunities for professional development that could arise from participation as an OST prescriber is another option.

Exprescribers participating in this study all indicated that they would not be willing to prescribe OST again. This may suggest that rather than seeking to re-engage exprescribers, interventions should aim to show appreciation for any level or length of involvement, and to allow GPs a sense of control over their involvement, without feeling a sense of pressure when they choose to give up prescribing.

Implications for general practice

- Ceasing OST prescribing is not necessarily linked to GPs' negative experiences of their involvement.
- Experienced OST prescribers reported benefits gained through their involvement, including increased ability to assess, manage and treat patients with drug issues.
- Recruitment may be improved by highlighting to GPs the lasting benefits of prescribing OST that may be achieved, even through short episodes of involvement with low numbers of patients.

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