Management of opioid substitution treatment in the primary health care setting – a national training course for service providers

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ABSTRACT

Background

In 2000 a national opioid treatment training programme in primary health care was introduced in New Zealand as a strategy to recruit, train and support a primary health care workforce in the provision of methadone treatment.

Aims

To describe the programme and outline an evaluation of its effectiveness following its first year of operation.

Methods

A written questionnaire was used to evaluate the programme after its first year of operation. The subjects of the evaluation were the GP, PN and pharmacist participants of the training programmes held throughout New Zealand in 2000.

Results

One hundred and forty-five (98%) participants reported that the overall quality of the course was good or better, and that relevant issues were, in general, covered. However a recurring theme related to difficulties in designing a course relevant to the three different professional groups (GPs, PNs and pharmacists) with some material not equally applicable to all. Another prominent theme pertained to the issue of funding. GPs lamented the failure to address the issue of transferring patients from a free specialist clinic to their GP for care.

Conclusions

The evaluation of this pilot programme indicates that this training in methadone maintenance treatment was well-received by primary health care providers. However there is no benchmark with which to compare it. Formal research is needed to measure the effects of the programme and to assess whether increased practitioner knowledge and attitudinal change translates into better health care outcomes for patients.

(NZFP 2002; 29:172–175)

Introduction

An estimated 13 500 to 26 000 people are opioid dependent in New Zealand, and this number is predicted to grow by 15% per annum.[1] In 1996, approximately 2 500 opioid dependent patients were on methadone treatment.

The desire to have comprehensive services for opioid-dependent people in New Zealand runs in accord with the national protocol for methadone treatment, which focuses on harm reduction and stabilisation of the patient's health status.[2] Throughout New Zealand, methadone treatment is delivered by specialist methadone clinics, and by authorised general practitioners (GPs) to patients whose dependency condition has been stabilised. There is a significant pool of untreated patients who pose a risk both to themselves and to the community.

In 1996 it was identified that the service could be improved if the majority of patients, after initial registration and assessment at a specialist clinic, were cared for directly by GPs to whom the specialist clinic would provide highly accessible backup consultation.[1,3] Identified benefits of GPs taking over the care of patients once their methadone dose has been stabilised include using limited spe-

cialist services for those most in need of intensive specialist intervention, with resultant cost-saving and reduction of waiting lists.[2] Improved social integration by normalisation of the delivery of treatment (i.e. not having to attend a 'drug clinic') is also widely recognised. This is in line with the blueprint for mental health services which recommends that '*primary health care should be able to provide ongoing clinical care after specialist services have provided assessment and diagnosis, treatment plans are in place, support is available, and conditions are stabilised*.'[4]

Such an integrated service requires a GP workforce with the willingness and training to provide clinical care for opioid dependent people. GPs wanting to become authorised or gazetted are required to have a full knowledge of methadone treatment issues.[2]

National opioid treatment training programme

In 2000 a national opioid treatment training programme in primary health care was introduced in New Zealand as a strategy to recruit, train and support a primary health care workforce in the provision of methadone treatment. The aim of this paper is to describe the programme and outline an evaluation of its effectiveness following its first year of operation.

The programme is designed for general practitioners (GPs), practice nurses (PNs) and pharmacists providing methadone services in the primary health care setting. It is funded by a Ministry of Health (MOH) mental health directorate contract with Auckland Uniservices Ltd for the Goodfellow Unit to deliver the programme throughout New Zealand. Course attendance is free to all participants.

The training programme aims to enhance the knowledge, skills and attitudes of health professionals providing methadone treatment, in order for them to meet the specific needs of opioid dependent patients in the primary health care setting. In this way, GP prescribing of methadone occurs in an environment that reduces risk for patients, staff and the community. The programme was developed in full consultation with key stakeholders: specialist services providers, GPs, PNs, pharmacists and consumer groups, with the latter being actively involved from the outset.

The programme consists of attending a regional course and reading key literature in the training manual. The courses are held in the evening or weekends and are of eight hours' total duration. Table 1 outlines the programme content.

Table 1. Programme content

- Introduction: Why methadone treatment?
- Assessment/initiation of treatment stabilisation/restabilisation
- Public health issues relating to methadone treatment
- How the primary health care team can maximise treatment delivery
- Clinical practices
- The pharmacist as a member of the methadone treatment team
- The regulatory framework
- Review of treatment
- The challenges of methadone maintenance treatment

Table 2. Course evaluation tool summary

Course participants were asked to identify their profession (GP/Practice Nurse/ Pharmacist) and their regional location. A 5-point Likert scale (1 = V. Poor, 3 = Good, 5 = Excellent) sought feedback on the following questions:
1. Overall quality of Regional Course
2. Overall quality of course administration • Registration
3. Course content • Coverage of relevant issues • Usefulness for your practice
4. How could coverage of the course content be improved? • Issues you believe should be covered • Issues you believe should be left out
5. Overall presentation • Pace • Opportunity to interact with presenter
6. How could individual presentations be improved?
7. National Training Manual • Usefulness • Comments
8. Name the workshop you found most useful and give the main reason
9. Name the workshop you found least useful and give the main reason
10. Any further comments or suggestions you wish to share:
11. Would you be willing to assist us please with a future survey on programme outcomes?

The outcome from the programme for the participants is a formal, independent assessment of their knowledge of, attitudes towards and practices of opioid treatment in primary health care. The assessment involves, at the end of the course, a test containing 30 multiple choice questions of 20 minutes duration. For example, a knowledge-based question asks the half-life of methadone; a practise-based question deals with the management of a patient who in treatment is found to be hepatitis C antibody positive; and

a question testing attitudes asks whether a person who is opioid dependent can be trusted (with a 5-point Likert score from Disagree to Agree).

Participants' performance is assessed as satisfactory or not satisfactory. Participants need to pass to achieve recognition for continuing education points.

Initial evaluation of the programme

A written questionnaire was used to evaluate the programme after its first year of operation. The subjects of the evaluation were the GP, PN and pharmacist participants of the training programmes held throughout New Zealand in 2000. All participants were asked to complete an evaluation questionnaire at the end of their course, and return it to their course facilitator or by mail in a freepost envelope provided.

The evaluation questionnaire was developed by incorporating questions from a selection of questionnaires made available by relevant education providers (see Table 2). The participants were expected to complete the questionnaire within 20 minutes. It required them to rate statements using a 5-point Likert scale (ranging from 1 = very poor to 5 = excellent) and gave them an opportunity to provide comments. The questionnaire was piloted with a small representative sample for feasibility.

Data were collated and analysed using the statistical package SPSS. Univariate statistics were used to describe questionnaire responses. Differences by occupation were only reported where these were statistically significant ($p < 0.05$) and to demonstrate appropriateness of training delivery for the three groups of participants.

Out of a total of 212 participants who attended the 17 regional courses run in 2000, 148 returned their evaluation questionnaires (response rate of 70%). Table 3 lists the professions of the respondents and course attendees. There was no significant difference between the percentage of GPs attending the course and those who responded to the evaluation ($p = 0.86$).

Table 3. Responses to course evaluation

	Course attendees		Questionnaire respondents	
	Number	%	Number	%
GPs	83	39.2	60	40.6
PNs	37	17.4	19	12.8
Pharmacists	84	39.6	51	34.5
Other/missing	8	3.8	18	12.1
TOTAL	212	100	148	100

One hundred and forty-five (98%) participants reported that the overall quality of the course was good or better, and that relevant issues were, in general, covered. Some made suggestions on how to improve the course content. These included case studies and role plays, management of dual diagnosis and funding issues. Others identified a number of issues that did not need to be covered in as much depth (such as Hepatitis C and dispensing of methadone) or were not relevant to their own practice. The majority of the participants (111; 75%) rated the usefulness of the course content to their practice as 'very good' or 'excellent', although four GPs rated it as 'poor'. Similarly the course clarity and pace was generally rated highly, despite a minority of participants (12 GPs and one pharmacist) indicating that the pace of the course was 'poor'.

Barriers to primary health care workers providing opioid substitution treatment include lack of training; funding issues and prevailing attitudes

Two of the authors (AG and FG) read and re-read the collated responses and reached consensus regarding the main themes expressed. A recurring theme related to difficulties in designing a course relevant to the three different professional groups (GPs, PNs and pharmacists) with some material not equally applicable to all. While the value of the interdisciplinary team approach was acknowledged, a number of participants highlighted the problems inherent in presenting material for mixed audiences – either wanting more in-depth coverage of issues pertaining to their discipline, or resenting time given to issues not relevant to their own management role. One GP did not want to spend time on *'issues not specific to general practice. As a GP, there are many demands on time and consequently less relevant issues are a nuisance.'*

Another prominent theme pertained to the issue of funding. GPs lamented the failure to address the issue of transferring patients from a free specialist clinic to their GP for care: *'I see it as a shifting of a community-based non-fee-for-service to a GP-based fee-for-service, with a fee that will likely never get paid. These patients would be very hard work indeed – and, without reward to the GP (remuneration), fall into the 'too hard' basket of health care rationing'.* Several other GPs made similar comments about this issue: *'the ugly subject of funding the GP service.'*

Discussion

Barriers to primary health care workers providing opioid substitution treatment include lack of training; funding issues and prevailing attitudes. The multidisciplinary training programme aims to enhance the knowledge, skills and attitudes of health professionals in order to increase and improve their management of opioid dependent patients in the primary health care setting. Overall the training programme was well received from the GP, PN and pharmacist groups throughout New

Zealand. Key findings from the evaluation clearly demonstrate that the programme was considered valuable to the health providers who attended. Participant feedback suggests that ongoing training, including modules on specialised topics, would be worthwhile.

Comments were generally positive although there was some concern about the amount of information presented given the limited time available. The pace of courses was the only variable showing statistically significant differences by occupation. The difficulties associated with the varying relevance of the material presented could be addressed by splitting the mixed audience by professional group for some sessions, while retaining some combined sessions to augment the team approach, enhancing the PN role and actively involving the pharmacist as a member of the management team.

Participants' varied feedback indicated the need for follow up workshops, designed to maintain ongoing development, and updates in the speciality of treatment for opioid dependent patients. Some of the more specialised topics, for example detailed information on Hepatitis C, might be more suitably presented in depth at follow-up workshops.

A key issue highlighted by the evaluation is the cost to the patient of being transferred from the secondary to the primary sector. While one of the aims of the initiative is the more 'holistic management' of a patient provided by the GP and normalisation of treatment provided in primary care,[2] transferring patients from specialist services is also designed to free up waiting lists. In this regard it is recognised that opioid dependency is often a chronic relapsing condition and transferred patients may well require further specialist assessment and stabilisation in the future.

From a client perspective, patients are transferred from a free specialist service to their GP who will charge them a fee for a generalist service, plus they will have to pay the pharmacist for their methadone. This anomaly could influence patients' compliance with their treatment. Patient education and information, including the importance of their re-integration into primary health care services as an indicator of successful treatment, could help redress this issue.[5] However, an evaluation of community-based methadone services in Australia found that the majority of patients were satisfied with their programme and the services delivered by dispensing pharmacies and prescribing doctors.[6]

Some patients may destabilise and during this period not pay their GP bills. This lack of remuneration for GPs could limit the numbers of GPs who are prepared to undertake training and became authorised or gazetted. If the directive for transfer of stabilised patients to primary care services is to be adequately implemented, the MOH needs to review the funding issues inherent in this project. Specifically this review should involve specifically the level of funding needed to support general practice treatment for opioid dependent persons via remuneration or capitation.

The training programme also aimed to inform attitudinal change among practitioners towards opioid–dependent patients. A study of pharmacists found that positive attitudes correlated with improved provision of their methadone service, including methadone dispensing and supervision, needle exchange and health promotion services.[7] British studies indicate that GPs tend to view drug misusers as relatively difficult to manage, and that adequate training plus specialist service support can ameliorate this attitude.[8]

While the evaluation of this pilot programme indicates that this training in methadone maintenance treatment was well-received by primary health care providers, there is no benchmark with which to compare it. Formal research is needed to measure the effects of the programme and to assess whether increased practitioner knowledge and attitudinal change translates into better health care outcomes for patients.

Key points

- An estimated 13 500 to 26 000 people are opioid dependent in New Zealand, and this number is predicted to grow by 15% per annum.
- The service could be improved if the majority of patients, after initial registration and assessment at a specialist clinic, were cared for directly by GPs to whom the specialist clinic would provide highly accessible backup consultation.
- A key issue highlighted by the evaluation is the cost to the patient of being transferred from the secondary to the primary sector.

References

1. Sellman J, Hannifin J, Deering D, Borren P. Delivery of treatment for people with opioid dependence in New Zealand: Options and recommendations. Wellington: Ministry of Health; 1996.
2. Ministry of Health. Protocol for methadone maintenance treatment in New Zealand draft document. Wellington: Ministry of Health; 2001.
3. Ministry of Health. National protocol for methadone treatment in New Zealand. Ministry of Health: Wellington; 1996.
4. Mental Health Commission. Blueprint for Mental Health Services in New Zealand: How things need to be. Wellington: Mental Health Commission; 1998.
5. Bell J, Mattick R, Hall W. Chapter 4: Training health professionals to deliver methadone treatment. In: Ward J, editor. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic Publishers; 1998.
6. Ezard N, Lintzeris N, Odgers P, Koutroulis G, et al. An evaluation of community methadone services in Victoria, Australia: results of a client survey. Drug and Alcohol Review 1999; 18:417-423.
7. Matheson C, Bond CM, Mollison J. Attitudinal factors associated with community pharmacists' involvement in services for drug misusers. Addiction 1999; 94:1349-59.
8. Seivewright N. Chapter 6: Treatment of drug misuse in primary care. In: Community treatment of drug misuse: more than methadone. Cambridge: Cambridge University Press; 2000. p.167-175.